Not just a teenage phase

- functions of non-suicidal self-injury in adults

Maria Beijmo

2014

Student thesis, Bachelor degree, 15 HE
Social Work
Study programme in Social Work, Specialisation International Social Work

Supervisor: Tomas Boman
Examiner: Torbjörn Bildtgård
Abstract

The aim of this study was to investigate how adults 25 years old and over describe the functions of their non-suicidal self-injury (NSSI) and to explore whether they report any changes in their experience with NSSI as they become older. Qualitative e-mail interviews were used in order to capture the participants’ experiences. The results of the study were analysed based on coping theory and previous research. The results indicate that, consistent with previous literature, adults self-injure for mostly the same reasons as adolescents – however, as the previous research shows adolescents are more likely to hurt themselves in order to communicate with others. The adults in the present sample report using problem-solving coping strategies to the same extent as emotion-focused strategies; a slight deviation from previous research which has suggested that people who self-injure are more likely to employ emotion-focused strategies. The participants of the study generally experience a feeling of increased control and deliberation of their self-injury as they have gotten older; hurting themselves has become a purposeful coping strategy. The results of this study might have implications for treatment of self-injury in adults; focusing the treatment on strengthening the adults’ autonomy and encouraging further problem-solving coping strategies might be beneficial.

*Keywords: self-injury, non-suicidal self-injury, NSSI, adult, functions, self-harm, e-mail interviews*
Acknowledgement

I would like to thank my supervisor, Tomas Boman, for the support and expertise in aiding me in this project. Thank you especially for your patience and for the encouragement you have given me throughout the process.

Thank you friends and family, who have been more or less willing commentators on the various drafts and other bits of the essay. Thank you also for your understanding when I have forced you to listen to something “extremely interesting” I read, for the fifth time.

Thank you, mum. For everything, always.

Most of all, I would like to thank the participants in this study. Your answers to my interview questions made this thesis come to life. Your experience and insight is invaluable and I am positive that it will help others understand non-suicidal self-injury better. In sharing your experiences, you are enabling others to benefit from what you have gone through. Without you, this thesis would not have been possible, so thank you.

For my beloved Madicken, who passed away just as this thesis was finished – I will always love you.

Maria Bejmo
August 2014, Gävle.
# Table of contents

Abstract .............................................................................................................................. 3  
Acknowledgement ............................................................................................................ 4  
Table of contents ................................................................................................................ 5  
1. Introduction ................................................................................................................... 7  
   1.1 Aim .......................................................................................................................... 9  
   1.2 Essay disposition ..................................................................................................... 10  
2. Previous research ......................................................................................................... 11  
   2.1 Definition ............................................................................................................... 11  
   2.2 Prevalence ............................................................................................................. 12  
   2.3 Why do people self-injure? .................................................................................... 13  
   2.4 Functions of non-suicidal self-injury ..................................................................... 14  
   2.5 Functions of non-suicidal self-injury in adults ....................................................... 17  
   2.6 Summary of the previous research on non-suicidal self-injury ........................... 17  
3. Theoretical framework ................................................................................................. 19  
   3.1 Coping theory ......................................................................................................... 19  
      3.1.1 Non-suicidal self-injury and coping ................................................................. 22  
   3.2 Summary of the theoretical framework .................................................................. 22  
4. Methodology ................................................................................................................ 24  
   4.1 Research design ...................................................................................................... 24  
   4.2 Mode of procedure ................................................................................................. 25  
   4.3 Literature search ..................................................................................................... 25  
   4.4 Sample ................................................................................................................... 26  
   4.5 Tools of analysis ...................................................................................................... 27  
   4.6 Essay credibility ...................................................................................................... 28  
      4.6.1 Validity ............................................................................................................. 28  
      4.6.2 Reliability ....................................................................................................... 29  
      4.6.3 Generalisability ............................................................................................. 30  
   4.7 Ethical considerations ............................................................................................. 30  
5. Results and analysis ..................................................................................................... 33  
   5.1 Presentation of participants ...................................................................................... 34  
   5.2 Functions ................................................................................................................ 35  
      5.2.1 Emotion regulation ......................................................................................... 36  
      5.2.2 Self-punishment & self-hate .......................................................................... 38  
      5.2.3 Anti-suicide ..................................................................................................... 39  
   5.3 Coping ..................................................................................................................... 41  
      5.3.1 NSSI as a coping strategy ................................................................................. 41  
      5.3.2 Alternative coping strategies .......................................................................... 43  
   5.4 Age-related changes ............................................................................................... 45  
      5.4.1 Change in functions ........................................................................................ 45  
      5.4.2 Deliberation and control ................................................................................ 48
6. Discussion........................................................................................................................................ 52
   6.1 Study’s limitations.................................................................................................................. 54
   6.2 Future research...................................................................................................................... 56
7. References .................................................................................................................................... 57
Appendix 1 – Interview guide ........................................................................................................ 62
Appendix 2 – Cover letter ............................................................................................................... 64
Appendix 3 – Instructions for answering the interview questions .............................................. 66
1. Introduction

Non-suicidal self-injury (NSSI) is the deliberate destruction of one’s own body tissue without suicidal intent and for purposes not socially sanctioned, also known as self-injury. An in-depth exploration of the definition can be found in chapter 2.1.

One of the first written references to self-injury is thought to be from the Gospel of Mark in the Bible. A man who was seemingly possessed by a demon was locked up by the townspeople, but kept breaking free of his shackles, crying out and cutting himself with stones (Favazza in Nock [ed.], 2009b). Despite this early reference, self-injury did not receive a lot of attention in the media prior to 1980, after which the attention has increased dramatically (Whitlock, Purington & Gershkovich in Nock [ed.], 2009b). Many theories have since then been suggested to explain why some people engage in self-injury, ranging from the psychodynamic theories focusing on sexual urges to the developmental psychopathology theory, which focuses on the development of an individual who has experienced childhood maltreatment (Yates in Nock [ed.], 2009b). Self-injury has been regarded as a failed suicide attempt, but many researchers now believe that while those who engage in NSSI are at a higher risk of attempting suicide, non-suicidal self-injury is a separate phenomenon and might even sometimes be an attempt to avoid killing oneself (Klonsky & Muehlenkamp, 2007). Self-injury has also been regarded as a symptom of severe mental illness, yet research has found that while self-injury is often associated with a variety of mental health problems, it also exists within non-clinical populations (see e.g. Klonsky, 2011; Borrill, Fox, Flynn & Roger, 2009; Wilcox, Arria, Caldera, Vincent, Pinchevsky & O'Grady, 2012). People who self-injure have commonly been labeled as manipulative and attention seeking; however more recent research has paid attention to the fact that most people who self-injure do so in private and choose to conceal the behaviour from others (Gratz, 2003; Favazza, 2011).

Recent research into the functions of NSSI has led to an increased understanding that self-injury serves different purposes for the people who hurt themselves. The recognition that self-injury can be an effective, if maladaptive, coping mechanism which serves specific functions for the individual
can lead to improved treatment where the focus is on reducing negative affect and learning how to use healthier coping strategies (Klonsky, 2009).

While some of the earlier beliefs about self-injury have been challenged through the increased research attention and awareness, the belief that self-injury is a teenage phase and something one “grows out of” still remains. When discussing NSSI with the general public, a common perception seems to be that self-injury does not exist in the adult (non-clinical) population. One possible explanation to the lack of knowledge about self-injury in adults is that little is published about the problem in this population. In Sweden, the published material available from official institutions is mostly focused on self-injury in adolescents or youths. In a search on the website (in May 2014) of the Swedish National Board of Health and Welfare (Socialstyrelsen) using the keyword “självskade*” (approximately translated to “self-injur*”), no reports were found that were specifically focused on adults, while many of the reports presented on the website are focused on self-injury in children and adolescents (see e.g. Socialstyrelsen, 2004a; 2004b). In 2013, The Swedish government gave the Swedish National Board of Health and Welfare a directive to undertake The National Self-Injury Project (Nationella Självskadeprojektet), which is a project aimed at increasing awareness and co-ordinating resources for people who self-injure (Socialstyrelsen, 2013). Additionally, in 2014, the Swedish government ordered another large investigation of the state of knowledge of self-injury in Sweden as well as recommendations for division of resources (Socialstyrelsen, 2014). Both reports from the projects concluded that interventions should be made to support organisations that give care and support to young people who self-injure (Socialstyrelsen, 2013; 2014, my emphasis).

“... adults do self-injure. It's not simply some attention seeking teenage stage /.../ people need to know that it's not just something linked to teens” (Petra, in the present study).

Adolescents and young adults are at a particularly high risk for engaging in NSSI with estimates ranging from 5%-17% with some studies showing up to 38% (Rodham & Hawton in Nock [ed.], 2009b). The high prevalence that has been reported in the literature is an important factor in providing resources to investigate self-injury in teenagers and young adults. It should be noted, however, that an estimated 4% of adults engage in NSSI (Briere & Gil, 1998; Klonsky, 2011), which makes studying self-injury in adults an important task in itself. As an illustrating example,
4% of the adult (individuals 25 years old and above) population in Sweden amounts to 271,328 people (Statistiska Centralbyrånen, 2013). Due to the stigmatizing nature of self-injury, the lack of awareness of the fact that adults do engage in NSSI could have the consequence that an adult who self-injures might experience a double stigmatization and therefore might hesitate to seek help.

1.1 Aim

Non-suicidal self-injury is a phenomenon that has gained increasing attention in both the media and the research community. This attention has increased the awareness that NSSI is an issue in its own right and that it does not have to be a suicide attempt or necessarily a symptom of a severe mental illness. The prevalence of NSSI is, according to some researchers, rising (see e.g. Jacobson & Gould, 2007) and much effort is made to develop effective treatment for the individuals who engage in self-injury. An important advance in this research has been the understanding that self-injury can be a purposeful and effective (if maladaptive) coping strategy and that it is important to understand the specific functions self-injury serve for the individual. Research has thus far often been focused on adolescents who self-injure and there seems to be a lack of research on the described functions for adults. Research is needed to increase awareness of the fact that self-injury is not limited to adolescents and to highlight the need for effective interventions that include adults.

Social workers all over the world are likely to come in contact with individuals who engage in NSSI and must be aware of that a wide range of people engage in the behavior and that there are a multitude of ways that self-injury can be expressed. An increased awareness of the fact that self-injury might serve specific functions for an individual and that self-injury can be found in all ages will benefit both the social worker and the person who self-injures.

The aim of this study is to investigate how adults describe the functions of their non-suicidal self-injury (NSSI) and to explore whether they report any changes in their experience with NSSI as they become older. For the purpose of this study, an adult is an individual who is 25 years or older.
Research Questions

How do adults describe the functions that NSSI serve for them?

Do the individuals describe the same functions for their self-injury regardless of how old they were when harming themselves?

What changes, if any, do the individuals describe in regards to their self-injury as they age?

How do individuals who self-injure cope with their emotions?

