NEGATIVE EMOTION AND NON-SUICIDAL SELF-INJURY

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NEGATIVE EMOTION AND NON-SUICIDAL SELF-INJURY

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ABSTRACT

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This seminar paper resulted from a review of completed research in the area of negative emotion and non-suicidal self-injury (NSSI). In addition, the seminar paper included a discussion of the association between emotions and body regard. This research reviewed the relationship between emotional awareness and deliberate self-harm and examined the association between non-suicidal self-injury (NSSI) and emotional relief.

This study also reviewed the current definition used to describe NSSI and the barriers/challenges that adolescents and young adults encountered as it pertained to NSSI and body regard. This seminar paper discussed the psychology of self-harm and behavioral problems as they pertained to daily emotion. Finally, the seminar paper analyzed ways to raise awareness and solutions for handling people who engage in NSSI. Most importantly, it introduced an inventory/survey that was designed to capture feelings and thoughts of participants involved in NSSI.
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Chapter One: Introduction

Three previous studies measured the association between emotion and non-suicidal self-injury (NSSI) assessing whether or not a significant relationship existed between the two variables. First, Gratz, Chapman, Dixon-Gordon, and Tull (2015) examined the strength of the association between deliberate self-harm (DSH), also known as non-suicidal self-injury (NSSI), and emotional relief. Findings indicated that participants with a recent recurrent history of DSH/NSSI had a stronger association between DSH/NSSI and emotional relief than those participants without a history of DSH/NSSI.

Second, Muehlenkamp, Bagge, Tull, and Gratz (2013) examined the role of body regard in the association between emotion dysregulation and NSSI. Muehlenkamp et al., predicted that emotion dysregulation would be associated with NSSI only in the context of low body regard. Interestingly, emotion dysregulation, Borderline Personality Disorder, and general negative affect were not significantly related when controlling for low body regard.

Third, Victor and Klonsky (2014) examined specific emotions that individuals experienced when engaging in NSSI. Findings indicated that participants in the NSSI group experienced higher levels of negative emotions and lower levels of positive emotions. Dissatisfaction with self was a common negative emotion that many participants in the NSSI group reported experiencing.

Statement of the Problem

The problem addressed was whether or not a significant relationship existed between negative emotion such as depression and non-suicidal self-injury (NSSI) in the context of low or
high body regard. In addition, this study investigated if the relationship of NSSI to negative mood would be moderated by body regard. This study was designed to extend previous research by identifying if a relationship existed between negative emotion and NSSI in the context of low body regard.

**Purpose of the Study**

The purpose of this study was to identify whether body regard was a moderator of the relationship between negative emotion and NSSI. Research showed that negative emotions such as, anger, sadness, jealousy, etc., can often lead to disliking oneself, self-esteem issues, and self-harming behaviors. Exploring this relationship not only raised awareness to individuals engaging in self-harming behaviors but also provided researchers and other professionals the opportunity to confirm if negative emotion is a contributor to NSSI. By reviewing this study, readers were expected to develop an understanding of both negative emotion and NSSI, know the difference between low and high body regard in the context of negative emotion and NSSI, and determine if any significance exists between NSSI and negative emotion in the context of body regard.

**Significance of the Study**

The findings of this study enhanced the understanding of negative emotion, NSSI, and the relationship between the two. Self-harm was prevalent among the adolescent population and was becoming a popular self-medicating approach for treating negative emotion (Muehlenkamp, Bagge, Tull, & Gratz, 2013). The increase in individuals engaging in self-harming behaviors justified the need for more education related to this topic as well as to effective coping strategies. Based on the results from this study, individuals, professionals, and researchers were able to more effectively treat and educate those who experienced negative
emotion, engage in self-harming behaviors, and have low/high body regard. Researchers were able to better identify how one variable impacted the other by adding this study to the limited research that assessed the relationships among these variables.

