Non-suicidal self-injury: Suicide risk or social activity?

Cate Curtis
University of Waikato, Hamilton

Deliberate self-harm (DSH) has been conceptualised as indicative of mental illness, on a continuum ending with suicide. Recently our understanding of DSH has become more nuanced, with distinctions made between suicidal behaviour and non-suicidal self-injury (NSSI). Indeed, there is some evidence that NSSI may be consciously counter-suicidal. Moreover, NSSI appears to have recently increased markedly among young women. This research explores the motivations, meanings and functions of NSSI in young New Zealand women through 19 in-depth interviews. The results show that precursors range from serious anguish including suicidality, to purely social, with functions from the alleviation of distress to participation in a social activity. Often minimal physical or psychological harm is involved, either preceding NSSI, or as a result. Previous beliefs about the dynamics and the social contexts in which NSSI occurs are thus problematic, as are assumptions about the appropriate support. Though a potential indicator of mental ill-health, NSSI may be a harm-reduction technique, or a relatively normalised teenage activity within the peer group.

Key words: NSSI; self-harm; suicide

Deliberate self-harm (DSH) has been conceptualised as indicative of mental illness, often as a result of psychological trauma resulting from abuse, and on a continuum ending with suicide. Recently our understanding of DSH has become more nuanced, with distinctions made between suicidal behaviour and non-suicidal self-injury[1] (NSSI; for example, Curtis, 2016). Some literature continues to combine the two, arguing that risk factors, trajectories, and treatments are very similar (see Kapur, Cooper, O'Connor, & Hawton, 2013, for a brief overview and discussion of implications). Nonetheless, differences between those who engage in suicidal behaviour and NSSI exist; indeed there is some evidence that NSSI may be consciously counter-suicidal in some cases (e.g. Lang & Sharma-Patel, 2011; Wester & McKibben, 2016).

DSH in general is a significant issue in New Zealand, accounting for 3,031 hospital admissions in 2012 (Ministry of Health, 2015) – though it must be noted that the intention of these acts is not known. Aside from these hospitalisation rates, which are fairly stable, there is some evidence that NSSI and DSH is increasing (for an international discussion, see Nock, 2009). Locally, for example, findings from a community-based study of twenty-six year old New Zealanders indicated that approximately thirteen percent had ever engaged in self-harm behaviour (Nada-Raja, Skegg, Langley, Morrison, & Sowerby, 2004); a decade later, forty-eight percent of secondary school students surveyed in the Wellington region reported that they had engaged in NSSI at least once (Garisch & Wilson, 2015). While these studies are not directly comparable, one would expect the earlier study, conducted with an older age group and a broader definition (self-harm without consideration of intent), to have found a higher prevalence rate than the more recent one.

Arguably, DSH and NSSI are more common among young women; in New Zealand, women are hospitalised at nearly twice the rate of men (Ministry of Health, 2015). NSSI has been strongly linked to suicide in young women, such that it was seen as a precursor, and linked to serious mental illness and trauma (recent examples include Kim et al., 2015; Ougrin et al., 2012; Webermann, Myrick, Taylor, Chasson, & Brand, 2016), especially sexual abuse (Curtis, 2006; Nada-Raja & Skegg, 2011). However, as it has become relatively common there is a possibility of normalisation, such that it is engaged in by a broader range of people. Therefore assumptions about mental illness, abuse and other trauma may no longer hold true to the same extent. Further, as hospitalisation rates have not increased significantly, it would appear that the increase in DSH may be at the lower end of (physical) severity. The over-arching aim of the current study is to explore these assumptions and changes from the experiences of young women who engage in NSSI.

The following literature review will briefly discuss pertinent issues, focusing on material relevant to the findings of the current research. This includes links between suicide and NSSI; NSSI as a means of dealing with suicidality; links to abuse; and the normalisation of NSSI. Subsequent to this overview the current study will be discussed, commencing with the methods employed.

Links between suicide and NSSI

Many researchers have found that self-injury is a predictor of later suicide attempts (e.g. Andover, Morris, Wren, & Bruzzese, 2012; Asarnow et al., 2011; Hamza, Stewart, & Willoughby, 2012; Tang et al., 2011; Whitlock et al., 2013; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011). NSSI and suicide have many of the same risk factors. These factors include depression, hopelessness, impulsivity, diagnosed mental disorder, suicidal ideation, anhedonia, negative self-evaluations (Hamza et al., 2012; Kapur et al., 2013). A review

1 NSSI is usually defined as 'deliberately injuring oneself without suicidal intent'.

Sometimes 'and for purposes not socially sanctioned' is added.

of the literature by Hamza and colleagues (2012) focused on the link between NSSI and suicidal behaviours, including both longitudinal and cross-sectional studies, and found that NSSI is a robust predictor of suicidal ideation and behaviours. These links existed even after controlling for factors including age, gender, ethnicity and socioeconomic factors.