1.2 Essay disposition

The first chapter of this essay gives a brief introduction to non-suicidal self-injury and outlines the issues discussed in the thesis. The aim, issues and research questions are also presented in the first chapter. The second chapter starts with a discussion about the definition of NSSI, which is vital to understanding the issue. After the definition, the second chapter continues with a presentation of the previous research. The theoretical framework, coping theory, is presented in the third chapter, which is followed by a fourth chapter with an in-depth description of the methodology of the study. The fifth chapter presents the results and analysis. The essay concludes with chapter six, containing the discussion of the results as well as the limitations of the study, ending with a brief discussion with suggestions for future research.
2. Previous research

2.1 Definition

The definition of NSSI is vital to any research of the behavior. Jacobson and Gould (2007) have described the difficulties in studying NSSI due to the fact that different authors use different terms to describe the behaviour. It also differs between authors what is meant with a specific term. This is complicated by the fact that some authors refer to any destructive behaviour (e.g. alcohol abuse, disordered eating) as “self-harm” or “deliberate self-harm”. One study defined self-harm thus; “A deliberate non-fatal act whether physical, drug overdose or poisoning, done in the knowledge that it was potentially harmful and in the case of drug overdose that the amount taken was excessive” (Gunnell, Bennewith, Peters, House & Hawton, 2004, p. 68). Other reports have not been clear whether suicide gestures or suicide attempts were included in the sample of the study. For example, in his study of deliberate self-harm in the elderly, Pierce (1987) described several terms used in various other studies that describe the behaviour: “non-fatal deliberate self-harm (DSH), parasuicide or simply attempted suicide” (p. 105). The sample in Pierce's study consisted of people aged 65 or over who “... were admitted to the medical or surgical wards of the hospitals /.../ for treatment of the effects of DSH” (Pierce, 1987, p. 106). The study described the methods the participants used to harm themselves, including drug overdose, wrist and throat cutting, suffocation and hanging (Pierce, 1987); some of them typical methods used in attempted suicide, making it unclear whether suicide was included in the study's definition of “self-harm”.

Nock, Holmberg, Photos and Michel (2007) expand on this problem, describing how different definitions make it difficult to study and compare data, which can lead to erroneous conclusions. The authors explain that some tools developed to measure self-injury group all “self-injurious behaviours as 'parasuicide' or 'suicide attempts' regardless of whether the individuals intended to die from their behaviour” (Nock et al., 2007, p. 309). Complicating the matter even further, different authors use different terms for the behaviour even when using the same definition. A common definition of self-injury is the deliberate destruction of one's own body tissue without suicidal intent and for purposes not socially sanctioned (Klonsky, 2009; Nock & Prinstein, 2004). However, while Klonsky use the term “non-suicidal self-injury”, Nock and Prinstein use the same definition while
labelling the behaviour “self-mutilative behaviour”. Suyemoto (1998, p. 532) also uses approximately the same description: “[the behaviour] is direct and socially unacceptable /.../ results in minor or moderate harm /.../ not suicidal in intent”, however Suyemoto uses the term “pathological self-mutilation”.

For clarity, the present study will use the term “non-suicidal self-injury”, shortened to “self-injury” or “NSSI” as the term clearly defines the behaviour as non-suicidal. The definition used in the present study is that non-suicidal self-injury is the deliberate destruction of one own's body tissue without suicidal intent and for purposes not socially sanctioned.

2.2 Prevalence

The difficulties that emerge from the fact that researchers use different terms to explain the same phenomenon as well as the confusion about the exact definition of non-suicidal self-injury have led to problems determining the prevalence of the problem. Some studies are not clear of the characteristics of the sample used or the definition of self-injury, which sometimes makes it difficult to draw conclusions from the results (Rodham & Hawton in Nock [ed.], 2009b). When discussing the prevalence of self-injury, it is therefore vital to be aware of what definition has been used in the studies discussed.

Studies on the prevalence of self-injury in adolescents show varied results. Studies on college students have presented numbers from 7% (Wilcox et al., 2012) to 27% (Borril et al. 2009). Relevant is that the prevalence rates vary widely depending on the characteristics of the sample, i.e. whether it is a community or a clinical sample and what the definition of “self-injury” is. Wilcox et al. (2012) employed the definition of NSSI also used in the present study, while Borril et al. (2009) used a broader definition. A cross-country study in 11 countries in Europe on self-injury among adolescents found an average prevalence of 27.6% (Brunner et al., 2014). The authors suggest that the discrepancy between these results and those of an earlier study of adolescents in 11 European countries (Madge et al., 2008), which showed an average prevalence of 17.8%, might suggest that self-injury is increasing - a suggestion which has been supported by other researchers (Jacobson & Gould, 2007). Important to note, however, is that the two European studies used different
definitions of self-injury; both studies used a broad definition of the term, including overdosing and other methods, but the study by Brunner et al. also included individuals who had harmed themselves both with and without suicidal intent (Madge et al., 2008; Brunner et al., 2014).

The prevalence of self-injury in adults is estimated to be approximately 4% (Klonsky, 2009; Brierie & Gil 1998). Klonsky (2011) reports a lifetime frequency of NSSI of 5.9% in a study of adults aged 19-92 (mean 55.5 years), where 2.7% had harmed themselves 5 or more times in their lifetime. The question used in the study to ascertain whether participants had engaged in self-injury was “In your lifetime, how often have you intentionally hurt yourself – for example, by scratching, cutting or burning – even though you were not trying to commit suicide?” (Klonsky, 2011, p. 1982-1983). The methods reported included cutting/carving, burning, biting, scraping/scratching skin, hitting, interfering with wound healing and skin picking. Both these descriptions indicate that the definition in Klonsky's study was in accordance to the definition of non-suicidal self-injury used in the present study.

2.3 Why do people self-injure?

The drive models associated with the psychoanalytic tradition attempt to explain the source of behaviours such as self-injury with the basic drives of life, death or sexuality inherent in the human being. One psychoanalytical theory suggests that self-injury is an expression of or an attempt to control sexual urges. The person who self-injures is either attempting to obtain sexual gratification or to punish him- or herself for sexual urges and actions (Suyemoto, 1998). The theory, which is primarily based on Freud's psychoanalytical theory, states that: “[self-injury] serves as a way to obtain sexual gratification while simultaneously punishing oneself for the sexual drive and expressing an unconscious wish to destroy the genitals at the root of this drive” (Daldin, 1988; Woods, 1988 as cited in Suyemoto, 1998, p. 541). Psychoanalytic theorists have also suggested that self-injury might be an attempt to deal with difficult feelings for menstruating women, suggesting that “[with self-injury] bleeding is exposed and controlled, turning passive into active” (Doctors, 1981; Rosenthal, Rinzler, Wallsh, Klausner, 1972 cited in Suyemoto, 1998, p. 541). The psychoanalytical anti-suicide model explains that people might use self-injury “to soothe themselves actively and to avert total suicide” (Firestone & Seiden, 1990; Menninger, 1938 cited in Nock, 2009b, p. 66).
Biological theories have also been proposed for understanding why some people engage in NSSI. Some groups of individuals who self-injure report feeling little to no pain while harming themselves and further show a decreased pain-response to stimuli in laboratory experiments (Sher & Stanley in Nock [ed.], 2009b). A proposed theory is that experiences of maltreatment in childhood might alter the individual's pain-pleasure response and thus lead to stress-induced analgesia i.e. a reduced sensitivity to pain brought on by stress (Prinstein et al. in Nock [ed.], 2009b).

Childhood abuse and neglect seems to be a risk factor to why some people engage in self-injury. Studies have found that experiences of sexual abuse in childhood in particular are predictors of NSSI. Physical abuse and neglect might also be risk factors for NSSI, but here, research has shown contradictory results. Important to note is that the association between the variables in these studies might have been influenced by a third variable, which would mean that the abuse in itself might not be the risk factor. Moreover, other experiences of a dysfunctional family might also contribute to an increased risk of someone hurting him- or herself (Gratz, 2003). The Dialectic Behavioural Therapy (DBT) approach developed by Linehan suggests that a combination of biological emotional vulnerability and an invalidating and unsupportive childhood environment might contribute to the development of pathology and a risk for self-injury (Gratz, 2003).

2.4 Functions of non-suicidal self-injury

An important advance in the study of self-injury is the research on the functions of the behaviour. While previous research has focused on psychosocial correlates with self injury, such as depression, anxiety or post-traumatic stress, a functional model tries to understand the functions of self-injury; i.e. what the purpose is for each individual to use NSSI and what antecedent and consequent events are associated with the behaviour (Nock & Cha in Nock [ed.], 2009b). Identifying the functions that NSSI serve for the individual might help to improve treatment of self-injury, as it could be focused on replacing the maladaptive behaviour with healthier coping strategies (Klonsky, 2009).

Nock and Prinstein (2004; 2005) have proposed a four-function model of self-injury, which draws on research and empirical evidence on which functions are common in initiating and maintaining
self-injury. The first function described in the model is automatic-negative reinforcement (ANR), which is used by the individual in an effort to reduce tension and decrease negative emotions or escape from strong emotions. The purpose of the automatic-positive reinforcement (APR) is instead to generate feeling, for example to end numbness. The model also describes two functions known as social reinforcement; social-negative reinforcement (SNR) where the purpose of self-injury is to allow the individual to escape from interpersonal tasks or demands and social-positive reinforcement (SPR), which an individual might use to get attention from others, for example self-injuring in order to get mental health professionals to take the individual more seriously (Nock & Cha in Nock [ed.], 2009b).

Nock and Cha (in Nock [ed.], 2009) suggest that the most common function of NSSI is the automatic-negative function; i.e. that which individuals use in order to regulate overwhelming emotions or escape from overwhelming pressure. In a study where the four-function model was used to describe the purpose of self-injury for a sample of adolescents in an inpatient setting, the authors reported that 24%-53% of the participants endorsed automatic reinforcement functions i.e. to either decrease (ANR) or to increase (APR) strong emotions, with over half of the participants stating that they used self-injury to “stop bad feelings” (Nock & Prinstein, 2004). Emotion regulation (sometimes referred to as affect regulation) is reported as the most common function for self-injury in numerous other research studies. In a review of the literature, Gratz (2003) describes a study conducted on college students in which 76% of the participants endorsed the emotion regulation function – self-injury was described as an attempt to relieve unwanted feelings. Other descriptions of emotion regulative functions in the study included an escape from worries and fears or to divert attention from internal painful experiences (Gratz, 2000). In the same review, Gratz (2003) describes Briere and Gil's (1998) study of adults where more than 70% of the participants chose different emotion regulative functions from a list, including reduction of tension, release of anger and distraction from and release of painful feelings. Emotion regulation was also reported as the most frequently endorsed function in a study of adults in the United States (Klonsky, 2011).

To end disassociation or to stop feeling numb (i.e. the automatic-positive reinforcement (APR) in the four-function model) are also cited in several studies as functions for self-injury. Individuals have described engaging in NSSI for example to try to feel something, to try to feel alive and human or to ground themselves (Horne & Csipke, 2009)
A previously commonly reported conception of self-injury is that it is primarily an attempt to get attention and elicit a certain response from others (Conterio & Lader, 1998; Favazza, 1992 cited in Gratz, 2003). This notion however, has been challenged in the more recent literature – researchers have found that getting attention from others is not one of the most common functions reported by individuals who engage in self-injury. Gratz argues that since most self-injurers engage in NSSI in private without informing anyone else about the behaviour, self-injury is likely not meant to be manipulative (Gratz, 2003). Some individuals do report engaging in self-injurious behaviour for social functions, e.g. to communicate with others (e.g. Klonsky, 2011; Lloyd-Richardson, Perrine, Dierker, Kelley, 2007), however the self-injury is then often primarily used to communicate distress and to get help and is often preceded by other ineffective means of communication – either due to an invalidating and negligent environment or because the individual is not able to communicate clearly (Nock, 2009a).