**Research Questions**

This research focused on the relationship between negative emotion and non-suicidal self-injury (NSSI) in the context of low and high body regard. The following two contrasting questions were the basis of this research:

- Would persons with low body regard have higher scores when measuring negative emotions and engage in non-suicidal self-injurious behaviors more frequently?
- Would persons with high body regard have lower scores when measuring negative emotion and engage in non-suicidal self-injurious behaviors less frequently?

**Definition of Terms**

**Beck Depression Inventory:** A 21-item, self-report rating inventory that measures characteristic attitudes and symptoms of depression (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).

**Body Attitude Scale (BAS):** An assessment used to measure the multidimensional construct of body regard (Muehlenkamp et al., 2013).

**Body Regard:** How one perceives, experiences, and cares for the body (Muehlenkamp et al., 2013).

**Emotion Dysregulation:** The inability of a person to control or regulate emotional responses to provocative stimuli, also termed “emotional hyperactivity” (Psychological Care and Healing Treatment Center, n.d.).
Inventory of Statements about Self-Injury (ISAS): An assessment used to measure the lifetime frequency of 12 methods of NSSI (Klonsky & Glenn, 2014).

Non-Suicidal Self-Injury (NSSI): Behaviors (burning, cutting, scratching, etc.) involving the deliberate, direct destruction of body tissue without suicidal intent (Muehlenkamp et al., 2013).

Delimitations of the Research

Delimitations of this research study included several important limitations of prior research in this area. First, the relation between different forms of body regard as it pertained to negative emotion, maltreatment, and NSSI remained unclear, as most studies examined only one type of neglect or abuse. This made it difficult to compare results across studies. Furthermore, participants in the studies reviewed might not have reflected the entire population of persons who were affected by negative emotions and non-suicidal self-injury.

Results of these studies were not generalized to the entire population because of the sample sizes. In addition, participants in the studies reviewed might not have accurately report their own behaviors and attitudes, as the participants may have had a history of engaging in non-suicidal self-injurious behaviors or experienced symptoms of negative emotions such as depression. Participants might not have wished to or have been unable to reveal such behaviors and attitudes due to their specific diagnoses.

Method of Approach

Few studies had investigated non-suicidal self-injury (NSSI), or the deliberate, direct destruction of body regard without conscious suicidal intent, and the motivations for engaging in NSSI among adults. This research consisted of a review of literature on negative emotion and non-suicidal self-injury with the following five-faceted focus:
• Exploration of the association of deliberate self-harm with emotional relief

• Exploration of the reciprocal relations among non-suicidal self-injury, negative emotions, and relationship

• Body regard as a moderator of the relation between emotion dysregulation and non-suicidal self-injury

• Rumination and emotions in non-suicidal self-injury and eating disorder behaviors

• Daily emotion in non-suicidal self-injury

Furthermore, this research paper sought to discover if a direct correlation existed between body regard and non-suicidal self-injury.

Research for this topic was done on the University of Wisconsin-Platteville campus in the Karman Library. The EBSCO Host database was used to locate studies to be reviewed. The following keywords were used to identify research that related to this completed study: Self-harm, Suicide, Body Regard, and Self-injury. In addition, related searches included the names of specific research professionals who had done work that was related to this topic.
Chapter Two: Review of Literature

Introduction

Self-injury had become very prevalent in the first two decades of the 21st century society with one (1) in five (5) females and one (1) in seven (7) males engaging in self-injurious behaviors each year. Non-suicidal self-injury (NSSI) was a common mental health threat among individuals. Non-suicidal self-injury is defined as the intentional, self-inflicted damage to the surface of the body without suicidal intent (Muehlenkamp et al., 2013). This definition excluded accidental and indirect self-injurious behaviors; e.g., disordered eating or drug abuse, suicidal behaviors, as well as socially accepted behaviors like tattooing, piercing, or religious rituals. The most common methods in evidence were cutting, scratching, hitting or banging, carving, and scraping.