It has been argued that the highest correlating risk factor for suicide is suicidal ideation with NSSI, mediated by the frequency of NSSI and use of multiple types of NSSI (Grandclerc et al. 2016). Similarly, in a meta-analysis examining which risk factors for suicide are more predictive among self-harming individuals Victor and Klonsky (2014) found that frequency of NSSI behaviour and using various methods of NSSI were both moderate predictors of suicide, behind that of suicidal ideation.

In order to explain the link between NSSI and suicidality several models have been suggested. These include the gateway theory, the third variable theory, Joiner's theory of pain tolerance and capability for suicide (see Grandclerc, Labrouhe, Spodenkiewicz, Lachal, & Moro, 2016; and Hamza et al., 2012 for reviews) the experiential avoidance model (EAM; Chapman, Gratz, & Brown, 2006) and Curtis' (2016) cyclical model. The gateway theory is that NSSI and suicidal behaviour occur on a spectrum as different degrees of the same self-injurious behaviour (Brausch & Boone, 2015), and that NSSI may precede suicidal behaviour, with escalating NSSI behaviours leading to eventual suicidal behaviours. The third variable theory argues that a third variable links both NSSI and suicidal behaviour. This is based on evidence that NSSI and suicide have many of the same risk factors such as higher levels of psychosocial maladaptivity including depression, suicidal ideation and low self-esteem (Andover et al., 2012; Brausch & Boone, 2015). Joiner's theory of capability for suicide (Cooper et al., 2005) argues that individuals may become desensitised to pain and fear, and thus acquire the capability to commit suicide. This could occur through NSSI (or through other behaviours such as substance abuse; Van Orden, Witte, Gordon, Bender, & Joiner, 2008). The EAM proposes that NSSI functions primarily as a strategy to manage (through avoidance) unwanted emotions. Engaging in NSSI provides temporary relief from severe emotional distress and is self-reinforcing. Over time, NSSI becomes a conditioned response to negative emotions, in turn impeding the use of other means of emotion regulation (Chapman et al., 2006). Curtis' cyclical model includes aspects of all of these, arguing that NSSI is used as a means of dealing with severe emotional distress, typically depression or anxiety (accompanied by suicidal ideation in some cases), is found to be extremely effective initially and in some cases is consciously counter-suicidal. However, over time efficacy reduces and in some cases hopelessness sets in, resulting in a suicide attempt. A further cycle of self-harm may then occur.

Despite this linkage, a recent review of 172 longitudinal studies of self-injurious thoughts and behaviours (SITBs, including ideation, suicide attempts, NSSI and DSH in general), found that engagement in SITBs are significant risk factors for later engagement in suicidal thoughts and behaviours but that this risk was weaker than anticipated, only providing marginal improvement in diagnostic accuracy above chance. Both history of NSSI and prior attempts at suicide showed the most risk for later suicide attempt, but NSSI only increased odds to 0.013 (Ribeiro et al., 2016). Granclerc and colleagues' recent systematic review of the literature on the link between NSSI and suicidality in adolescents found that adolescents with a history of NSSI have fewer psychiatric symptoms and psychosocial dysfunctions than those who have engaged in suicidal behaviour (Grandclerc et al., 2016). Thus the argument for a self-harm continuum is not as strong as had been thought.

In addition, the function of NSSI frequently appears to be to deal with intense emotions, and therefore it may be counter-suicidal. Grandclerc et al. (2016), among others, describe NSSI as a way to relieve unbearable emotions, through seeking to modify rather than eliminate the state of consciousness. Although those who engage in NSSI may be more likely to engage in suicidal behaviour, Lang and Sharma-Patel (2011), Taylor and Ibañez (2015), Curtis (2016) and others argue that the assumption that self-injury is a *precursor* to suicidal behaviour has begun to be called into question, with evidence that many of those who self-injure do so in an effort to cope; therefore it may *delay* suicidality. That is, NSSI is 'non-suicidal' insofar as there is no suicidal intent at the time the injury occurs. However, the individual may be experiencing suicidal ideation.

NSSI as counter-suicidal

As mentioned, NSSI may be used as a way of dealing with suicidality. For example, Wester and McKibben's (2016) qualitative survey of experiences of self-injury among adults found that NSSI was described as a protective factor against suicide by many participant responses, as they used NSSI to deal with suicidal ideation. Thus NSSI could be considered counter-suicidal, as the intent is to relieve distress.