A number of studies report that self-punishment is a common function described by people who injure themselves (see e.g. Briere & Gill, 1998; Gratz, 2000; Nock & Prinstein 2004; 2005). Klonsky (2011) found that 32% of the participants in his study of adults endorsed self-punishment as one of the main functions of their self-injury. In a research review of the literature, Klonsky and Muehlenkamp (2007) report that self-punishment was one of the most prevalent reason for self-injury, after affect regulation. Other functions are also reported by individuals who self-injure, including anti-suicide, revenge, self-care and toughness (Klonsky & Glenn, 2009).

Nock (2009a) suggests several reasons why an individual might choose to engage in self-injury to serve these functions rather than using another way to regulate emotions. Self-injury can be a pragmatic decision; it is an effective method of reducing emotional distress and regulating negative emotions while also being easily accessible. An individual might also engage in NSSI after having observed the behaviour in others; many people who self-injure report having first learned about the behaviour from others. Several studies show that while not all individuals who engage in NSSI have been abused, childhood abuse is strongly associated with self-injury. An individual who has been abused might have learned to direct punishment toward him- or herself and might engage in self-injury for this reason. Another hypothesis is that self-injury might be a way to signal distress to
others. Self-injury might be particularly effective at this, since it is considered to be costly and therefore might be more likely to be noticed by others.

2.5 Functions of non-suicidal self-injury in adults

Few studies have been conducted regarding the functions of self-injury in adults (Klonsky, 2011). However, Brierie and Gil (1998) conducted a study of an adult sample of 93 people who reported having engaged in self-injury. The most common reasons given for self-injury by these adults were “to distract yourself from painful feelings” and “to punish yourself”. Other functions included anti-dissociation, reducing stress, demonstrating a need for help and to reduce anger. Using the four-function model developed by Nock and Prinstein (2004; 2005), Klonsky (2011) conducted a study on an adult non-clinical sample. In addition to the four functions described by Nock and Prinstein, Klonsky included two other functions that had previously been described as prominent in the literature: “self-punishment” and “to release emotional pressure”. The results were similar to those reported in previous research on adolescents; the participants reported emotion regulation as the main function of their self-injury. Klonsky (2011) concluded that the findings in his study were consistent with research on the functions of NSSI in adolescents, meaning that self-injury serves the same functions for adults as for adolescents. In a study of adolescents, Jacobson and Gould (2007) came to a similar conclusion about the consistency between functions of self-injury in adolescents and adults, but added that their findings suggested that younger adolescents might partly engage in self-injury to elicit social reinforcements. The authors state “it is possible that the younger adolescents may initiate NSSI for social reasons but maintain engaging in NSSI for internal reinforcement” (Jacobson & Gould, 2007, p. 139). This finding was corroborated by Nock and Prinstein (2005) who found that younger age was associated with the social functions of the four-function model.

2.6 Summary of the previous research on non-suicidal self-injury

Non-suicidal self-injury is a prevalent problem that seems to be increasing. Adolescents seem to be at a particularly high risk of engaging in self-injury, however the behaviour also exists in the adult population. Many theories have been suggested to explain non-suicidal self-injury, ranging from the
notion that an individual might self-injure in order to protect his or her genitals to the idea that a decreased pain-sensitivity might lead some individuals to use self-injury to cope with their emotions. A functional model suggests that NSSI serves a purpose for the individual. The most common function endorsed for self-injury is emotion regulation; people who self-injure report using NSSI to for example “get rid of bad feelings” or “to feel something”. Most of the research of the functions of non-suicidal self-injury has been conducted on adolescent populations, but research suggests that adults engage in non-suicidal self-injury for the same reasons as teenagers.
3. Theoretical framework

3.1 Coping theory

Coping is “a process of managing the discrepancy between the demands of the situation and the available resources – a process that can alter the stressful problem or regulate the emotional response”. A coping strategy is an attempt an individual takes to “alter the relationship between the self and the environment and to reduce emotional pain and distress” (Ahmadi, 2007, p. 22).

The psychoanalytical theory developed by Sigmund Freud is concerned with the concept of defense mechanisms; strategies an individual might subconsciously employ in order to protect him- or herself in difficult situations and thus reduce the suffering the situation might cause. Coping strategies is a related concept; however coping strategies are intentionally employed in order to help the individual manage difficult situations. While the psychoanalytical theories are concerned with the psychosexual development of coping, other researchers are mainly focused on the cognitive-motivational processes in coping theory (Lazarus, 1993).

Psychoanalysts and ego-psychologists often adhere to a belief that coping is trait-based. The trait theory states that coping is stable characteristic of an individual, which does not alter depending on time or conditions. The individual, according to this theory, will tend to use the same coping strategies independent of the situational context (Lazarus, 1999). Some researchers instead believe that coping is a process and argue that individuals use different coping strategies in different situations. These researchers believe that coping is a purposeful process; they argue that people choose to use different strategies depending on their acquired experience - they choose what has worked before – and then select the strategy they believe will have the desired outcome (Morrison & Bennett, 2012; Lazarus, 1999). Some coping strategies that are maladaptive in one situation might be beneficial in another, depending on the context of the situation. An example is a patient facing a diagnosis of cancer, for whom denial can serve to be both efficient and inefficient (Lazarus, 1999).
Two central concepts in coping theory are problem-focused coping and emotion-focused coping. Problem-focused coping refers to coping strategies with which an individual attempts to change the person-environment relationship, in other words tries to deal with the problem that is causing emotional distress (Lazarus, 1999). After arguing with a friend, an individual who is angry might seek to talk to the friend in order to resolve the issue at hand, thus employing a problem-focused coping strategy. Using instead an emotion-focused strategy, the individual might seek to alter the emotions he or she experiences by denying his or her anger or engaging in behaviour that distracts the person from his or her emotions.

Lazarus (1999) makes the argument that strictly categorising certain coping strategies as either problem-focused coping or emotion-focused coping may be erroneous, as the same coping strategy might function as both. Using a strategy to alter an emotional state might also facilitate in altering the person-environment relationship and thus handling the problem. An example is taking an anti-anxiety medication during an important exam in order to calm down and be able to focus. By taking the medication, the individual uses an emotion-based strategy to reduce the anxiety. Taking the medication will also likely increase the individual's chances of performing well at the examination, thus altering the reality; an example of problem-focused coping. Attempting to declare one type of coping better than the other is, according to Lazarus, not meaningful, as the efficiency of a coping strategy depends on the situation. Being able to use both emotion-focused and problem-focused coping strategies increases the chance of the individual being able to cope with different situations.
Folkman and Lazarus (1988) describe a model of coping as a mediator of emotions (Figure 1) that depicts the coping process as a response to an appraisal of a difficult situation and where the coping process affects the subsequent emotional response. The process begins with a first appraisal of a situation (labeled the “person-environment encounter” in the model) in which the individual determines whether the situation is beneficial or harmful. A second appraisal is then made where the individual takes into account the resources and coping strategies available to him or her. The emotions generated by the appraisals motivates the individual to employ a coping strategy, which can be emotion-focused and thus intended to regulate the emotions in the situation or problem-focused, intended to alter the person-environment relationship. If the individual considers the situation to be unchangeable and out of his or her control, the individual tends to use emotion-focused strategies, while problem-focused strategies are often used in situations where the individual believes in his or her own ability to change the situation. After using a coping strategy, a new appraisal is made where the quality and intensity of the individual's emotions are assessed. The
assessment determines whether the individual needs to employ any further coping strategies (Folkman & Lazarus, 1988).

3.1.1 Non-suicidal self-injury and coping

The most common function of self-injury described in the literature is emotion regulation (e.g. Klonsky, 2011, Nock & Prinstein, 2004; Gratz, 2003), which is an integral part of coping theory (Power & Brown, 2010). By applying the model of coping as a mediator of emotions (Folkman & Lazarus, 1988) to non-suicidal self-injury, the self-destructive behaviour can be understood as a maladaptive coping strategy. An individual who makes an appraisal of an event might conclude that self-injury could be an effective coping strategy that will serve the purpose of regulating his or her emotions. According to Wilcox et al., (2012) the temporary relief from distress may reinforce non-suicidal self-injury and thus make repetition of the behaviour likely. Klonsky (2009) further suggests that the change in affect-state following an episode of self-injury might reinforce and increase the likelihood that an individual harms him or herself in the future.

Some researchers have presented a theory that individuals who self-injure might use different coping strategies than those who do not. According to this theory, individuals who self-injure tend to use emotion-focused coping rather than problem-focused strategies (Borrill et al., 2009) and they are also more prone to ruminate. Rumination, i.e. focusing on one's problem in a compulsive way, is distinctive from reflecting on a problem in a constructive manner and is proposed to have an aversive effect in people who self-harm (Armey & Crowler, 2008 cited in Borrill et al., 2009). In the study by Borrill et al., (2009), rumination was a predictor of self-harm, indicating that focusing on reducing rumination and encouraging more problem-focused coping strategies might be a useful approach when treating people who self-injure.

3.2 Summary of the theoretical framework

A significant part of coping theory is dedicated to explaining coping as a process. According to the cognitive-motivational model developed by Folkman and Lazarus (1988), an individual who is faced with an emotional problem uses a coping strategy, which can be emotion-focused and
intended to divert attention from the problem or handle the individual's emotions. The individual may also use a problem-focused strategy, intended to solve the underlying problem. Research on adolescents has shown that people who self-injure tend to use different coping strategies from people who do not self-injure; the coping strategies employed by individuals who engage in NSSI are often emotion-focused coping strategies rather than problem-focused. Non-suicidal self-injury is an effective, yet maladaptive coping strategy; self-injury tends to reduce an individual's negative emotions and bring relief in the short term but it is not an effective long-term solution, as it does not resolve the initial conflict.
4. Methodology

In order to explore individuals' reasons for engaging in non-suicidal self-injury in their own words, a qualitative study seemed most appropriate. With a qualitative study, the meaning and essence in the participants' self-experience can be emphasized (Kvale & Brinkmann, 2009).

4.1 Research design

The decision to conduct e-mail interviews arose from a belief that being a participant in an interview through e-mail might feel more comfortable for the research subjects; due to the fact that self-injury can be a sensitive and stigmatising subject and that it might be a difficult topic to talk about in a face-to-face interview. The sample frame of the study consisted of members of an international web-based forum, which made e-mail interviewing suitable for the study, as it would have been geographically impossible to interview the members face-to-face (Hunt & McHale, 2007).

