NON-SUICIDAL SELF-INJURY AMONG ADOLESCENTS AND YOUNG ADULTS: EXPLORING THE TYPES AND UNDERSTANDING OF TRIGGERS AND FUNCTIONS

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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 food intake and other 'risk-taking' behaviors such as driving at high speeds and having unsafe sex. The current study attempts to comprehend the types and cause or reasons of persons who intentionally harm themselves. The aim of the study was to understand the nature of Non-Suicidal Self-Injury by exploring the different types and understanding the functions NSSI serves. A detailed and thorough review of the literature was done. 80 adolescents/young-adults were selected from the normal population first, and only the participants (N=40) engaging in self-harm were selected for further investigation .Inventory of statements about Self-Injury was given to the participants and the types and functions of self-harm behaviors were identified. The results show that the major types of Self-Harm identified were: Cutting, Biting, Pulling Hair, Pinching and Banging and Hitting Self. The study also highlighted the functions that DSH/NSSI serves. The major functions explored were: Affect-Regulation, Self-Punishment, Interpersonal Boundaries, Marking Distress, Autonomy and Anti-Dissociation and Feeling Generation etc.

Keywords: Non-Suicidal Self Injury/Deliberate Self-Harm, Affect-Regulation, Anti-Dissociation, Self-Punishment.

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INTRODUCTION:

NSSI as mentioned in DSM-5-TR (2022) is- "In the last year the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising or pain, with the expectation that the injury will lead to only minor or moderate physical harm". The individual engages in the self-injurious behavior with one or more of the following expectations: To obtain relief from a negative feeling or cognitive state, to resolve an interpersonal difficulty or to induce a positive feeling state. 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 hitting oneself, and intentional drug overdose. They may also include limiting 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.

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. 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. Being trapped in the situation, they believe that the only way to escape is by putting an end to their life. Self-harm is a common clinical problem, but it is poorly understood. Individuals at risk for self-harm often report experiencing chronic emptiness, alienation, and isolation in combination with intense, overwhelming negative emotions (Connors, 1996; Favazza & Conterio, 1988, 1989; Leibenluft, Gardner, & Cowdry, 1987). However, although some of the consequences of self-harm behavior are negatively reinforcing (e.g., the reduction in tension that follows; Haines, Williams, Brain, & Wilson, 1995), others may inadvertently increase the emotional pain and isolation of the self-harming individual. Moreover, the shame, guilt, and regret that often follow an act of self-harm may exacerbate the negative emotional arousal of the individual, as well as increase the likelihood of further isolation (Leibenluft et al., 1987). The negative physical consequences of self-harm (e.g., scars) may also result in shame, necessitate greater isolation from others, or both (Favazza, 1989). In the current literature, several models have been proposed to outline why individuals engage in deliberate self-harm and each model describes deliberate self-harm as an attempt to cope with intense emotional states.

We planned to conduct this study because people have trouble seeking help due to the stigma associated with self injury and the lack of a clear grasp of the notion. Self-harm is not a topic that has been extensively studied or discussed in the Indian context. Alarmingly, self-harm instances are on the rise.

Methodology

Aim: To understand the nature of Non-Suicidal Self-Injury by exploring the different types and understanding the functions NSSI serves. The lack of clear understanding regarding self-harm among adolescents and young adults led us to plan this study.

Research Questions:

- What is Non-Suicidal self-injury behavior?
- What personality traits are most prevalent in people with deliberate self-harm?
- What functions does the Non-Suicidal self-injury behavior serve?

Sample: The study used a mixed method approach, and targeted 80 adolescents and young adults, and (N=40) participants who were doing self-harm (age range of 13-30 years) were selected using a purposive sampling method from the general population .

Procedure: 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 parental consent was taken 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.

Tools:

Inventory of statements about Self-Injury

The Inventory of statements about Self-Injury (Klonsky et.al.,2009) 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).

Inventory of statements about Self-Injury was given to the participants and the functions of self-harm behaviors were identified and analyzed.

Results and Findings

Table 1: *Data showing number of participants who experience pain following the administration of Non-Suicidal Self-Injury/Self-Harm*

PHYSICAL PAIN	No. of Participants	Percentage
Yes	15	42.85%
Sometimes	10	28.57%
No	10	28.57%

The result table shows that 15 people experienced physical pain following the administration of self-injury but most of the participants denied the presence of physical pain after harming themselves.

Table 2: *Data showing how many participants were alone while inflicting self-harm*

ALONE	No. of Participants	Percentage
Yes	18	51.42%
Sometimes	13	37.14%
No	4	11.42%

The result table shows that the majority of participants who harmed themselves were alone when they attempted self-injury. 18 participants reported being alone and 13 reported being alone sometimes whenever they experienced an urge/impulse to harm themselves.

Table 3: Data showing the amount of time lapsed from experiencing the urge/impulse to inflicting self-harm

Time Lapsed	No. of Participants	Percentage
<1 hour	22	62.85%
1-3 hours	1	2.85%
3-6 hours	0	0

6-12 hours	1	2.85%
12-24 hours	2	5.71%
>1 day	9	25.71%

The result table shows that the majority of participants had difficulties with self-control and acted on their impulses quickly. 22 participants reported the time gap between the impulse and attempt to be less than 1 hour.