However, this link between NSSI and the deliberate alleviation of suicidal feelings is unclear, as in a qualitative study of adolescents who had either never self-harmed, had self-harmed once, or had engaged in self-harm multiple times, no clear link to suicidality could be determined (Klineberg, Kelly, Stansfeld, & Bhui, 2013). Of course, this could in part be attributable to the small sample size; 30.

Links between NSSI and sexual abuse and other trauma

In the current author's own research (Curtis, 2006, 2010, 2016) most participants spoke passionately about the key role that sexual abuse had played in their DSH. As discussed in a review of the research by Lang and Sharma-Patel (2011) there is support for a relationship between NSSI and abuse history. These authors argue that associations have been found between NSSI and maltreatment, with consistent associations found for child sexual abuse and NSSI, and NSSI and child physical abuse, though findings for NSSI and neglect are less conclusive. However, many of the studies were cross-sectional making determining causality difficult.

A meta-analysis of correlates among those engaging in NSSI found that a history of sexual and physical abuse displayed small or negligible associations, despite being frequently cited in the literature as a risk factor (Victor & Klonsky, 2014). In a

more recent review, Smith, Kouros and Meuret (2014) assert that the research on the link between trauma and NSSI is inconsistent and inconclusive, and that trauma symptoms, such as on-going depression, intrusive thoughts and memories, rather than the experience of a traumatic event per se, underlie the relationship wherein NSSI is a coping mechanism to deal with such symptoms. Thus, it appears that abuse alone will not necessarily result in NSSI, but rather the *impact* that the experience of abuse has on the individual is of primary importance.

Logically, it may also be the case that abuse was once a precipitating factor for the majority, but as the prevalence of NSSI has increased, this relationship has weakened. That is, one explanation for the lack of conclusive evidence of a relationship, especially in more recent studies, is that abuse history is no longer as common as it was among those who self-injure.

The normalisation of NSSI

Many adolescents know what NSSI is, and a majority will know of someone who has engaged in it (Purington & Whitlock, 2010). Taylor and Ibañez (2015) argue that self-injury may "gain some acceptance as a transitional coping strategy for those experiencing difficulties" (p.1007). Indeed, in some qualitative studies some participants who self-harm normalised the behaviour and thus did not want help (Curtis, 2010; Klineberg et al., 2013).

NSSI has been described as a social contagion (Jarvi, Jackson, Swenson, & Crawford, 2013; Wilkinson et al., 2011) and likened to a spreading disease; "like bacteria that result in disease, behaviours and attitudes are transmissible" (Purington & Whitlock, 2010, p. 11). Jarvi et al. (2013) conducted a review of the evidence for the social contagion of NSSI and cite evidence for individuals' affiliation with peers who also self-injure; that friend's NSSI preceded one's own, similar methods of self-injury used amongst friends, and of exposure to self-injurious behaviour and a subsequent increase in prevalence of NSSI.

NSSI appears to be normalised and more prevalent among some youth subcultures. Young, Sproeber, Groschwitz, Preiss and Plener (2014) found that those youths affiliated with an alternative subculture, such as emo, goth or punk were four to eight times more likely to self-harm than their peers, with around 50 percent engaging in NSSI and 20 per cent attempting suicide. This effect remained after adjusting for other confounders and risk factors such as socioeconomic status, substance use and victimisation. These youth endorsed many reasons to self-injure including regulating their emotions, as well as social reasons such as wanting to 'belong'. Le Cloux (2013) also argues that in some groups of adolescents self-injury may become 'normative because it is deviant' and used as a way to rebel.

Jarvi and colleagues (2013) also argue that behaviours including NSSI are disseminated and normalised in the media and note that reference to NSSI in media was rare before the 1980's, while Purington and Whitlock (2010) argue that NSSI behaviours are now common in the media, with many references to self-injury on the internet and in film and music. They further argue that the nature of the portrayals of NSSI also appear to have evolved, as prior to the1980's NSSI was "most commonly depicted as an indicator of mental illness and a harbinger of suicidality" (p.12), yet more recent portrayals of NSSI involve situations that are more common, such as the usual challenges of growing up, and using NSSI as a coping strategy.

Research aims

It appears that NSSI has evolved quite rapidly and has become increasingly common and to some extent normalised; therefore the relevance of previous associations with severe psychological distress and suicidality may be reduced. The aims of the current research included the exploration of NSSI from the point of view of young women who have engaged in it, in order to understand the context in which NSSI currently occurs and the functions and meanings they attribute to it. This exploratory research examines links to suicidality and severe distress at one extreme, and possible normalisation at the other.