This review aimed to present the current literature on the correlation between adolescents, psychological behavior problems, emotion dysregulation, body regard and self-harm to raise awareness of the condition of NSSI. Information gathered in this study could provide researchers and other professionals the opportunity to confirm if a reciprocal relation existed among NSSI, negative emotion and relationships. Another focus of this study was to identify whether body regard was a moderator of the relationship between negative emotion and NSSI. In addition, this review sought to clarify the distinction between eating disorders and negative emotion and how depression, body image, and self-harming behaviors intertwine with NSSI. Furthermore, this review addressed emotional links to NSSI and how information regarding these topics might be used to prevent NSSI or to encourage persons so involved to seek help.
**Exploration of the Association of Deliberate Self-Harm with Emotional Awareness Relief**

Gratz, Chapman, Dixon-Gordon, and Tull (2015) conducted a correlational study examining the strength of association between deliberate self-harm (DSH)/non-suicidal self-injury (NSSI) and emotional relief. Diagnostic interviews, self-reports, and laboratory tasks such as the Implicit Association Test were used to assess the various aspects of DSH/NSSI, personality, negative emotions, and the strength of association between DSH/NSSI and emotional relief. Gratz et al., found a strong association between DSH/NSSI and emotional relief, especially among those who had a history of recent recurrent DSH/NSSI. Several characteristics such as DSH/NSSI methods, higher levels of intrapersonal motives (emotion regulation) versus interpersonal motives for DSH/NSSI, and greater Borderline Personality Disorder (BPD) pathology were linked to greater DSH/NSSI. Gratz, Chapman, Dixon-Gordon, and Tull examined a community sample of young adults (113 with recent recurrent DSH; 135 without DSH). As hypothesized, results revealed stronger associations between DSH and relief among participants with DSH versus without DSH, as well as among DSH participants with BPD versus without BPD. Moreover, the strength of the DSH-relief association was positively associated with DSH frequency and versatility (both lifetime and at 6-month follow-up), BPD pathology, emotion dysregulation, experiential avoidance, and self-reported emotion relief motives for DSH. Findings provided support for theories emphasizing the role of emotional relief in DSH (particularly among individuals with BPD), as well as the construct validity, predictive utility, and incremental validity (relative to self-reported emotion relief motives) of this Implicit Association Test.
Correlations Among Non-Suicidal Self-Injury, Negative Emotions, and Relationship Problems

You, Leung, and Fu (2012), explored the linkage between non-suicidal self-injury (NSSI), negative emotions, and relationship problems. You et al., were interested in assessing the associations between negative emotions and relationship problems and integrated both emotional and relationship problems into the same model. You et al., found that adolescent girls reported engaging in NSSI behaviors more than adolescent boys. Both adolescent girls and boys reported engaging in pulling hair and scratching behaviors more frequently than bleaching skin or dripping acid onto the skin. Lastly, negative emotions did not predict NSSI over time. Thus, this study highlighted the relative importance of four major BPD features, which are affective instability, disturbed interpersonal relationship, unstable sense of self, and behavioral impulsivity, in explaining the presence, initiation, repetition, and discontinuation of non-suicidal self-injury (NSSI). You et al., found affective instability, disturbed interpersonal relationship, and behavioral impulsivity were significantly associated with the presence of NSSI both concurrently and longitudinally. These three BPD features were also related to the future initiation of NSSI. On the other hand, only behavioral impulsivity made a significant contribution to the repetition of NSSI. Additionally, a lower level of affective instability was also associated with quitting NSSI. Thus, this aspect of the study tied into Gratz, Chapman, Dixon-Gordon, and Tull’s conclusions regarding some possible mechanisms underlying the effects of different BPD features on different developmental stages of NSSI.