Using a structured interview approach in the e-mail interviews meant that the participants could receive and reflect on the interview questions and respond in their own time without needing to send multiple e-mails back and forth. The e-mail interview also allowed the participants to review their answers before submitting them, which gave them the chance to reflect further (Hunt & McHale, 2007). While the interview was of a structured nature, the questions were intentionally worded to have conversational feeling, in an attempt to set a relaxed and open tone with the hope of encouraging the participants to feel comfortable with sharing their experiences about non-suicidal self-injury. The questions were open-ended as the intention with the interviews was to allow the participants to freely describe their experiences in their own words (Patton, 2002).
4.2 Mode of procedure

After approval from the administrators of the web-based forum to use the forum's members as a sample frame, a request with information about the purpose of the study and the criteria for participating in it, as well as information on consent and confidentiality was posted on the forum. The request included the definition used in the present study for non-suicidal self-injury, which according to Rodham and Hawton (in Nock [ed.], 2009) is an important thing to consider when conducting research, in order to avoid the participants having to interpret the definition subjectively and thus, risking that all participants do not fill the intended criteria. Rodham and Hawton also suggest that researchers ask participants to use their own words to describe their self-injury, as an additional effort to ensure coherency in the results through a common understanding of the definition.

Members were encouraged to contact the researcher by e-mail to receive further information. Upon e-mail contact, the respondents received an e-mail with instructions on how to reply to the interview questions (Appendix 3), together with the cover letter (appendix 2) and interview questions (Appendix 1) as attached files. A request was made in the cover letter to respond with a statement of consent before answering the interview questions. The attachments with questions were returned to the researcher with the participants' answers included. When the researcher received the completed interviews, the participants received a code name in order to secure their confidentiality. These codes were used when saving the interview to the author's computer.

4.3 Literature search

In the search for literature to use in the study, the primary database used was Discovery; as it offered the ability for the author to search for articles in several databases at once, which allowed for a good overview of the field of knowledge. The search terms used were combinations of the words self-injury, self-mutilation, self-harm, adult, functions, non-suicidal self-injury, deliberate self-harm. When a suitable article was found, the reference list was studied to discover more
relevant articles. The library database LIBRIS was also used in search of relevant books on the subject of inquiry.

4.4 Sample

The aim for the study was to investigate how adults describe the functions of their non-suicidal self-injury and to explore whether they report any changes in their experience with NSSI as they become older. The author chose to define an adult as a person 25 years old or over, as many of the previous research studies have used participants up to 25 years old.

The aim of the study necessitated that the participants of the study fulfilled specific criteria, namely that they were over the age of 25 and that they either currently were self-injuring or that they had done so in the past. To make sure that the participants in the study had sufficient exposure to self-injury to be able to reflect over the functions of the behaviour, aspecifier was included in the list of criteria, stipulating that the participant should have engaged in self-injury at least 5 times before and 5 times after the age of 25. This was an attempt to make a distinction from those who might have self-injured on a singular occasion. The criterion also ensured that the participants would be able to reflect on any possible differences in their experience with self-injury both prior to and after the age of 25.

The criteria for participating in the study were therefore:

1. That the participant was 25 years old or over.
2. That the participant had self-injured at least 5 times before the age of 25.
3. That the participant had self-injured at least 5 times after the age of 25.

Due to the fact that the study required participants with personal experience of non-suicidal self-injury, a purposeful sampling was executed. A purposeful sampling “enable[s] the researcher to satisfy the specific needs for [the] project” (Robson, 2002, p. 265). Participants were recruited from a large international web-forum dedicated to people who have experience with self-injury; both self-experienced and those who are otherwise affected by self-injury (e.g. family or friends). By
using a purposeful sampling, the researcher can ensure that the data collected from the participants will yield rich and in-depth information (Patton, 2002).

Salmons (2010) suggests that when the research participants are recruited from a web-forum or an e-mail list, discussing your goals and intentions with the forum's moderators before approaching the participants is an important consideration. While this study did not collect data from the web-forum itself, but rather from the members via e-mail, etiquette suggested that contacting the moderators of the forum beforehand seemed appropriate. This also tied together with the forum's explicit rules for any research activity on the forum.

In total, 14 people responded to the invitation on the forum to take part in e-mail interviews. Of those, three individuals did not reply to the interview questions that were sent out and one individual did not fill the criteria to take part in the study and subsequently was not included in the analysis and results. In the end, 10 e-mail interviews were conducted. The respondents received information about the study and gave their consent for the data to be used and then responded to 18 interview questions in a file attached to the e-mail.

4.5 Tools of analysis

An advantage with conducting e-mail interviews was that no transcription of oral data was necessary, thus eliminating the possibility of misinterpreting the participants’ words when transcribing the material. The interviews were saved on the author’s computer and thereafter printed out in order to facilitate coding. A thematic analysis seemed appropriate, as it allowed the researcher to analyse the participants’ answers in relation to the aim of the study (Boyatzis, 1998). The material was first coded to make it easy to see patterns in the data. These codes were then merged into categories or themes. The analysis was both deductive and inductive; some of the themes were derived from previous research while other themes emerged from the data itself. Using both a deductive and inductive approach seemed appropriate since the previous research on adolescents suggests many important points of interest that corresponded to the aim of this study. However as the area of interest, self-injury in adults, has not been extensively studied the author felt that there was a need to also be able to inductively create new themes. The first theme, functions,
seemed like an important inclusion, as it was one of the core components of the study. The sub-themes, *emotion regulation, anti-suicide and self-punishment/self-hate*, were also derived from previous research as well as from the interview data as these themes were those functions most commonly reported. The second theme, *coping*, was derived from previous research and the chosen theory, however the sub-themes in this category, *NSSI as coping and alternative coping strategies*, were allowed to emerge inductively from the data that was collected. The third theme, *age-related changes*, was determined by the aim of the study. However, only the first sub-theme, *change in functions*, in this category was derived from previous research. The second sub-theme, *deliberation and control* was created inductively, as it emerged from the data.

**4.6 Essay credibility**

**4.6.1 Validity**

Validity refers to the question of if one is measuring what one has intended to measure. The present study intended to measure what functions adults report for their self-injury and what coping strategies people who self-injure use. Kvale and Brinkmann (2009) suggest using other sources to back up one's findings in order to strengthen the validity of the study. The most common function listed by the participants in the study was emotion regulation, which is also the most common reported function in the literature. The research participants in the present study also reported other functions found in previous studies, e.g. self-punishment, anti-dissociation and anti-suicide.

Validity is concerned with truth and trustworthiness (Kvale & Brinkmann, 2009). An argument has been made that it is difficult (if not impossible) to determine whether a research participant is “telling the truth”. Jackson and Gould (2007) mention that one flaw of self-reported studies is that the participants might not be able or willing to report the truth of the factual aspects of their experiences with self-injury. However truth is not always objective; the participants might be telling the truth of their experience, even if their reports are not factually correct (Kvale & Brinkmann, 2009). The participants in the present study presented open and detailed explanations of their self-injury, which helped to strengthen the study's validity.
Transcribing data from oral language to written can cause problems with validity, as the researcher must interpret the recorded data and attempt to write it down correctly (Kvale & Brinkmann, 2009). Using e-mail interviews can thus help strengthen the validity of the study, as no transcription of the data is needed. The researcher must then base the analysis on the words the participant has used.

4.6.2 Reliability

Reliability is concerned with whether other researchers can replicate the study by using the information available in the report. To achieve reliability, it is therefore important to describe the methods and procedure used as fully as possible (Kvale & Brinkmann, 2009). The mode of procedure for the present study is described in this report and the structured interview guide (Appendix 1) should facilitate for any other researcher interested in replicating the study. However, qualitative research is dependent on the participants and their individual experiences and thus, it might be difficult to replicate this study without using the same research participants. Even if the same participants were used, the results would probably not be the same as the interaction between the research participants and the present researcher will most likely have influenced the study (Hunt & McHale, 2007).

The fact that the author conducted the interviews and analysed the results alone might have ensured consistency in the results of the present study. If one conducts research together with another, one risks using different interpretations when analysing the data. However, using another researcher might have allowed for a chance to discuss the results and analysis, which might have strengthened the reliability (Kvale & Brinkmann, 2009).

In qualitative research, the instrument used is often the researcher his- or herself. It is therefore important to note that the author of the present study is not a professional researcher and as such is a novice at conducting research. The process of the study has been methodical and careful, but the experience of the researcher is an important factor when judging the reliability of the study (Patton, 2002).
4.6.3 Generalisability

One of the problems with qualitative studies is that the sample is often too small to make it possible to generalise the results to the whole populations. However, the goal of qualitative studies is not always to generalise, but to investigate a particular individual's (or individuals') experience of a phenomenon (Kvale & Brinkmann, 2009). The present study sought to examine how the adult participants in the study described the functions of their self-injury. With a foundation of previous research and well-reasoned arguments, the researcher can use analytical generalisation to suggest expectations of results in a similar situation. Previous research of the functions of NSSI present similar findings as the present study, which suggests that the results might be generalisable to a similar situation. The validity of the generalisation depends on rich descriptions of the findings in the study, which has been achieved in the present study through using quotes from the interviews and thus, allowing the reader of the report to read the participants' original words (Kvale & Brinkmann, 2009).

4.7 Ethical considerations

According to Vetenskapsrådet (the Swedish Research Council), four main clauses are important to adhere to when conducting research with human participants (Vetenskapsrådet, 2002):

Information

The research request presented to the administrators of the web-forum contained brief information about the study's aim and research questions, information about how confidentiality and consent would be treated and what would happen to the data once the study was finished as well as how the information would be presented.

Before the interviews, the participants were likewise informed in an introductory e-mail of the study's aim and the other aspects included in the information clause, i.e. confidentiality, consent, data collection and data protection. The participants were also informed that they could withdraw from the study at any time.
Consent

Upon e-mail contact, the participants received information regarding consent and were asked to make a statement declaring that they were voluntarily participating in the study. They were informed of the possible risks of participating in the study (such as being unsettled or “triggered” by the questions) and were given information that they had the right to withdraw their consent for the author to use the information they had given in the interviews at any time.

Confidentiality

The participants' identifying information, such as their e-mail address or the handle they use on the web-forum has only been disclosed to the author, to protect the participants' confidentiality. Some statistics are presented in the present study, however the data displayed in the report cannot be connected to a specific individual. When the study has been properly concluded (i.e. when it has passed examination), the corresponding raw data will be destroyed.

Use

The data collected for this study will only be used for the completion of the research project in question. After the research project's completion (after examination), the data will be destroyed. The raw material from the interviews will only be available to the researcher, the researcher's supervisor and the examiner(s) of the project, if there is a need for its presentation to the aforementioned parties.

There is a debate whether true informed consent can be achieved when conducting a study in an online relatively public setting, e.g. a forum, as obtaining consent from all members would be time-consuming and might be viewed as intrusive (Johansson, 2010). However, determining what is a “public” setting versus what is a “private” setting when collecting data from your research participants is not always clear-cut. Depending on the expectations and culture of the forum where the participants are chosen from, the individual members might expect a certain level of privacy without non-members being able to read their words. Information from an open website might not require the researcher to obtain informed consent from the participants, whereas an e-mail interview is typically considered to be a “private online environment” where the expectation is that the researcher and the participant are the only ones included in the data collection. In such a setting,
getting informed consent is preferable (Salmon, 2010). As mentioned previously in chapter 4.4, asking permission of the forum's moderators to conduct research is considered appropriate. This study did not collect information from the web-forum itself (“the public setting”); however in accordance to the directive from the literature (Salmon, 2010) as well as per the forum's rules, the administrators were nonetheless contacted and gave their approval for the researcher to recruit participants on the forum.