Methods

This section details the methods used to recruit participants, describes their relevant demographic features and discusses the data collection methods and analysis. The research was approved by the School of Psychology Research and Ethics Committee, University of Waikato.

Recruitment

Participants were recruited using three methods:

1. through postings on relevant Facebook pages, which included a flyer advertising the research
2. flyers circulated electronically to psychology students
3. through the provision of flyers to social service agencies that work with young women.

The same flyer was used for all, briefly introducing the research. It included text numbers and an email address for interested people to make contact with the research team. Once contact was made, a more detailed information sheet was provided, with an invitation to make contact again to either have a discussion about the research (if that was the potential participant's preference) or to arrange an interview time, at a place and time convenient to both the researcher and participant. The information sheet also included a list of support services and urged participants to carefully consider their involvement due to the potential for distress in discussing what may be a sensitive topic. These points were reiterated before interviews commenced as part of the informed consent process.

Participants

The participants were 19 women aged 16 to 25 years (inclusive); the most common age was 19 (six participants). They were all resident in either Auckland, Hamilton or Whangarei at the time of the interview. Twelve of the participants were of European descent or described their ethnicity as 'kiwi', New Zealander or Pakeha; three identified as Maori, two middle-Eastern and one each identified as Indian

and African[2] .

With regard to education, employment and socio-economic status, three had secondary education only, twelve were current undergraduate students, three had completed an undergraduate degree (and all of these were currently engaged in postgraduate study) and one had completed a polytechnic qualification. Eleven described themselves as full-time students, six were employed (though some of these were also studying), one was a full-time mother, one unemployed, and one neither working nor studying due to pregnancy. Socio-economic status was mixed and in some cases had changed. For example, one described a privileged background but now being "poor" while studying, another described a childhood in which there was sometimes not enough to eat and in comparison considers herself to be well-off, working as a retail assistant.

Most considered that they had been diagnosed with a mental illness (though exactly what that entailed varied; some had had medication such as anti-depressants prescribed by a general practitioner, others had been described as depressed by a counsellor; a few had been formally diagnosed by a psychiatrist or psychologist). Nine had not had a diagnosis applied to them, although most used the term 'depressed' or 'anxious' to describe themselves[3] . Seven discussed a history of depression, five referred to anxiety, two described an eating disorder, one had experienced post-natal depression although her self-injury had initially been linked to anxiety, and one discussed substance addiction. Several had experienced more than one of these.

Most had ceased engaging in NSSI, but two had recently had what they termed a 'relapse' after an extended period without NSSI and one did not consider it necessary to cease NSSI.

Data Collection

Data collection was conducted via in-depth interviews. Although participants were offered the opportunity to take part in a follow-up interview if they wished to elaborate, as it happened every participant took part in one interview only. The amount of time involved varied from three-quarters of an hour to one and a half hours; the average was a little over one hour. The interviews were largely unstructured. As noted above, participants volunteered as a result of having seen recruitment information which gave an overview of the research, and were then provided with a more comprehensive information sheet. The aims of the research were reiterated verbally before interviews began and the participants were given the opportunity to ask questions. Interviews began with an open question such as, 'When you saw the research flyer, what made you volunteer?' or 'As you know, this research is about self-injury. Perhaps we could begin with what you know about that?'. From this point, with some variation, participants usually commenced talking about their experiences, with the researchers' role largely being one of seeking clarification as necessary, ensuring that key sub-topics such as precipitating factors and suicidality were addressed, and checking that the participant felt that everything relevant had been covered.

Data Analysis

Thematic analysis of the transcribed interviews was undertaken (Labouliere, Kleinman, & Gould, 2015; Michelmore & Hindley, 2012). Initial coding of the data took place as interviews were completed, and concept diagrams were developed alongside preliminary notes. Theories were developed by an iterative process of re-reading transcripts and subsequent modification of concept diagrams and notes.

Findings

In this section the key findings of the research are discussed. These include material on the links between NSSI and suicide in general; the evidence for and against the existence of a self-harm continuum; the deliberate engagement in NSSI as a counter-suicidal measure; the relationship between abuse and NSSI; and the normalisation of SSI, including in friendship groups and via the media.