The Association Between Emotion Dysregulation and Body Regard

Muehlenkamp, Bagge, Tull, and Gratz (2013) examined the role of body disregard in the association between emotion dysregulation (the inability to control emotional responses) and
NSSI, predicting that emotion dysregulation would be associated with NSSI only in the context of low body regard. For example, if an individual did not care for his or her body properly or was experiencing self-dissatisfaction he or she was more likely to experience emotion dysregulation and engage in NSSI behaviors. Muehlenkamp et al., suggested that body regard had to be a contributing factor for an association to exist between emotion dysregulation and NSSI. The findings of Muehlenkamp et al., indicated that emotion dysregulation, BPD, and general negative affect were not significantly related to NSSI when controlling for body regard.

**Rumination and Emotions in Non-Suicidal Self-injury and Eating Disorder Behaviors**

Arbuthnott, Lewis, and Bailey (2015) examined the relationship between repeated rumination trials (a strategy used for regulating emotions) and emotions in NSSI using the emotional cascade model. The emotional cascade model predicted that individuals with a history of NSSI or Eating Disorder Behaviors (EDB) would experience increasingly negative emotions after negative cognitive processes. The goals of the Arbuthnott et al., study were to test this component of the emotional cascade model, specifically, changes in emotions after rumination, and to explore the role of mediators of the relation between behavior history and increasingly negative emotions in a sample of young adults. Findings indicated that individuals who experienced negative emotions and emotion dysregulation were at a greater risk for NSSI and EDB as a means to regulate affect and cognitions.

**Daily Emotion and Non-Suicidal Self-injury**

Victor and Klonsky (2014) conducted two studies examining specific emotions that individuals experienced when engaging in NSSI. Participants in the first study were college students. Individuals who had engaged in NSSI in the previous six months were placed in one group and individuals who did not have any history of NSSI were placed in the second group.
Participants in the second study, Victor and Klonsky (2014), were adults in the U.S. who chose to participate in the study for compensation. Adults participating in this study had to have either a recent history (previous six months) of NSSI or no history of NSSI.

Findings from both studies indicated that individuals in the NSSI group experienced higher levels of negative emotions and lower levels of positive emotions. Dissatisfied with self was a common negative emotion that many participants in the NSSI group reported experiencing; however, no specific emotions associated with NSSI history were found (Victor & Klonsky, 2014).

Exploration of Adolescent Definition and Perception of Self-Harm

Laye-Gindhu and Schonert-Reichl conducted a study examining self-harm among adolescents. This study assisted with identifying the prevalence and types of self-harm amongst the adolescent population. According to Laye-Gindhu and Schonert-Reichl (2005), there existed a dearth of empirical research examining the motivations underlying self-harm and the function that self-harm serves. Results from research indicated that self-harm motivations included to express, reduce, or distract feelings of loneliness, depression, and/or emptiness; to release anger or tension; to punish oneself; to regain control; and/or to detach. Words such as loneliness, depression, and anger described negative emotions which tended to motive self-harming behaviors. A primary focus of this particular study was to understand how adolescents defined and perceived self-harm (Laye-Gindhu and Schonert-Reichl, 2005).

A total of 424 participants were in this study--236 were female participants and 188 were male participants who attended a public high school in Canada. In this study 70% of the study participants identified as European; 13% identified as Asian; 7% identified as mixed ethnicity; and 10% identified as other. Several questionnaires, inventories, and reporting scales such as
Self-Harm Survey, Reynold's Adolescent Adjustment Screening Inventory (RAASI), Anger Discomfort Scale, etc. were tools available for such research. These tools were used to assess self-harm, motivations of self-harm, psychological adjustment difficulties, and negative emotion such as anger.