Table 4: *Data showing the desire to stop Self-Harm for study participants*

Desire To Stop	No. of Participants	Percentage
Yes	33	94.28%
No	2	5.71%

The result findings show that almost all the participants have a desire to end the deliberate self-harm acts, and only 2 participants denied the desire to stop the acts.

Table 5: *Data showing the functions NSSI/DSH serves for various participants as per Inventory of statements about Self-Injury*

Functions	No. of Participants	Participants with high scores	Percentage
Affect Regulation	29	22	82.85%
Interpersonal Boundaries	25	6	71.42%
Self-Punishment	29	14	82.85%
Self-Care	24	5	68.57%
Anti-Dissociation /Feeling Generation	25	3	71.42%
Anti-Suicide	23	9	65.71%
Sensation-Seeking	16	0	0
Peer-Bonding	16	3	45.71%
Interpersonal Influence	20	4	57.14%
Toughness	23	7	65.71%
Marking Distress	25	5	71.42%
Revenge	10	1	28.57%
Autonomy	26	7	74.28%

The result findings show that the participants engage in Non-Suicidal Self-injury or Deliberate Self-Harm due to various reasons. Affect Regulation, Interpersonal Boundaries, Marking Distress, Anti-Dissociation/ Feeling Generation, Autonomy and Self-Punishment were the highly endorsed reasons for self-harm.

Table 6: *Data showing the different forms of NSSI/DSH identified by our study participants as per Inventory of statements about Self-Injury*

Types of Self-Harm	No. of Participants	Percentage
Cutting	13	37.14%
Biting	16	45.71%
Burning	3	8.57%

Carving	1	2.87%
Pinching	15	42.85%
Pulling Hair	13	37.14%
Severe Scratching	9	25.71%
Banging or Hitting Self	21	60%
Interfere w/Wound	11	31.42%
Rubbing Against Rough Surface	6	17.14%
Sticking Self w/Needles	2	5.71%
Swallowing Dangerous Substances	4	11.42%
Other	7	20%

The result table shows the different forms of Self-Harm behaviors used by the study participants. Cutting, Biting, Pinching, Pulling Hair and Banging and Hitting Self were the main forms of self-harm identified by the participants.

Table 7: *Data showing the other forms of self-harm identified by the study participants*

OTHER FORMS IDENTIFIED
Disordered Eating
Slapping
Choke On
Unsafe Sex/Multiple sexual partners
Excessive Porn Viewing

The result table shows the other forms of Deliberate Self-Harm identified by the participants. Disordered Eating and Unsafe Sex/Multiple sexual partners were the most frequently reported alternatives.

Discussion

Non-suicidal self-injury is the deliberate destruction of body tissue in the absence of any intent to die and occurs for purposes that are not socially sanctioned . Deliberate self-harm behaviors most commonly include cutting, scratching or hitting oneself, and intentional drug overdose. They may also include limiting food intake and other 'risk-taking' behaviors such as driving at high speeds and having unsafe sex. Despite this recent increase in interest, there are few empirical studies on the behavior of adolescents in community samples who self-harm in Indian context. In fact, an important caveat that underlies much of the work on adolescent self-harm is that it has been undertaken primarily with psychiatric samples, making it doubtful that the findings can be generalized to nonclinical samples of adolescents. The study's main goal was to comprehend how participants themselves understood self-harm and what they considered to be "self-harming behavior." and understanding the "whys". It's interesting to note that adolescents and young adults not only reported behaviors that have been repeated in earlier studies, including biting, cutting, and recklessness, but some also said they viewed disordered eating, unsafe sex and substance abuse to be forms of self-harm.

The results showed that 15 participants experienced physical pain following the administration of self-injury but most of the participants denied the presence of physical pain after harming themselves (Table 1). One of self-harm's principal purposes appears to be to provide relief from unpleasant mental states (Kirtley et.al., 2016). Furthermore, according to Gratz's research from 2003, those who participate in

non-suicidal self-injury (NSSI) believe that it serves as a way to externalise mental distress by turning it into a tangible physical sensation. The topic of whether those who self-harm may have a different pain threshold and tolerance arises since self-harm appears to bypass the "safety-catch," the innate system that encourages the avoidance of potentially painful experiences . The physical pain provided by DSH may serve to distract the individual from emotional distress – an emotion regulation strategy regarded as particularly difficult for individuals with borderline traits and related behaviors such as DSH (Tantam & Huband, 2009).

The majority of our study participants who harmed themselves were alone when they attempted self-injury. 18 participants reported being alone and 13 reported being alone sometimes whenever they experienced an urge/impulse to harm themselves (Table 2). The findings are contrary to the common perception that people harm themselves to grab attention. Participants reported an inability to communicate their emotional hurt to people. As they become more and more involved with their substance, or behavior (loneliness or isolation), those who are struggling with a desire to harm recurrently find themselves cut off from their connections. When they were actively self-harming, they frequently experienced isolation because they would put up barriers between themselves and others around them. Some people claimed that they felt alone and unable to confide in others or communicate their difficulties, and that this made them more motivated to damage themselves. It's possible that the sentiments of loneliness were present before self-harming or that they were brought on by the withdrawal that follows.