Links between NSSI and Suicide

As discussed above, a large amount of research has found a link between NSSI and suicide, with NSSI being a possible precursor (e.g. Nock, Joiner Jr, Gordon, Lloyd-Richardson, & Prinstein, 2006, found that 70% of adolescents who engaged in NSSI reported a suicide attempt and 55% reported multiple attempts). Recent research has queried this, asserting that this link is not as strong as had been believed. The current research may support the latter argument, as although all had engaged in NSSI many participants had not been suicidal, and only four of the 19 had made a suicide attempt and describe NSSI as a way of coping with suicidal ideation. These four clearly articulated the links and differences. For example, Aroha[4] discussed NSSI as both a means of coping with distress and a 'cry for help' when suicidal:

> "After my mother died, I would think about suicide all the time… [NSSI] was a coping mechanism. And it's a way of saying 'Yeah I'm harming myself. Are you going to help me?'".

Claire also described NSSI as a form of emotional regulation (a common finding in recent literature, though precise functions require clarification. See, e.g. McKenzie & Gross, 2014):

> "In my first year of high school I made my first suicide attempt. I made three attempts all together, though what I really wanted was to get rid of the [emotional] pain. I got into self-harm[5] when I moved schools at 14; a couple of friends did it. Cutting provides a physical pain to deal with the emotional, the suicidal – it takes your full attention".

Participants who had been suicidal and engaged in NSSI were able to clearly differentiate between the behaviours, in contrast to research that suggests that most people who

2 Despite being asked about their ethnicity, apart from the three Maori participants almost all volunteered their nationality, at least at first.

3 This willingness to use such terms was somewhat surprising given earlier research about the stigma of mental illness.

4 The names given are pseudonyms.

5 Although it was made clear before commencing interviews that a key area of interest was non-suicidal self-injury, all participants used the term 'self-harm' rather than NSSI. The context usually indicated that they were discussing NSSI and this was clarified if there was any doubt.

engage in DSH are unclear about the intended outcome. For example, Anna had this to say:

> "In terms of doctors and stuff, they take it [NSSI] out of proportion quite quickly and fly to 'Are you gonna kill yourself?' and it's like 'Whoa! No, not there!'.

Anna had engaged in NSSI and made suicide attempts, and was easily able to differentiate between the forms of self-harm that she engaged in. This also reflects the data provided by other participants who had engaged in both suicidal and non-suicidal behaviours (discussed further with regard to NSSI as a counter-suicidal act).

As discussed above, NSSI has often been conceptualised as a point on a self-harm continuum, but current evidence is mixed. Although only four of the participants in the current study had engaged in suicidal behaviour, several others discussed suicidal ideation.

Evidence for and against a self-harm continuum

Some participants spoke about NSSI as part of a continuum that has been considered typical. For example:

> At 14 I would get very on edge, very anxious and it just got worse to self-harm, suicidal thoughts and … my first suicide attempt…There was another girl who used to self-harm…having seen how she coped I kind of experimented with things …then it was cutting, it kind of progressed and it just became a need to feel physical pain instead of emotional pain and it was a slight relief for a short period of time and then of course you are left with both [emotional pain and a need for physical pain].
>
> Linda

This extract illustrates a progressive pattern of self-harm, commencing with NSSI to reduce anxiety, followed by suicidal ideation and behaviour. Further discussion revealed a pattern of increasingly severe NSSI, as it became less effective over time, culminating in a suicide attempt. Social transmission is also seen in the form of copying the NSSI of another.

In contrast, Kate spoke about suicidal ideation, and used NSSI as a way to cope with this; her self-harm never progressed to suicidal behaviour:

> "There would be times where I thought 'if things get really bad I could always off myself and then I wouldn't have to deal with it' but it was just kinda in the back of my mind. I never made a plan or anything."

Sandra initially identified self-injury as a step toward suicide, but found that it helped her to deal with her emotions (discussed further below):

> "I was super-suicidal at the time [of the first instance of NSSI] and I thought you had to build up to the point where you finally killed yourself, so self-harming was the step up into doing that. Like you do self-harm then you plan and then you kill yourself".

Thus, NSSI served as a means of retreating from suicidality, rather than a step towards it.

Natalie, an immigrant, adds a cultural dimension to her discussion of DSH:

> "I've thought about it but never gotten a plan together… People make the jump that if you self-harm you're automatically going to be suicidal and make an attempt …you can live with the idea for years and never make that attempt… I have a close friend who attempted suicide and I've talked to him about it. We are similar [African] cultures and the cultural thing about, you don't commit suicide if you're a migrant person. That's the thing kiwis do. It's their way, not ours".

Thus the relationship between NSSI and suicidality appears complex and evolving. While some participants did experience suicidal ideation, and a small number made suicide attempts, they were clearly in the minority. Less than a quarter had engaged in suicidal behaviour, and less than half the participants (seven, including those who made suicide attempts, of a total of 19) discussed suicidal ideation, adding further evidence to research that suggests that the notion of a continuum is not (or no longer) fully justified. Of the small number who had engaged in suicidal and non-suicidal behaviour, there largely appeared to be movement between the two types of behaviour rather than a linear trajectory. Further, all the participants who had experienced suicidal ideation considered NSSI to be a way of dealing with this. This provides some support for the EAM (Chapman et al., 2006) and Curtis' (2016) cyclical model of self-harm.