Findings from this study indicated that of the study participants, 15% reported self-harm with more females than males engaging in these types of behaviors. Participants reported common self-harming behaviors such as cutting, hitting, biting, bonebreaking, and recklessness, but also perceived substance abuse and eating disorders as a type of self-harm. This particular study highlighted the importance of acknowledging the viewpoints and perceptions of adolescents as it related to self-harm. Furthermore, the emotional states reported by the self-harmers as leading up to a self-harming incident were predominantly negative, with the most common emotions being anger, depression, loneliness, and frustration (Laye-Gindhu and Schonert-Reichl, 2005). According to the findings, self-harmers were more likely to be emotionally distressed, less social, lack confidence/low self-esteem, and have difficulties controlling anger.

Five limitations were acknowledged by the researchers. (1) Only 16 of 188 boys reported self-harm, which had a significant impact on categorical variables and cell sizes. (2) The study had limited generalizability with the targeted population being adolescents. (3) The study only targeted adolescents who were in school. Researchers acknowledged the increased psychopathology amongst adolescents who are no longer in school. (4) Only self-reports were used to assess self-harm. If other measures were used such as informational interviews with physicians and close family members, more information could have been gathered regarding past and present history of self-harm. (5) Lastly, emotional states before, during, and after self-harm
were gathered. Researchers acknowledge the benefit of gathering this data as participants experience these emotions. Overall, findings from this study support the notion that, in most cases, negative emotion motivates self-harming behaviors.

**Youth Self-Harming and Psychological Behavior Problems Associated with Non-Suicidal Self-Injury**

E.D. Klonsky (2011) conducted a study examining the prevalence and nature of NSSI. Klonsky (2011) referenced previous research acknowledging the percentages of youth engaging in self-harming behaviors and a variety of psychological problems associated with NSSI. Depression, anxiety, and suicidality are examples of psychological problems associated with NSSI, to name a few. Klonsky’s study focused on providing more information regarding NSSI as a lack of empirical research examining NSSI amongst a diverse population of adults existed in 2011.

This study sample was selected using a random-digit dialing procedure to contact individuals across the U.S. Of 1,557 eligible households, 439 agreed to complete an interview. Klonsky (2011) provided contact information for mental health services following the interview because self-harming could be a sign of psychological distress and suicide risk. A 40-question interview was conducted with each participant to assess the following: characteristics of NSSI, sociodemographics, and mental health history.

Findings from this study suggested that the lifetime prevalence of NSSI in the US was 6% and was higher amongst younger adults than older adults. Participants reported common self-harming behaviors such as burning, hitting, and biting, which were consistent with previous research. Additionally, participants in the study reported having had mental health treatment of some sort which supported previous research and its findings regarding the relationship between
NSSI and mental illness. Regarding functions of NSSI, most injurers in the study reported that the motivation for self-harm was related to the regulation of negative affect (release emotional pressure, to stop bad feelings, etc.) (Klonsky, 2011). This information was consistent amongst the younger and older adult populations.

Limitations of Klonsky’s study included the following: (1) the sample size lacked generalizability and (2) the study did not measure mental disorders, which could have helped determine the relationship between NSSI and mental illness. These limitations could be addressed in future research. Overall, Klonsky’s study did provide supporting information related to NSSI and negative emotion.

Non-Suicidal Self-Injury and Impulsivity

Glenn and Klonsky (2010), conducted a study examining the relationship between NSSI and impulsivity. This study hypothesized that self-injurers would display some forms of impulsivity. The primary goal was to examine impulsivity using the Impulsive Behavioral Scale (UPPS). Previous research suggested that individuals who self-harm typically have had difficulties regulating negative emotions and used NSSI to cope with these emotions (Klonsky, 2010). Furthermore, this study also hypothesized that those who engage in self-injurious behaviors would exhibit less premeditation than non-injurers.

Approximately 1,110 college students from introductory psychology courses were screened for a history of NSSI behaviors. Researchers screened for the following behaviors: skin-cutting, burning, etc. Of these 1,110 students, 216 students reported engaging in at least one NSSI. Of 216 participants, only 82 students were willing to participate in this study. The total sample included 82 students who engaged in at least one self-harming behavior, and 86 who had not.
A variety of assessment tools were used to gather relevant information from each participant including: questionnaires, self-reports/inventories, and self-rating scales. These tools were used to assess the frequency and functions of NSSI, mental illness, impulsivity, and inhibitory control.