Examining the motives of one's self-injury in depth might be unsettling. The researcher must take care to ensure the participants' well-being, as much as possible, by spending time to consider the phrasing of the questions as well as provide enough information so that the participants can make an informed decision about whether to participate or not. The participants of this study were informed of the risks of participating i.e. that it might be unsettling to examine their motives for self-injury and that they were advised to abort their attempt at answering the questions should they become upset.
5. Results and analysis

Three main-themes emerged from the interviews and the previous research. These themes and their sub-themes are presented in this chapter. The first theme is directly related to the first research questions, concerning which functions people who are 25 years old or over report for their self-injury. The second theme discusses how self-injury works as a coping mechanism for the participants of the study and explores the alternative coping strategies they use. The third theme is about age-related changes and attempts to understand what aspects of self-injury have changed as the participants have grown older. Due to the fact that there is not a lot of research conducted on adults who self-injure, this theme might be seen as a new important concept in the research of non-suicidal self-injury.

Note that the following quotations have been cleaned up for increased readability; however any changes to the participants’ words are clearly marked.

<table>
<thead>
<tr>
<th>Functions</th>
<th>Coping</th>
<th>Age-related changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotion regulation</td>
<td>NSSI as a coping strategy</td>
<td>Change in functions</td>
</tr>
<tr>
<td>Self-punishment/self-hate</td>
<td>Alternative coping strategies</td>
<td>Deliberation and control</td>
</tr>
<tr>
<td>Anti-suicide</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table 1 – Themes of the analysis.*
5.1 Presentation of participants

The participants have all been given code names to protect their confidentiality:

Mary is a 26 year old woman living in the United States. She began to hurt herself at the age of 17 and reports having engaged in the behaviour for approximately 3 years in total (excluding any longer gaps). Mary has hurt herself once or twice every few months, but for the last two months she has engaged in NSSI a few times a week.

Elizabeth, a 45 year old woman from Canada, has hurt herself since the age of 10. She has hurt herself for a period of 16 years in total. Elizabeth says that she has not engaged in self-injury according to the definition in the present study in the past year, although she has hurt herself using other methods not included in the definition.

Ellen lives in the United Kingdom and has hurt herself for 19 years. She is 32 years old and started engaging in NSSI when she was 9 or 10 years old. Ellen says that she has hurt herself twice in the past year.

Rebecka is a 34 year old woman and resides in the United States. She was 20 years old when she started harming herself and reports having done so for 10-12 years. Rebecka’s self-injury has increased to 2-3 times per month recently, before which she hurt herself once a month or less.

Mike started hurting himself at the age of 15 and has hurt himself for a total period of 25 years. He is 45 years old and lives in the United States. Mike says that he has hurt himself in average once every two months in the past 12 months.

Anna identifies as gender-queer and lives in the United States. Anna is 31 years old and has engaged in NSSI for 16 years, with an age of onset of 11. Anna reports that she has not engaged in self-injury at all during the past 12 months.
Sandra lives in Canada. She is 33 years old and has hurt herself for over 10 years. Sandra reports that she is not sure when she started to hurt herself. She has hurt herself once every few months during the past 12 months. Sandra says that she was 3 years free of self-injury but after losing her job and going back to school, she found it difficult to cope.

Petra is a 40 year old woman from Canada who started hurting herself when she was 12 or 13 years old. She says that she has engaged in self-injury for 22 or 23 years. Petra has not engaged in NSSI during the past 12 months.

Eve lives in the United States of America. She is a 33 year old woman who has engaged in self-injury for 8 years. Eve reports that she has hurt herself once during the past 12 months. She was 21 years old when she started hurting herself.

Penny is a 32 year old woman from Germany. She has hurt herself for 14 years in total and was 17 years old when she started engaging in self-injury. Penny says that it’s hard to estimate the frequency of her self-injury for the past 12 months as it differed a lot throughout the year. She would guess that she has engaged in self-injury a few times a week on average, with an increase of the behaviour during the last two months.

5.2 Functions

A functional approach to non-suicidal self-injury (NSSI) focuses on observing the functions that self-injury serves for the individual. Self-injury often serves multiple functions simultaneously; the most common being emotion regulation (increase or decrease), anti-suicide, anti-disassociation, self-punishment & self-hate and social reinforcement or communication (Klonsky & Muehlenkamp, 2007). The participants in the present study report a host of different functions for their self-injury, mainly corresponding with the functions reported in the previous literature. The most common functions found in the present study are presented below.
5.2.1 Emotion regulation

The most common function of non-suicidal self-injury described in previous literature is emotion regulation (e.g. Klonsky, 2011; Gratz, 2000; Gratz, 2003; Brierie & Gil, 1998). The results of the present study show similar findings; most of the participants report that they engage in self-injury to regulate their emotions. Participants describe engaging in NSSI to reduce tension and decrease overwhelming emotions but also to increase emotion when they experience a feeling of numbness or a sense of not feeling alive.

The primary function is to deal with overwhelming emotions – It’s like a giant black wave of emotions just builds up and I feel so tense I think my body is going to explode. Self-injury relieves the pressure and calms me down (Elizabeth).

The participants commonly describe the feelings that build up before self-injury as overwhelming, unbearable and like they are going to explode if they do not do something about it. Sandra explains: “I use [self-injury] when I start to feel [emotions] because I just can't deal with a dam burst”.

Mary also uses self-injury to regulate her emotions

when I'm feeling something so intense that I can't even figure out how to respond to it, I can [self-injure] and I'll calm down and think more rationally and not be so wound up. Usually this is anger, but sometimes it can be other emotions too.

Several of the other participants say that they use self-injury to regulate anger in particular. Sandra says

anger is my strongest trigger. There are times when I feel the need to lash out when I am mad enough, and self-injury is the only thing that allows me to get myself back under control when in those states, which can get pretty bad – bad enough that I have hurt people.
While self-injury is most commonly used to decrease unbearable emotions, it can also function as a way to increase emotion when the individual is feeling numb or unreal (Home & Csipke, 2009). The experience of not feeling any or little emotions can be frightening and undesirable and thus, an individual might use self-injury to start feeling. Penny says that she sometimes uses self-injury “… when I am numb to feel more alive…”

Anna explains that she uses self-injury to decrease her emotions, but also that “… if I wasn't in pain, it was in order to feel something other than numb”.

Mary describes one of the functions of her self-injury in terms of increasing her energy when she is depressed. This has here been interpreted as equivalent to the experience of “feeling too little” or being numb when I'm really depressed and I can't get up the energy to do day-to-day life stuff, I can [self-injure] and know that I'll have more energy the next day, that I might be happier, and that I'll definitely be able to get stuff done.

Anti-dissociation is sometimes reported as a distinct function of non-suicidal self-injury; however anti-dissociation can also be understood as affect regulation. Suyemoto (1998) argues that the anti-dissociation model “… agrees that self-mutilation serves to regulate affect, but [that the model also] focuses on the experience of dissociation and the way in which self mutilation interacts with this defensive strategy for affect regulation” (Suyemoto, 1998, p. 545). The anti-disassociation function is here presented under the sub-theme emotion regulation, as it is often concerned with generating some kind of feeling to end a dissociated state. Disassociation can be understood as a detachment from reality. People experience disassociation in different ways; an individual can experience everything from daydreaming while driving a vehicle to a more or less severe separation of one's physical or emotional perception of reality (Home & Csipke, 2009). Disassociation can be a desired state, acting as a coping mechanism when an individual experiences unbearable emotions; however it can also be a frightening experience, which an individual might wish to stop.
Often, the purpose of self-injury is to achieve a dissociated state, which promotes a profound distraction from psychological and/or physical distress. … Interestingly, self-injury is also used, by some, as a means of escaping from a dissociated state, breaking out of the experience of depersonalization or derealisation or out of a flashback, for example (Kennerley, 2004, p. 374).

Penny says that she sometimes uses self-injury “… to ground myself, bringing me back to earth when I am dissociating”.

Petra says “… other times it was because I had dissociated and it helped me 'return' so to speak”.

For some individuals, physical pain might be easier to handle than emotional pain. By externalizing the pain, the person who self-injures can create a physical injury that is easier to deal with. Having an external injury as opposed to internal pain might seem more legitimate and valid to society at large as well as to the individuals who harm themselves. Mike gives an example “… put the overwhelming emotional anguish into something I can manage, i.e. physical pain.”

5.2.2 Self-punishment & self-hate

Self-punishment and self-hate are closely related in the experiences of those who self-injure and have here been merged into one sub-theme.

Klonsky and Muehlenkamp (2007) found in a research review of the literature that self-punishment was the second most common reason for self-injury. For example, Klonsky (2011) found that 32% of adults engaged in NSSI to punish themselves. The present study is much too small to generalize from, however, similar to Klonsky's findings, 30% of the adults in the sample reported self-punishment and self-hate as one of the functions of their self-injury. Nock (2009a) describes that research has shown that there is a link between childhood abuse and non-suicidal self-injury and have proposed a theory that individuals who have been abused in childhood might have learned to direct self-hate and self-abuse against themselves and are therefore punishing themselves as adults. It is here important to note, however, that not all of those who self-injure have been abused.
Favazza (2011) describes how some people who think very poorly of themselves might feel that they need to be punished for any perceived wrongdoing. Favazza argues that in these cases self-injury might represent “the workings of a harsh superego that functions as police officer, judge, jury and jailer to enforce punishment on a criminal” (Favazza, 2011, p. 231). In accordance with coping theory, the individual might use punishment to manage his or her emotions, which can often be overwhelmingly powerful. People who hurt themselves often report feeling a large degree of self-hate, which might lead them to attempt to punish themselves, in order to achieve release.

In the present study, Mike describes that self-punishment is one of his main reasons for hurting himself: “… first, to punish myself. Because in that moment I loathe myself more than everything in the world and desire nothing more than a hateful act against my own body”.

When Ellen was younger, she used to harm herself by using other (arguably more aggressive and damaging) methods than she does today. Self-injury used to be an expression of self-hate for her, however that is less common when she hurts herself now. A number of other participants also report using other similar (more destructive) methods like Ellen did when they are experiencing feelings of anger or self-hate.

5.2.3 Anti-suicide

Non-suicidal self-injury has historically been assumed to be a failed suicide attempt or an expression of suicidal feelings. Recent research has shown that those who self-injure are more likely to have attempted suicide (Jackson & Gould, 2007), however previous research and the present study both conclude that self-injury can have an anti-suicide function for some individuals (Klonsky & Muehlenkamp, 2007). “When I want to kill myself, I [self-injure] instead until the acute suicidal feelings go away” (Mary).

Elizabeth says that when her emotions are too overwhelming and she feels suicidal, self-injury can be a way of harm reduction for her “I've used self injury to release emotions because I was feeling suicidal, and didn’t want to kill myself, but had to deal with the emotion somehow, so really it was a case of harm reduction”.