NSSI as counter-suicidal

As mentioned in the quote from Claire above, engaging in NSSI was sometimes a conscious decision to deal with suicidal ideation. She elaborated:

> "Initially after cutting I'd just feel blank, nothing. It was therapeutic, and stopped me thinking about suicide, for a while. But I'd need to do it more often, I'd still be feeling suicidal, and would plan it, quite detailed plans, but there'd always be a reason to put it off. So when self-harm wasn't working so well I stopped eating to get an extra feeling, of being hungry. Another distraction".

Linda and Anna expressed similar views:

> "[Parents] don't see how self-harm was beneficial to me or to other people, didn't see how that was a coping mechanism at all. [Stopping NSSI] was incredibly difficult. I did still have suicidal thoughts and tendencies. It's almost like an itch, it's like 'this is helping me. You are stopping something that's helping me from being self-destructive even more'".
>
> "It was a coping mechanism…It kept me in control; instead of committing suicide I'm gonna hurt myself… I've had [suicidal thoughts] quite a lot, [NSSI] was always to do something else to not get to that point [of making a suicide attempt]…I've definitely sat there and worked out how many of which pills I should take…"

However, many participants did not see a suicidal element to their NSSI at all. Kelly was shocked by the assumed link to suicidality:

> "I remember my Mum seeing my arms and saying 'just go outside and slit ya fucking wrists if you think life is that bad'. I was horrified because that was not what I was doing at all. Why would you say that?".

As will be discussed below, Kelly's attitude is that NSSI is a useful coping mechanism for dealing with normal anxiety

and depression and may be unrelated to suicidality. However, where there is a history of abuse, it may be the case that NSSI is more severe and therefore raises the question of whether suicide risk is increased for this group.

Links to abuse and trauma

In contrast to some earlier research, as discussed above, relatively few participants mentioned a history of abuse (a few more did refer to bullying at school). Aroha discussed her abuse history and also considered that abuse was a factor for friends:

> "Quite a few friends did self-harm. A lot of my friends had problems with people that had touched them. They hated themselves, [NSSI] was their way of coping… I hated that I couldn't stop things from happening [to me]. And I thought if I can't get rid of him, I might as well get rid of myself because otherwise it's gonna continue happening".

Aroha found that NSSI was a way of coping with ongoing sexual abuse and also linked abuse to suicidal thoughts. Jane's description, with themes of sexual abuse leading to suicidal ideation, dealt with by NSSI in order to gain a sense of control, fits perfectly with some earlier models of NSSI (such as that of Curtis 2006):

> [My father] would end up lashing out and the other major factor was sexual abuse when I was seven. …. after moving out of home I started having very strong intrusive thoughts about killing myself, hurting myself. It wasn't too long after that that I started cutting. I'd had friends who'd self-harmed; I think that's what really popped the idea into my head… As it goes on it gets deeper and deeper because it's never quite enough… it's going 'I just want to feel better…I want to feel like I can fix something'. Having that control to be able to go, I can put a bandage and feel like I'm fixing.

In this account, Jane also reiterated the theme of NSSI as counter-suicidal. Gail discussed a similar trajectory:

> I was abused by my uncle when I was 10 and I went through this really hard stage. I was cutting, I was suicidal, I was taking pills…I don't know where I got the idea [to cut] from… I guess I just tried it one time to calm down and it worked…I couldn't manage what was happening…somehow watching the blood was calming and I guess it made me feel good to know that I could manage that, that I'm strong because I can handle that pain.

For these young women sexual abuse was an important factor in their DSH. However, the majority did not indicate that they had a history of abuse.

The normalisation of NSSI

Most participants were aware of NSSI by others, usually school-mates (as is included in some of the quotes above), though some mentioned 'stumbling across' NSSI on the internet. The degree to which NSSI was considered normal varied. Kelly and Sandra saw NSSI to generally be unproblematic:

> "I think people should be allowed to do it…I don't think healthcare, psychologists, should be deterring people away from it if they can honestly say it helps them. Maybe they could just be taught ways of keeping safe [harm reduction such as ensuring knives are clean]. It's not a bad thing to have something for yourself that helps. Let's try and accept everything".
>
> "I haven't self-harmed in a really long time because it doesn't work anymore. It's really hard because clinicians have a very strong 'no self-harm' bias, but I personally think that it's useful. I don't *like* seeing other people self-harm but I know it's useful".