Findings from this study suggested that self-injurers were characterized by impulsivity as they tended to engage in risky behaviors when experiencing a negative affect and/or emotion. Similar to previous research, self-injurers reported experiencing frequent intense negative emotions and using NSSI to cope with this negative emotional experience (Glenn and Klonsky, 2010). This study supported the hypotheses that self-injurers exhibited less premeditation as findings suggested there was a relationship amongst self-injurers and poor planning.

Researchers acknowledged several limitations including: (1) the study sample only consisted of college students and was not a good representation of self-injurers, (2) the range of impulsivity was restricted to a college sample, (3) the relationship between impulsivity and emotionality was not examined. Researchers suggested that future studies focus on impulsivity as it related to emotion regulation, and lastly (4), the temporal relationship of impulsivity and NSSI was unclear. Researchers suggested conducting a longitudinal study to clarify the role that impulsivity played in NSSI.

**Conclusion**

As a result of this review of literature, clearly a relationship was shown to exist between negative emotion, NSSI, and body regard. The Gratz, Chapman, Dixon-Gordon, and Tull (2015) study revealed a connection between emotional relief and individuals practicing NSSI. You, Leung, and Fu (2012), found that persons who had practiced NSSI had done this as a result of difficulties in building and sustaining significant relationships. Muehlenkamp, Bagge, Tull,
and Gratz (2013) concluded that individuals practicing NSSI tended to have low body regard and difficulties regulating emotion. Arbuthnott, Lewis, and Bailey (2005) revealed that individuals who experienced negative emotions and emotion dysregulation were at a greater risk for NSSI and eating disorders. Laye-Gindhu and Schonert-Reichl (2005) found that more females than males engaged in NSSI behaviors. Glenn and Klonsky (2010) found a connection between NSSI and impulsivity in that individuals experiencing negative emotion engaged in risky behaviors and used NSSI as a coping mechanism. Conclusions and recommendations resulting from this review of literature follow in Chapter 3.
Chapter 3: Summary, Conclusions, and Recommendations

Summary

Males and females of all ages, ethnic groups, and religions self-injure according to a study done by Laye-Gindhu and Schonert-Reichl (2005). While the study showed evidence that males injured in almost equal numbers to females, males did not present in treatment nearly as frequently. Why this might be was unclear, except that male participants in the study tended to have a much more difficult time asking for help (Laye-Gindhu & Schonert-Reichl, 2005). Additionally, persons engaged in self-injury in adolescence or preadolescence and continued into early adulthood. However, myths continued to exist that self-injury was a "teen" problem. In the experience of this researcher in working with adults and adolescents, older adults engaged in self-injury as well, although it usually, but not necessarily, began in adolescence.

Conclusions

The research discussed in Chapter 2 indicated that emotional dysregulation, emotional experience, and negative emotions were strongly associated with NSSI. However, a third variable such as body regard needs to be factored in for there to be a significant association with NSSI. Evidence from the studies reviewed indicated that girls reported having engaged in NSSI significantly more than boys; however, boys and girls used similar methods when engaging in this behavior (Laye-Gindhu and Schonert-Reichl, 2005). In the study by Gratz, Chapman, Dixon-Gordon, and Tull (2015), Exploration of the Association of Deliberate Self-Harm with Emotional Awareness Relief (2015), some individuals who reported having engaged in NSSI sought temporary or long-lasting emotional relief. On the other hand, due to limited research, it was unknown if a direct relationship between negative emotional experiences and NSSI existed.
only in the subjects in the study or if this relationship might apply to a broader range of persons. If other variables such as low body regard were present, the relationship was more likely to occur; but whether a direct relationship existed between the two was unclear.