39
Besides the functions mentioned above, the participants report a number of other functions. Due to the fact that these are neither the most common functions in the previous literature or commonly mentioned by the participants, they are not presented separately. However, it is important to mention that people endorse a variety of functions for their self-injury, for example as self-care and exerting control over oneself (Klonsky & Muehlenkamp, 2007). Anna and Penny here describe how self-injury was a way of taking care of themselves: “It was also a method of taking care of myself when I felt that I could not in other ways” (Anna).

When I’m sad, lonely, needing to take care of myself, longing for touch, I often cut /.../ It feels comforting, tender. Taking proper care after it, like cleaning it and especially wrapping a bandage around it, really helps with the ‘caring for myself aspect’ (Penny).

Penny also describes how self-injury helps her to take control over her feelings and over the situation “It’s a lot about having/getting control over feelings and/or the situation. Being in control over who is hurting me in a way. I can deal better with things when I am the one doing the hurting”.

The functions of self-injury can be understood with the help of coping theory, as the functions participants describe are commonly attempts to cope with difficult situations. An individual who is faced with a situation makes an appraisal after which the individual employs the coping strategy he or she feels is most likely to achieve the goal – this can be reducing negative emotions, punishing oneself for perceived failures or ending disassociation. Coping strategies are intentional, purposeful actions designed to allow the individual to manage the situation (Folkman & Lazarus, 1988). Self-injury serves as a coping strategy for the participants in the present study and while it is ultimately not an ideal strategy, as it doesn’t resolve the situation, it is effective in bringing relief and a reduction of unbearable emotions. The participants of the present study, like the participants in previous research report that self-injury fills several different functions for them, which is an important thing to keep in mind when developing treatment – self-injury seems to be a multifaceted phenomenon and treatment strategies might need to be adjusted to include exploring other coping strategies for a variety of functions.
5.3 Coping

An integral part of coping theory is that of emotion regulation. Folkman and Lazarus (1988) developed a model of coping as a mediator of emotions, describing the process in which an individual uses a coping strategy to handle difficult situations.

5.3.1 NSSI as a coping strategy

The participants of the present study describe using non-suicidal self-injury (NSSI) as a mediator of their emotions in many situations. They describe often experiencing strong negative emotions prior to self-injury, which elicits a need for a coping strategy in order to change their affect-state. Using a strategy that has been effective before, such as self-injury, increases the chance that the individual achieves the desired outcome, which can be a relief from strong emotion or a sense of having punished oneself sufficiently. The respondents frequently describe feelings of relief and satisfaction after engaging in NSSI. The below quotations are examples of the change in affect-states following self-injury: “Before /.../ sometimes I just feel tired and generically sad, sometimes I feel anger or sorrow, sometimes panic /.../ After: calm, satisfied, relieved, silly (by silly I mean kind of like stupid, but without the negative connotations” (Mary).

The best way I can describe it is that I feel like the walls are closing in on me. Like I’ve been holding my breath for a long time, or I reach such a level of emotion discomfort that I just...have to let it all out. After it’s euphoria. Straight up euphoria like when oxygen hits the brain when you’ve been holding your breath for seemingly forever (Anna).

While self-injury is an effective coping mechanism for some people, it is also maladaptive. The change in affect-state following self-injury often does not last for long, meaning that the individual will likely experience further strong emotions. The strong emotions call for another coping strategy to be used and as the individual has previously found NSSI to be effective, there might be an increased risk that he or she will engage in self-injury again (Wilcox et al., 2012; Klonsky (2009). Hurting oneself can evoke further strong feelings of shame or anger, which might make the experience yet more painful and make it even more likely that the individual will engage in NSSI in the future. Elizabeth describes her feelings before and after she hurts herself “Before:
Overwhelmed, like I'm going to explode, like I can't cope, like I want to kill myself /.../ After: Initial – relief, peace. Next day: Angry with myself for doing it, and sad that I felt that bad”.

Beforehand I typically feel an intense negative emotion (sadness, anxiety etc.) but rarely it might even be a strong positive emotion (intense love and longing, for example) /.../ Directly after I feel relief; but it's not long at all before feelings of regret, embarrassment, and self hate start to creep in, often at an overwhelming intensity (thoughts of ’what is wrong with me? Why did I do that? Why am I so screwed up?’) (Eve).

For those who might engage in NSSI to increase emotion or bring an end to disassociation, hurting oneself can bring a feeling of peace and grounding (Home & Csipke, 2009). Penny describes how self-injury helps her when she is disassociating or feeling numb

Before: I feel numb, not really feeling anything. To make me feel again I need pain, to feel more alive, to feel like I live I need blood /.../ After it I feel my feelings and emotions again but mostly in a quite calm and controlled way /.../ When I dissociate, I'm normally feeling very detached to my surroundings and my body /.../ I feel very 'ungrounded' /.../ and out of reality /.../ After it I often feel kinda exhausted but glad to be back.

Non-suicidal self-injury works as a coping strategy for the participants in various ways: “[Self-injury] allows for the ability to put distance and thinking space between the emotions and feelings to be able to decide how else to approach the situation” (Petra).

I don't know how it works, I just know it does. It turns the volume down on all my negative feelings and it energizes me, but in a calm way /.../ [Self-injury] is a coping strategy. Is it the best coping strategy? No, of course not. But it works and it's getting me through, and I'm okay with that (Mary).

Elizabeth says “It's like an escape valve on a steam pipe. If the emotion builds up to[o] much, self-injury releases it”.

I feel much more grounded, like I can see and cope with the world better. I want to say that things 'disappear' but it's more like they're somewhere more...grounded? I feel like I can FUCKING DO THIS, like I'm almost high. Nothing matters (Anna).
5.3.2 Alternative coping strategies

Previous research has found that adolescents who self-injure more often use emotion-based coping strategies, which are intended to regulate their emotions, rather than problem-solving strategies focused on altering the situation that provoked the emotions (Evans et al., 2005). When asked which coping strategies other than self-injury they use when dealing with strong emotions and difficult situations, the participants in the present study give an array of examples. Several of the participants report using emotion-based coping strategies, such as distracting themselves with a movie or knitting, however many of the participants also use problem-focused coping strategies when dealing with these difficult situations.

Emotion-based coping strategies include distracting oneself from the emotions that are overwhelming. Elizabeth talks about which coping strategies she used when she didn’t engage in self-injury

I distract through mindful knitting /.../ I get lost in the act of knitting and don't focus on the emotion /.../ It's hard at first, but I just keep doing it, and eventually the emotion passes, and I'm ok /.../ Writing also helps – I just brain dump the emotions, and that gets them out of my head and makes them more manageable.

Penny uses a variety of different emotion-based strategies to cope with the urges to self-injure. She is aware that the coping strategies she uses don't really deal with the feelings and emotions behind the urges and that the feelings are likely to come back

I often used music, my stress ball or a heart of smooth wood, writing on [the forum] or just my laptop /.../ trying to call someone. I also tried taking a cold shower, painting [my] arm red, chewing really sour bubble gum and stuff like that. When I'm at home, I mostly use distraction (normally TV and internet) till the urge is getting less (though I know that I don't really deal with my emotions and feelings behind the urge when I'm just distracting and for me it doesn't make it really go away, it'll come back later most of the time, it only works when the urges aren't that strong in the first place).
Some of the participants describe using a mix of emotion-based and problem-solving strategies. Eve gives some examples and stresses that it is important for her to be proactive

I do have an array of options /.../ (things like getting out of the house for a walk, intense exercise, breathing/meditation, etc.). I've made a point of sharing what I have been feeling with my husband (instead of bottling it up, which is more likely to lead to my hurting myself), making sure to maintain some amount of physical activity (running, etc.), and taking moments to do guided meditation /.../ Being proactive like that is key: if I let myself get to a place where I want to hurt myself, it is much harder to resist in the moment, because it does offer an attractive escape.

Ellen also describes that she has found that talking about her feelings is a very helpful tool for her to deal with her emotions

I find that the most helpful is talking to my husband about how I feel /.../ I feel like the security of our relationship and his ability to listen has removed the need for self-injury in its original form and I no longer need it as an emotional crutch.

Rebecka describes that she sometimes tries to use problem-solving coping when she is in emotional distress, by asking herself whether she needs e.g. food or sleep, as she knows that not having enough of either can increase her emotional vulnerability. If those needs have been met, Rebecka focuses on trying to distract herself by focusing on her favourite TV show or another activity. She also describes using mindfulness-techniques, such as engaging her sense like taste and smell.

Lazarus (1999) argues that it is not clear whether being able to use problem-solving coping strategies makes a difference in the way adolescents handle stress, but that it seems likely that it would. The results of the present study seems to indicate that the adults who use a mixture of emotion-based and problem-solving strategies are more equipped to cope more effectively with their emotions in a number of situations.
5.4 Age-related changes

In his study on US adults, Klonsky (2011) reports that 35% of the participants (n = 439) said that they had started engaging in NSSI at or after the age of 18. Klonsky describes further that the participants in his study had a median offset (i.e. the age when they stopped hurting themselves) of 20 years. Klonsky argues that this suggests that people engage in non-suicidal self-injury after adolescence in more than or equal to 50% of cases. Additionally, 30% of the participants in Klonsky's study reported that they had hurt themselves after the age of 25. The consequences of the relative dearth of studies on NSSI in adults mean that not much is known about how the experience of self-injury changes depending on the individual’s age. By examining the previous research of adolescents as well as the few studies of adults who engage in the behaviour, however, the researcher can attempt to hypothesize on the results. The aim of this study was partly to examine whether there were any age-related changes in the participants’ experiences of self-injury – the following sections explore changes in functions as well as other changes of the experience. Many participants describe different aspects of increased control and deliberation in their experience of NSSI as an adult, thus the second sub-theme is here labeled “deliberation and control”.

5.4.1 Change in functions

Consistent with the findings of Klonsky (2011), the present study found that the adults in the sample engaged in NSSI for similar reasons as those previously endorsed by adolescents. Emotion regulation is the most common function reported by the adults in the present study and the participants also describe other well-known functions, such as self-punishment, anti-suicide and anti-disassociation. A notable difference in the functions the participants describe for their self-injury in adolescence and in adulthood is that the participants more often described using self-injury as a way of communicating when they were younger. While most people do not hurt themselves to elicit attention and go to great lengths to hide it from others, some people self-injure in an attempt to communicate with others, for example to get health professionals to take the individual more seriously (Nock & Cha in Nock, 2009b). Nock's model (2009a) of self-injury as a distress signal when previous signals have not been strong enough is illustrated in the below quote by Ellen “[Previously, self-injury was also a way] to get the mental health team to understand there was something desperately wrong”. Jackson and Gould (2007) report in their review of the literature,
that it seems like younger adolescents are more likely to engage in NSSI for social reasons (e.g. as communication) than older individuals. The authors suggest that “... it is possible that the younger adolescents may initiate NSSI for social reasons but maintain engaging in NSSI for “internal reinforcement” (Jackson & Gould, 2007, p. 139). Several of the participants in the present study report that communication was one of the main functions of their self-injury when they were younger, but that they now hurt themselves mainly for emotion regulation, i.e. what Jackson & Gould term “internal reinforcement”. Nock and Prinstein (2005) corroborates these findings in their study where they found that younger age was associated with the social functions (e.g. communication) of their four-function model. These findings suggest that the results of the present study show some validity.