The majority of participants had difficulties with self-control and acted on their impulses quickly. 22 participants reported the time gap between the impulse and attempt to be less than 1 hour (Table 3). Impulsivity is considered a possible phenotype underlying the expression of self-harm and suicidal behavior (McHugh and colleagues,2019). Another study by Rawlings and colleagues (2015) showed association between trait affective impulsivity and self-harm behavior.

The findings also show that almost all the participants have a desire to end the deliberate self-harm acts, and only 2 participants denied the desire to stop the acts (Table 4). Most of the participants felt that if they had appropriate resources or skills to reduce the occurrence of self-harm they would feel better. Only 2 participants showed an active desire to continue the act as it was physically gratifying and it gave them an opportunity to avoid the deep emotional turmoil. The major reasons identified by participants for self-harm are: Affect Regulation, Self-Punishment, Interpersonal Boundaries, Marking Distress, Autonomy and Anti-Dissociation/Feeling Generation (Table 5).

The result also led us to a discovery that many adolescents and young adults used self-harming as a way to punish themselves. Klonsky's (2007) study on the reasons behind self-harm highlighted the role of self-punishment. In another community sample Laye-Gindhu and colleagues (2005) identified self-punishment reasons, where more than 70 percent endorsed the reason "I did not like myself", and others selected "I

felt like a failure", and "I was angry at myself". These study findings align with the reasons given by our study participants as most of them reported they are "punishing themselves", "expressing anger towards themselves for being worthless or stupid" , and "self harm as a way of reacting to feeling unhappy with myself or disgusted with myself". The results indicate participants suffering because of low perceptions of themselves.

Dysfunctional emotion regulation, which has been defined as an impaired capacity to flexibly and adaptively modulate the intensity and duration of emotional states and to control impulsive behaviors when distressed in order to facilitate engagement in non-mood dependent goal-directed activities, plays a key role in the development and maintenance of self-harming behaviors. Self-Injury behavior in adolescents serves primarily to regulate dysphoric affect and displays many addictive features, and those with clinically elevated levels of internalized anger appear at risk for more addictive features of this behavior (Nixon and colleagues,2002).

The elimination of undesired internal experiences, particularly emotional responses, serves to adversely reinforce DSH behavior. According to the Experiential Avoidance Model, people who engage in DSH have strong experiential avoidance responses or repertoires, which may be brought on by more intense emotional reactions, a reduced capacity for handling distress, deficiencies in the ability to regulate one's emotions, and/or challenges using alternative coping mechanisms when one's emotions are aroused. 71.42 % of our study participants endorsed anti-dissociation and feeling generation as the reasons for engaging in self-harm. "Causing pain so I'll stop feeling numb", "trying to feel something (as opposed to nothing) even if it is physical pain" and "making sure I'm still alive when I don't feel real" were the responses most identified on Inventory of statements about Self-Injury. The boundaries model of self-mutilation also provides an explanation. The perceived abandonment created intense emotions and it threatened to engulf the self of the individual, as the lack of boundaries led to them experiencing the loss of others as a loss of self; and this loss was combated by self mutilation. The boundaries model is rooted in the Object Relations theory as the patients were unable to adequately separate or individuate from others because of problems with the attachment style (Ness et.al., 2008).

The study participants indulged in different forms of Self-Harm behaviors. The results also highlight the fact that a significant number of study participants engage in more than one form of Self-Harm (Table 6). The major forms of Self-Harm on the basis of the participant's responses were : Cutting, Biting, Pinching, Pulling Hair and Banging and Hitting Self. They also reported the other forms of Deliberate Self-Harm: Disordered Eating and Unsafe Sex/Multiple sexual partners were the most frequently reported alternatives (Table 7).

CONCLUSION

These findings highlight the fact that for some adolescents and young adults, the behavior is an isolated incident in addition to highlighting how chronic and recurring the behavior is. This finding raises questions about why and how some individuals are able to quit harming themselves, as well as

how such young people may differ from those whose behavior is more difficult to control. And, given the prevalence of self-harm, health and mental health professionals should test adolescents and young adults for self-harming behavior more frequently. The people engaging in self-harm should also undergo screening for risk of suicide and the presence of additional dangerous or harmful behaviours. The present analysis concentrated on affect regulation , self-punishment, interpersonal boundaries, autonomy, marking distress and anti-dissociation/feeling generation as a driving force behind self-harm. External reinforcement (i.e., influencing others, being noticed) was also reported as an underlying motivator for the behavior, although less frequently. Misconceptions such as the belief that self-harm is merely attention-seeking have impeded the help-seeking of individuals struggling with self-harm and have no doubt led to much frustration. Different motivations may indicate different treatment approaches; it is important to understand the specific meanings, motivations, and functions of the behavior for each individual.

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