Although Kelly and Sandra were in the minority with their pro-NSSI stance, several other participants felt that the abhorrence parents, teachers and health professionals express is excessive. While they acknowledged that it was preferable not to self-injure (e.g. due to potential scarring and the distress evoked in others), it was generally considered a useful coping mechanism and that others' reactions were due to a lack of understanding.

NSSI within social groups

Many participants knew of people who engaged in NSSI, especially at school, although the age, form and function did vary. For example, Kate discusses a low-level form of causing oneself pain as part of a game:

> "I remember at intermediate people where they would get the prickly side of Velcro, it was like a game to see who had the highest pain tolerance as you scraped it along your arm and whoever lasted the longest would win. And they did it to me and I lasted for ages. I think I liked doing it because I felt like I had some level of control. And I just took that idea and ran with it…"

Whether this qualifies as NSSI is debatable. However, for Kate, it was the starting point for more serious injury. Behaviour that would be considered NSSI was also common at her secondary school:

> "[Cutting] was very normal. I went to an all-girls school, it was quite widespread and people would kinda talk about it a lot…It was really casual. I was doing it because I was anxious, I think they would do it so – I dunno – they would do tiny wee scratches on their arm and show everyone and I thought that was really weird. I didn't want anyone to know but they were really open about it".

Many participants spoke about minor NSSI that was clearly 'the thing to do' rather than a signifier of distress, as further illustrated by the following quotes from Laura, Nicola and Catherine:

> "In my year there was a group, they would cut themselves on their arms and they'd just be like 'Mine is better than your's'. I don't think they understood that there is something [psychologically] deeper than that".
>
> "[At intermediate] with your friends you'd carve their initials into your hand and that sort of thing was really, really normal and it was cool… it was only when our parents noticed that we realised that this wasn't something that everybody did".

> Catherine: I cut myself once when I was twelve. All my friends were doing it. I don't know why they were… maybe because everyone else was. They were just depressed I think, not sure what about though. We all just cut ourselves a bit, but it wasn't even that deep…It's just silly things you do when you're a kid. It was a phase, real big for a while…I think maybe emo culture got big".

The relationship between NSSI and 'emo culture' was a common theme:

> "It was something that everyone spoke about and it was like the whole emo phase…all the emo stuff everywhere…I regret it because it wasn't really a true reflection of me, it was just kind of the culture at my school and just being an impulsive dumb teenager"Delia

Carla also discussed NSSI as part of the emo sub-culture, but also affecting others whom she met as part of a support group:

> "Most of the girls were the popular girls – I was so surprised - as well as the emo girls".

The level of distress participants experienced was varied and sometimes, at least initially, seemed to be little more than the normal stresses and conflicts of adolescence.

> Alice: It was year seven, my friends did it, that's what gave me the idea. I didn't know anything about self-harm. The girls in my class had these big cuts on their arms and I was thinking 'What does it mean'? I asked one, and she said 'That's for pain, if you feel pain you cut yourself and you don't feel it any more'…So I tried it …and it was very much to belong. It just becomes normal. All sit there at lunchtime and cut your thighs and talk about how your life sucks…like 'My problem is this'. 'Oh well, mine is this and it's worse than your's'. It just turned into this big competition … We were so wrapped up in our weird little issues.

Caitlyn also discussed the transmission of NSSI in a competitive manner:

> I had this friend, Angela, she had severe depression. I tried to get help [for her], but I ended up getting depressed too, it escalated really quickly. She tried to commit suicide a few times and I'd always been, I guess, an anxious person and it got much worse and that also made me depressed. So Ange was self-harming, she got it from an old friend who sent her snapchats of her cutting and challenged her to do better. Ange thought it might help. So I tried it too.

However, this social element was certainly not a consistent theme. Other participants spoke about a desire for secrecy:

> "A few of my friends in high school, I knew they self-harmed but we didn't talk about it. We all knew who did it but it wasn't accepted [that you mentioned it]… Even now [with current friends], I'm like 'I don't actually need to know this. If you want to get help go get help, or don't'. They know I self-harm or have self-harmed but we don't really talk about it because it tends to dramatise it". Anna

Some participants felt that NSSI was unhelpful and potentially problematic:

> "I started realising that it wasn't quite normal and I sort of distanced myself from that group. Because they've got unhealthy behaviours and it doesn't help me get better when I'm around people who think of it as normal and casual and ok". Kate

Laura engaged in an insightful discussion about the differences in social groups and the potential ramifications of associating with them:

> I had some friends that did it and in their group it was normal. They glorified it, the way they talked about it and I didn't feel it was this great, this cool thing … I didn't spend a lot of time with them. But my normal group of friends, when they talked about kids that cut I'd be like 'yeah that's weird'. Even with the group of friends that did cut, I didn't talk to them about my cutting. I knew it was a maladaptive way of coping. …I didn't want to be put into that box of 'She is one of those kids who has issues'…and I didn't know how to explain. I also didn't want to be in with kids that thought it was cool. So best not to tell anyone.