Besides using self-injury to express her despair to her mental health team, Ellen describes that she also used self-injury to express her feelings to others e.g. her parents, when she was younger

In my preteens and teens it was an expression of hurt, fear, anger and deep sadness. I feel that I used self-injury as an expression of these things on the outside and I felt that I was punishing my parents by hurting myself and causing them distress. I felt it was the only way I could communicate with them. [Later on,] self-injury became more about hurting myself and was born out of anger at myself and self-hate.

Penny also used self-injury to communicate when she was younger: “I mentioned somewhere [in the interview] that I did self-harm to communicate with professionals /.../ I stopped doing that years ago”. Expressing herself was one of the functions for Anna when she started hurting herself: “[Self-injury] was like a language to me, it was a way of expressing how I felt when I didn't have the linguistic capacity to do so”.

Mary reflects on whether the functions of her self-injury have changed, as she has grown older

I think that [self-injuring] for energy /.../ is new to me as an adult. I didn't do that when I was younger. But I'm also still [self-injuring] for all the same reasons as I did as a teenager too, I don't think there's a huge difference.
Rebecka states that she initially hurt herself to “cope with extreme emotional distress but I also used it to deal with normal everyday stuff like a bad grade, a fight with a friend or to prevent myself from sharing what was going on in my head”. As she has grown older, Rebecka now “/…/ use it to deal with unbearable emotions/thoughts/feelings.”

Mike says that self-injury serves the same functions for him now as it did when he was younger: “My purposes were nearly identical to what they are today. Need to lash out against myself and need to physical-ize overwhelming emotions.”

Sandra describes that when she started to hurt herself at age 21, “it was about the pain more than anything else /.../ the pain of [self-injury] instantly stopped how I was feeling”. Initially she was thinking about wanting to die when she hurt herself, but she later realised that “it was never a serious suicide attempt /.../ and the pain always worked instantly to make [the feelings] stop”. As an adult, Sandra uses self-injury to regulate her emotions in particular anger, stress, grief and sadness /.../ I do not deal well with my emotions and generally I try not to feel them. For the last four years, I've barely felt much of anything and I use [self-injury] when I start to feel because I just can't deal with a dam burst. I am too busy and I have too much at stake right now, and not a single bit of support, so I have to do what I can to keep going. [Self-injury] helps me not to feel, and that allows me to function.

Petra says that when she was younger, there were many times when she wasn't aware of why she hurt herself. She explains as I became older I was more aware of learning about why I was [self-injuring]. As I had almost always experienced my self-injury as an automatic response until I was about 30 years old I am unsure if it served a different purpose before 25 but I don't believe so.
Eve says that she has become more aware of the functions of her self-injury as she has gotten older.

I’ve become far more aware of the role that anger and self-punishment plays in hurting myself. In my younger years I looked at it primarily as a release, which was it certainly was (and still is), and I would have fought the proposition that it was an *aggressive* act against myself, often for purposes of self punishment—as obvious as that now seems.

### 5.4.2 Deliberation and control

Several of the participants in the present study have experienced an increase in control over their self-injury and describe that they have expanded their knowledge of the mechanisms behind the behaviour as they have grown older. They also report a greater awareness of different coping strategies and say that self-injury is not as instinctual and chaotic as when they were younger, but instead is a deliberate attempt at coping with difficult situations. The respondents also report that they have encountered attitudes from professionals that might suggest an understanding that self-injury in adulthood might be a slightly different experience than self-injury in adolescence. The professionals that the respondents have met in adulthood seem to express recognition that self-injury is not necessarily a behaviour that needs to be stopped immediately, but rather that it is a maladaptive coping strategy and that the treatment of self-injury in adults might need to be adapted to acknowledge the adult’s autonomy and ability to make his or her own choices. Focusing on exploring the cognitive-motivational processes of coping and developing more adaptive coping strategies might be suitable in the treatment of adults who engage in non-suicidal self-injury.

I think self injury as an adult is more measured in general and loses much of the running around crazy desperation it had as a teenager. I no longer crave the attention nor to punish those around me. I am more able to cope, I can make my own choices. I think this is central to the control of self injury (Ellen).

I think it's always been to manage strong emotions and that it was easier to deal with physical rather than emotional pain. I think the difference for me is in the level of intent. As a kid, self-injury was more instinctual or habitual, while as an adult it was always deliberate and very much a conscious choice (Elizabeth).
I'm more in control on where and how I self-harm. And even IF I self-harm, in the past it often felt like an uncontrollable urge, I felt like I HAD to do it. Now – at least a lot of the times – I make a more conscious decision to harm (Penny).

Eve describes her own experiences of self-injury as she has grown older and also reflects over her observations of some differences between younger and older people who self-injure

I can only speak for myself, but one thing that has been really interesting and notable for me is how my awareness of the purpose that it serves has changed over time. I also have the sense that a really difficult element of stopping as an adult is understanding that the urge is unlikely to disappear, even if I choose to stop. When I was younger I thought that stopping was conditioned on no longer feeling like I wanted to do it. When I participate in forums like [the web-forum used in the present study], I think a major difference between some of the younger and older participants is that the former seem more likely to operate on a similar premise; that no longer feeling the urge to do it is necessary in order to stop. The post-25 crowd, while not uniform, often seem to respond to slips with more of an awareness that they could have chosen otherwise, and that they can choose otherwise, even in the face of a strong desire to hurt themselves. These are very broad generalizations, of course; but it’s something that I have noticed, and that has been part of my personal experience over time as well.

The respondents were also asked to describe the treatment they have received from professionals when they have been treated for self-injury or related conditions both before the age of 25 and after. A pattern that emerges from the answers is that the participants experience that the reactions have been more balanced and focused on emotions rather than the physical injuries when they have sought help as an adult. The participants state that they feel their self-injury is not treated as necessarily a pathological factor and that the professionals they encounter do not try to push them into stopping the behaviour, but rather are willing to discuss options and ways to keep safe. As adolescents, the participants felt that they encountered attitudes of disgust and ignorance from the professionals who treated them for self-injury related conditions.

I feel that attitudes have changed, though whether that is my age or that the world of psychiatry has moved on I don't know /.../ I think now my doctors see me as a capable person who occasionally self-injures as opposed to self-injury being a pathological sign of a personality disorder. I feel previously (in my teens and early twenties) that I was infantilised and treated as stupid for self-injuring. Actually now my doctors really ignore it, unless
they think it needs treatment, for the same reasons that I do. Neither of us sees it as a significant feature of my psychiatric condition (Ellen).

Petra also says that the reactions from the professionals she has encountered have gotten better as she has aged

Before I was 25 the type of reactions I had from anyone were disgust, a threat to tell my parents…I recall one school counsellor who suggested that they wouldn’t’ hesitate to turn me over their knee’ if I didn’t stop /…/
After the age of 25 though /…/ in terms of dealing with the behaviours – the initial reaction was I think minor surprise [from her therapist] /…/ In general – more of a willingness to discuss options with me as to how to keep safe. Still some directive stuff but not to the same degree as it was when I was younger.

Lazarus (1999) cites a study that was conducted by Seiffge-Krenke who theorized that adolescents who are older than 15 years old are more able to think about alternative solutions and reflect upon the consequences of their actions in order to better solve the problem at hand than those adolescents under the age of 15 (Seiffge-Krenke (1995) cited in Lazarus, 1999). The present study is much too small to generalise, but the tendency for the participants to use problem-solving strategies to the same extent as using emotion-based ones might be related to the fact that the participants in the present study are adults over the age of 25. Adults who self-injure might have had more time to reflect upon their self-injury as well as more opportunities to learn to use a variety of coping strategies than the adolescents interviewed in previous research. They might also be more developmentally matured and be able to make more appropriate cognitive decisions. These facts could explain why the participants in the present study report using problem-solving coping strategies as often as emotion-focused strategies, when previous research found that adolescents who self-injure primarily use coping strategies that are intended to deal with their emotions (Borril et. al, 2009; Evans et. al, 2005).

It should be noted that the results of the present study might depend on other variables than the age of the participants. Most of the participants have engaged in self-injury for a long time (most have hurt themselves for over 10 years and a substantial number have engaged in NSSI for over 15 years), which might indicate that they have had exposure to treatment efforts for longer periods than those in previous studies. The participants were also recruited from a web-forum that is focused on
recovery and exploring coping strategies and might therefore have experience in employing problem-solving strategies and reflecting on their behaviour. However, the previous research explored for the present study and the research on coping theory indicate that there might be small differences in the experience of self-injury in adolescents and in adults.
6. Discussion

The aim of this study was to investigate how adults describe the functions of their non-suicidal self-injury (NSSI) and to explore whether they report any changes in their experience with NSSI as they become older. Ten e-mail interviews were conducted with individuals who were 25 years old or over and had engaged in NSSI five times or more. The participants were recruited from an international web-forum which has a pro-recovery focus and is dedicated to people who have experience with self-injury, both those who engage in the behaviour themselves and loved ones of individuals who self-injure. The material that emerged through the interviews was analysed with the help of coping theory and previous research.

NSSI has gotten increased research attention in the past 20 years; one of the important advances has been the study of self-injury as a purposeful coping strategy as well as the understanding of the functions of NSSI. It has become evident from both research studies and empirical studies with testimonies from individuals who self-injure that NSSI is effective in regulating emotions but that it is also a maladaptive coping mechanism as it does not resolve the conflict that provoked the need for a coping effort. The research attention, as well as the awareness in the general public, has been heavily focused on adolescents and young adults who self-injure which has led to a lack of knowledge of the fact that adults also engage in the behaviour. While adolescents are clearly at a higher risk of hurting themselves, the lack of awareness and attention to adults who self-injure might give the impression that self-injury is purely a phenomenon that exists in adolescence that people “grow out of”. The implication might be that an adult who self-injure must be “abnormal” because they are still engaging in something that is commonly thought to be a “teenage phase”. As an adult, seeking help for self-injury might be made more difficult by this double stigmatization, which is a sentiment that was expressed in the interviews “I haven't sought help as an adult /.../ I'm really afraid that if I did, people would tell me that it's stupid that I haven't 'outgrown' [self-injury]” (Mary).

Consistent with previous research, the participant of the current study reported engaging in NSSI for several reasons. The most common reason was emotion regulation; a way to reduce and control
overwhelming and unbearable emotions. The participants' rich descriptions illustrated clearly how the emotion regulation function works for them, for example describing it as a vent on a steam-pipe. When the pressure builds up too much, engaging in self-injury can help the individual to release the pressure. Using self-injury to increase emotion or end disassociation was also common emotion regulative functions. The participants also used self-injury to punish themselves for perceived wrongdoings or because of their feelings of self-hate. A few participants reported that NSSI sometimes functioned as a way of harm reduction in an effort to avoid suicide. The results in the present study corroborated the findings of Jackson and Gould (2007), which suggest that younger adolescents use self-injury as a communication method to a higher extent than those who are older. Several of the participants of the present study described that self-injury functioned as communication when they were younger; this was not relevant to their experience of the functions as adults.

