

The functions of self-injury in young adults who cut themselves: Clarifying the evidence for affect-regulation

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Abstract

The functions of non-suicidal self-injury were examined in 39 young adults with a history of skin-cutting and other self-injurious behaviors including banging, burning, and severe scratching. Consequences, affect-states, and reasons associated with self-injury were assessed by a structured interview. Results indicate that self-injury is associated with improvements in affective valence and decreases in affective arousal. Specifically, participants tended to feel overwhelmed, sad, and frustrated before self-injury, and relieved and calm after self-injury. Further, these affective changes predict lifetime frequency of self-injury, suggesting that they reinforce the behavior. Finally, although reasons for self-injury related to both affect-regulation (e.g., to release emotional pressure that builds up inside of me) and self-punishment (e.g., to express anger at myself) were endorsed by a majority of participants, affect-regulation reasons were overwhelmingly rated as primary and self-punishment reasons as secondary.

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1. Introduction

Non-suicidal self-injury (henceforth *self-injury*) can be defined as intentional, direct damage to one's body tissue without suicidal intent (Herpertz, 1995; Muehlenkamp, 2005). Other terms that have been used to reference this behavior include *deliberate self-harm* (Pattison and Kahan, 1983), *superficial-moderate self-mutilation* (Favazza and Rosenthal, 1993), *self-wounding* (Tantam and Whittaker, 1992), and *parasuicide* (Ogundipe, 1999). Common forms of self-injury include

skin-cutting, scratching, burning, and self-banging or hitting (Briere and Gil, 1998; Favazza and Conterio, 1989; Herpertz, 1995; Nijman et al., 1999; Whitlock et al., 2006). Mental health professionals have long been concerned with self-injury because of the behavior's robust association with psychopathology and suicide (Skegg, 2005). Some argue that self-injury should constitute its own diagnostic syndrome in light of the behavior's clinical significance and presence across multiple disorders (Muehlenkamp, 2005).

Self-injury can be found in patients diagnosed with mood, anxiety, substance abuse and dependence, eating, and psychotic disorders, as well as each of the personality disorders, and especially borderline personality disorder (Haw et al., 2001; Herpertz et al., 1997;

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Simeon et al., 1992; Skegg, 2005; Stanley et al., 2001; van der Kolk et al., 1991; Zlotnick et al., 1999). Although self-injury is relatively common in clinical settings (Favazza, 1989; Suyemoto and MacDonald, 1995), it can also be found in non-patient populations. Approximately 4% of individuals from large community samples report a history of self-injury (Briere and Gil, 1998; Klonsky et al., 2003). Lifetime rates appear to be particularly high in adolescents and young adults, where approximately 15–17% report a history of self-injury (Laye-Gindhu and Schonert-Reichl, 2005; Whitlock et al., 2006).

Unfortunately, treatment of self-injury can be challenging (Muehlenkamp, 2006). Increasing our understanding of why people self-injure could improve treatment for these individuals. To date, studies have provided evidence for several functions of self-injury, including that self-injury is a means of regulating negative affect, punishing oneself, influence others, halting dissociative episodes, resisting urges to attempt suicide, and sensation-seeking (Briere and Gil, 1998; Brown et al., 2002; Coid, 1993; Herpertz, 1995; Kemperman et al., 1997; Nock and Prinstein, 2004; Shearer, 1994). A recent review of this literature suggests that evidence most consistently supports an affect-regulation model of self-injury (Klonsky, 2007). Specifically, three types of evidence support an affect-regulation function: (a) most participants who self-injure report that they do so to reduce negative affect; (b) self-report and laboratory studies suggest that negative affect precedes self-injury and that affect improves following self-injury; and (c) proxies for self-injury performed in laboratory settings cause reductions in negative affect. The review went on to outline several areas in need of further study (Klonsky, 2007).

First, although research documents that significant improvements in affect follow self-injury (Briere and Gil, 1998; Kemperman et al., 1997), the nature of these affective changes is unclear. At least two dimensions underlie affective experience, valence and arousal (Feldman, 1995; Russell, 1991). However, research has not determined whether the affective changes associated with self-injury involve changes in valence, arousal, or both. Valence refers to the pleasantness of emotion (e.g., ‘happy’ is pleasant and positive, ‘sad’ is unpleasant and negative), whereas arousal refers to the intensity of emotion (e.g., ‘excited’ is high arousal and ‘calm’ is low arousal even though both are pleasant; likewise, ‘anxious’ is high arousal and ‘hopeless’ is low arousal even though both are unpleasant).

Second, research has not specified the affect-states that are most associated with self-injury. For example, do people feel less lonely following self-injury? Less

empty? More exhilarated? More calm? Each of these outcomes is consistent with prior research indicating that affect improves following self-injury, but each would have different theoretical and clinical implications.

Third, it is not clear that the improvements in affect associated with self-injury can be conceptualized as providing motivation or reinforcement. For example, research has not addressed whether larger improvements in affect are associated with increased frequency of self-injury. An affect-regulation model of self-injury requires evidence that the affective improvements subsequent to self-injury encourage or reinforce the behavior.

Finally, it is unclear how to reconcile evidence for multiple functions. Although different functions may co-occur or overlap conceptually, some functions may be more common or fundamental than others. For example, in multiple studies reasons related to regulating affect and punishing oneself are endorsed more often than other reasons (Briere and Gil, 1998; Brown et al., 2002; Favazza and Conterio, 1989; Shearer, 1994). Other studies confirm that most individuals endorse reasons related to affect-regulation but find that self-punishment reasons are endorsed by a minority of participants (Herpertz, 1995; Nock and Prinstein, 2004). It would be useful to determine if affect-regulation reasons are indeed more fundamental than self-punishment reasons or if both types of reasons are equally prominent. Distinguishing primary and secondary reasons would inform case conceptualization and treatment planning in clinical settings, and provide a meaningful context for the design of future studies on the etiology, course, and treatment of self-injury.

The present study was conceived to address the gaps in the self-injury literature described above. Thirty-nine young adults with histories of repeated self-injury were administered a structured interview that assessed consequences, affect-states, and reasons associated with self-injury. The interview was designed to measure the affective experience of self-injury more comprehensively than previous studies and to allow participants to distinguish between more and less important reasons for self-injury.

2. Method

2.1. Participants

Participants were 39 young adults who screened positive for repeated self-injury and completed an interview about their self-injury. To ensure a clinically relevant sample, a conservative threshold was used to recruit participants. To be included in the study,

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