Overall, NSSI was quite common during the secondary school years and often seen as normal at the time, especially within some sub-cultures. However, attitudes were mixed across groups, and even within participants, with some discussing their internal conflicts around identification with groups engaging in NSSI, yet feeling uncomfortable about this and finding it necessary to hide their NSSI from other social groups. The transmission or dissemination of NSSI was not confined to 'real life' groups, as touched on above.

The transmission of NSSI via social media

Though not as common as via groups of friends, several participants spoke about learning of NSSI through the media, such as in these quotes:

> I went online … [and] I found other people who were talking about how I was feeling. I wouldn't say depression, but … And they were talking about cutting and how this helps and I thought that was a strange thing. But then one day I was so down, I figured anything would be better than how I'm feeling… it made me feel a part of that community. Natalie

> "Social media has made more things acceptable in sharing stuff about yourself you normally wouldn't. Some people like to air everything…". Linda

Dinah discussed a group of friends who were proud of their NSSI and transmitted images via social media, although other friends did not approve:

> "They'd roll up their sleeves and walk around…I had some friends who thought it was stupid but I had the few who thought it was cool and they'd post photos of it…"

Thus (in accordance with recent research by Jarvi et al., 2013; Klineberg et al., 2013; Taylor & Ibañez, 2015), NSSI had a social element for many.

Overall, a range of attitudes towards and functions of NSSI was in evidence, ranging from a perception of it as a socially acceptable thing to do – indeed, an element of peer pressure was apparent – with little, if any, relationship to distress, through to an indication of suicidality.

Conclusion

It appears that NSSI has evolved over the last decade and has become increasingly common and to some extent normalised. That is, whereas NSSI used to be strongly linked to suicide in young women, such that it was seen as a precursor, and linked to serious mental illness and/or trauma, especially sexual abuse, it has become prevalent to the extent that those assumptions no longer hold true to the same degree.

The range of attitudes to NSSI held by the young women who took part in this research were wide-ranging, from it being a "cool" or "normal" thing to do, displayed in person and online, to a "weird" thing, to be kept hidden. Similarly, the functions of NSSI varied, from it being a means to fit in with a peer group to a way of dealing with suicidal ideation. Some participants discussed tensions in crossing boundaries between groups, where their peer community had groups with opposing views of the acceptability of NSSI, and tensions within themselves when they felt uncomfortable with their own NSSI yet had friends who considered it acceptable, even desirable.

Links to severe distress remain, as do links to abuse; however, they appear considerably weaker than had previously been thought. In addition, these findings suggest that assumptions about NSSI as a precursor to suicidal behaviour are inaccurate in many cases. As the prevalence of NSSI has increased, so have the range of motivations and precipitating factors, and subsequently the psychological severity appears to have lessened. Further, participants experiencing suicidality considered NSSI to be counter-suicidal and they expressed concern at being urged to cease this behaviour. Clearly this has implications for treatment.

While further research is required to confirm these findings, this study suggests a need to reframe current understandings of NSSI. In the (minority) of cases in which NSSI was linked to suicidality, it appeared to play a counter-suicidal role. For many, NSSI was of relatively minor import, denoting little in the way of psychological distress beyond the usual stresses of adolescence. Nonetheless, the development of other coping mechanisms and/or means of emotion regulation is likely to be useful, including to reduce the concern of others, the possible need for medical treatment and subsequent regret over scarring. However, the social element present in some cases may act as a barrier to help-seeking and treatment.

Limitations

The main limitation of this research is the relatively small sample size, which means that no claims about representation can be made. However, given the depth of the data – such as many lengthy and complex discussions of a social element, and relatively few links to suicidality - plus some similar initial results in other recent research (as discussed above), these areas certainly seem worthy of further investigation. This research does provide an in-depth understanding of some specific aspects of the NSSI phenomenon, and the aims of the current research - the exploration of NSSI from the point of view of young women who have engaged in it - were realised.

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Correspondencing Author

Cate Curtis
School of Psychology,
University of Waikato
Private Bag 3105,
North Shore
Hamilton
New Zealand
Email: ccurtis@waikato.ac.nz