A recurrent theme that emerged in the interviews was that the interviewees described that their self-injury is more controlled and more deliberate in adulthood. Several of the respondents say that while self-injury was a chaotic and almost instinctual reaction when they were younger, as an adult they are aware of the fact that self-injury is a choice and a coping strategy. When the participants were asked to describe their emotions prior to and after self-injury, they confirm the theory that the coping strategy (i.e. self-injury) is used as a mediator of their emotions, in accordance with the model developed by Folkman and Lazarus (1988). The act of self-injury commonly alters the participants’ affect-state, which is often described as a relief. As adults, the participants of the present study have often reflected quite extensively on the advantages and disadvantages of the behaviour and while many agree that it is not the best coping strategy, it is effective and it helps them cope, at least in the short-term. Having reflected over the functions of the behaviour has often led to insights into the mechanisms of self-injury, which has enabled the participants to purposefully use NSSI in order to achieve the outcome they desire. The participants report that the attitude of the professionals they have been treated by for self-injury related conditions as adults have reflected an acknowledgement that self-injury in adults can be an effective coping strategy and not necessarily a symptom of a severe mental disorder, which would need to be prohibited. Before the age of 25, the participants have experienced feelings of disgust and an attitude that ending the self-injury is the main goal of treatment. Drawing from the experience of the adults in the present study, a suggestion for future treatment of this population could be that focus should be on
respecting the individual's autonomy and ability to make choices and on exploring what functions self-injury serve for them in order to replace the behaviour with more adaptive coping strategies.

In the present study, the participants reported that they use a host of different coping strategies, besides self-injury. Previous research conducted on teenagers found that people who self-injure are more likely to use emotion-based strategies. A deviation from previous research is that the participants in the present study use emotion-focused and problem-solving strategies to approximately the same extent. Most of the previous research into self-injury has been conducted on teenagers, which could indicate that adults who self-injure use different coping strategies than adolescents.

To summarise, the present study concluded that self-injury serves mostly the same function for adults and adolescents. The study found that as reported in previous research, the participants of the present study used self-injury to communicate more often as adolescents and young adults. The interviewees describe a feeling of increased control and deliberation in their self-injury as they have aged and also report a greater awareness and insight of the functions of the behaviour. The participants of the present study use both emotion-based and problem-solving coping strategies in addition to their self-injury, which could implicate that adults who have an increased knowledge about the functions and purpose of self-injury might be more likely to be able to use both types of strategies, which according to Lazarus (1999) is a preferable way of coping, as it enables the individual to use an appropriate coping strategy in many different situations.

6.1 Study’s limitations

Like many retrospective studies of the functions of self-injury, a methodological flaw might exist in the present study. Recall bias means that individuals might have problems recalling what their motives were for self-injuring in the past, a fact especially pertinent to episodes of self-injury which occurred many years previously. Another issue with retrospective self-report studies is that the individuals might not be able to accurately describe the functions of their self-injury, either because of confusion with the questions asked or because of a lack of knowledge and insight about the behaviour (Jacobson & Gould, 2007). The present study uses a foundation of theoretical knowledge
and results from previous research, which supports the results and strengthens the validity of the study, but the matter of recall bias should still be kept in mind.

One of the problems with conducting e-mail interviews is that the researcher does not have access to the respondents' body language and tone of voice and might therefore miss nuances in the non-verbal information that is communicated (Hunt & McHale, 2007). On the other hand, the fact that the participants cannot see the researcher might be beneficial, in that it might reduce researcher bias (Patton, 2002). As the interviewer and the participants cannot see each other, the interpretation of the content of the interviews will depend upon the written interaction and will not be influenced by body language or appearance (Hunt & McHale, 2007). Carefully formulating the questions in a way that allows the participants to freely express themselves is of great importance in order to get honest and open reflections about their experiences and can hopefully address some of the problems inherent in a text-based interview.

When conducting online research, the researcher has to be aware of the risk of bias in the sampling. Depending on the place where recruitment of participants is conducted, a certain type of people might be over-represented (Hunt & McHale, 2007). The participants in the present study were purposefully recruited using members of an international web-forum for people who have experience of self-injury as a sample frame. Important to note is that different web-forums might attract different types of individuals who self-injure. The forum the participants of the present study were recruited from has a heavy focus on pro-recovery and encouraging healthy coping strategies, which might mean that the participants have spent a lot of time reflecting on self-injury, coping and functions. Using a sample from a different type of forum might have resulted in getting other results.

One of the risks of conducting several e-mail interviews simultaneously is that the researcher might mix up the results and forget which participant has said what. The author of the present study used a labeling system within the e-mail program in order to keep track of the process. Labels were attached to the e-mails sent and received and were adjusted accordingly in the process (Hunt & McHale, 2007).
6.2 Future research

I wish there was more research specifically on adults. I've answered loads of [self-injury] research questionnaires, that simply excluded adult experiences, such as asking how we got along in school, but not about work, or whether we went to our parents for decision making, well no mine have been dead 20 years, that kind of thing (Elizabeth).

Non-suicidal self-injury in adults has received relatively little attention in previous research. Self-injury is a behaviour that is now commonly known and addressed in media, the literature and among healthcare professionals; however most of attention is dedicated to adolescents. The exclusion of adults' experiences of self-injury contributes to a lack of awareness of adults’ self-injury in the general public and professionals alike. The norm that defines self-injury as a “teenage phase” creates a stigma for the adult who self-injures and might contribute to the adult not seeking professional help. The research on which coping strategies are employed by those who self-injure is of great importance, as it might have important treatment implications. Further research on whether there is a correlation between which coping strategies are used and the age of the person who self-injures might give insight on how effective interventions should be designed.

Another potentially interesting research inquiry could be whether there is a correlation between age and an experience of more control and deliberation in NSSI. The present study is small and bigger studies might produce interesting information.

Self-injury in all ages – especially in adults needs to be recognized and talked about so that people who self-injure can allow themselves to realize they are not alone and that if they want, they can change (Petra).
7. References


http://nationellasjalvskadeprojektet.se/download/18.59ed6e76141e0456cb2061/1384268936164/Kvalitetsdokument+sj%C3%A4lvskadebeteende+Sk%C3%A5nenoden.pdf


http://www.scb.se/sv_/Hitta-statistik/Statistik-efter-amne/Befolkning/Befolkningens sammansattning/Befolkningsstatistik/25788/25795/Helarsstatistik---Riket/262459/


Appendix 1 – Interview guide

Background questions

1) How old are you?

2) Which country do you currently reside in?

3a) Have you self-injured 3 or more times while you were 25 or over?

3b) Did you self-injure 3 or more times below the age of 25?

4a) At what age did you start to self-injure?

4b) Can you estimate the total amount of time (years, months) you have self-injured (excluding any gaps between years/months)?

5) What gender are you? (your own definition)

----

6) Can you describe the frequency of your self-injury for the past 12 months? (in average; eg. twice a week, once a month etc.)

7) Can you describe the purpose of your self-injury? Please describe in as much detail as you can.

8a) What methods do you use to self-injure?

8b) Do different methods have different purposes, or work in different circumstances? Can you describe them?

9) Are there any differences in the methods you used when you were younger than 25 as compared to after the age of 25?

10) Do you remember what the purpose was for your self-injury when you started? Can you describe it?

11) Do you feel that there were any different elements to your self-injury when you were younger (younger than 25)? Did anything change? Specifically in regards to the purpose of your self-injury – do you feel that self-injury served different purposes for you when you were younger?

12) Can you describe your feelings and emotions before, during and after you self-injure?
13) Can you describe how self-injury helps you to cope with your feelings and emotions?

14) Can you describe the last few times when you used any other coping mechanisms (besides self-injury) to handle your emotions? What did you do? What were you feeling before you used the coping mechanism and how did you feel afterwards? Did it help?

15) What reactions have you experienced from others regarding your own self-injury as an adult?

16) Have you ever sought professional help (such as for example a therapist or doctor) for your self-injury (or related issues where the professional knew about your self-injury) when you were over 25? How did they react to your condition? If you received treatment before the age of 25, can you identify any differences in the attitudes of staff towards younger people and adults?

17) If you currently self-injure, do you want to stop? Why, or why not? (if you're unsure, please feel free to expand on that)

18) Do you have any other reflections on self-injury and adults?
Appendix 2 – Cover letter

Hi!

My name is Maria (Mia) Bejmo and I’m currently doing my bachelor's thesis at Högskolan i Gävle (University of Gävle) in Sweden.

I study International Social Work and the title of my thesis is “Functions of non-suicidal self-injury in adults”. The definition of self-injury that I'm using for this study is “the deliberate destruction of one's own body tissue without suicidal intent and for purposes not socially sanctioned.”, and adult is defined as aged 25 or above.

Much of the research in the area of deliberate self-injury has been centered on adolescents and young adults. I feel that it is important to extend this research to the adult population, to raise awareness that self-injury is not simply a “teenage phase” and to get a better understanding of self-injury in this population. I would like to extend to you the opportunity to assist with this research, by sharing your own experiences as an adult who self-injures (or has self-injured). Any insights that you would be able to provide would be greatly appreciated and would be kept confidential.

All participation in the study is entirely voluntary and you have the right to withdraw your participation at any time. The transcripts of the interviews will only be available to myself, my supervisor and the examiner(s) of the thesis. All identifying information will be kept completely confidential. Your e-mail address or name will not be connected to the results displayed in the thesis; all participants will be referred to using a code name throughout the work. Any personal information will only be visible to me. After completion of this project, all data and records will be destroyed.

The risks of participating in this study are minimal, however your wellbeing is my primary concern and I recognise that self-injury can be a distressing topic. Should you start to feel upset, it is strongly suggested that you step back from answering the questions. You can always come back to answering the questions at another time if you feel able to.
The interview will be conducted via e-mail and will consist of open-ended questions that explore the reasons for and functions of self-injury in your own words. To ensure that I get a rich and detailed picture of your opinions and reflections, I am hoping for the chance to follow up on the information that has arisen in the interview.

You are entitled to have access to the results of this study, which will be published in the form of a thesis. I can arrange with individual participants for a copy to be sent by email if required.

Should you have any concerns or questions, please do not hesitate to get in touch.

If you understand this information and you give your consent that the information you give in the interviews will be used for the purposes outlined for this study, please reply to this e-mail and clearly state that you give your consent.

Regards,

Maria Bejmo

[e-mail address]

Supervisor:

Tomas Boman

[phone-number]

[e-mail address]
Appendix 3 – Instructions for answering the interview questions

Please read the cover letter carefully before proceeding. If you understand the information and you give your consent that the information you give in the interviews is used for the purposes outlined for this study, please reply to this e-mail and clearly state that you give your consent.

The interview questions are attached to this e-mail – I have included both an Open Office version (.odt) and a Microsoft Word (.doc) version for your convenience, please let me know if you require another format. You can either answer the questions in the file itself and send it back to me as an attachment or copy and paste the interview questions and your answers into the body of an e-mail. Please make sure to indicate which question you are answering in your reply. Please also indicate whether you'd like to receive a copy of the study when it is completed.