**Recommendations**

The intent of this research was to raise awareness of individuals engaging in self-harming behaviors. Based on the literature review completed as part of this study, the following recommendations may be taken into consideration. Looking at factors that contribute to negative emotion and NSSI, it is safe to say something needs to be done to raise awareness.

My first recommendation is to have a clear understanding of the definition of self-harm, so if a person ever interrupts someone else who is in the act of deliberate self-injury, that person could intervene in a supportive and non-judgmental way. This action is only possible if that person had the proper awareness and information concerning NSSI.

Second, advice from this researcher includes the following: Although it is natural to feel upset, helpless, and even angry upon finding out that someone self-injures, try to remain calm and avoid expressions of shock or anger. Tell the person engaged in the behavior about concern for him or her and ask whether anything could be done to alleviate the distress. Ask if medical attention is needed.

Third, publicize and promote Self-Injury Awareness Day (SIAD), which is an international awareness day that takes place every year on March 1 and is a day meant for learning about self-injury behaviors and for providing resources to those who are in need of help. An orange ribbon, representing a sign of hope for a misunderstood problem, symbolizes this awareness day. The recommendation of this researcher is to use social media as an awareness
outlet to promote Self Injury Awareness Day prior to and on March 1 and to wear an orange ribbon.

Fourth, be willing to name NSSI behaviors as an issue that has solutions and can be stopped. Ultimately, once youth with NSSI issues become aware of this behavior as an issue, parents and counseling professionals can prepare the participants of NSSI for sessions to unpack the emotion barriers they face in their daily emotion dysregulation. They will be more likely to join the transition programs that are available to become aware of high and low body regard. The patients will increase their awareness, will be encouraged to want better, and will feel connected to a support team.

Fifth and most importantly, this researcher has created a survey (see Appendix A) to assess harmful behavior patterns and a body regard indicator. This researcher believes that answers for the questions in the survey can be helpful in the development of treatment, both in creating plans to help persons who participate in NSSI and in evaluating their daily emotional balance. The survey is comprised of four parts:

- **Inventory of Statements About Self-Injury (ISAS) – Part I**
- **Beck’s Depression Inventory – Part II**
- **Body Attitudes Scale (BAS) – Part III**
- **Demographic Information – Part IV**

Specifically, the **Inventory of Statements About Self-Injury (ISAS) – Part I** of the questionnaire was written to help professionals better understand the experience of non-suicidal self-harming individuals; the inventory is designed to help gage emotional imbalances and self-harming experiences. Secondly, **Beck’s Depression Inventory – Part II** evaluates daily emotion and feelings that occur over time to determine if there is a pattern over time that leads
individuals to feel depressed. Thirdly, the **Body Attitudes Scale (BAS) – Part III** of the questionnaire concerns body integrity, attractiveness, health and effectiveness to evaluate one’s perception of him- or herself. Lastly, **Demographic Information – Part IV** was included because gathering this type of demographic information is essential and will help future professionals develop an understanding of the history of depression, experiences that self-harmers have, and the perception self-injurers have of themselves. This information collected and accumulated over time is expected to inform professionals to tailor specific plans that suit individual needs of participants in NSSI. Use of this survey in future research is strongly recommended.

In conclusion, raising awareness of NSSI in the culture and recognition of SIAD will be a great benefit to NSSI participants, as a whole. When it comes to educating the public and participants themselves about the issues they face, the goal is to understand and become comfortable discussing the issues. Professional counselor/s and parents should serve as advocates for persons who participate in self-injury. These three recommendations--fostering programming, creating events and workshops, and trying to bridge the gap between fear of the unknown and creating awareness about NSSI--can impact all people, but especially ones who have resorted to NSSI behaviors as a means of emotional relief. The final recommendation to use the survey in future research could be invaluable to developing successful treatment regimens for NSSI patients.
References


Appendix A

Questionnaire
Appendix A
Questionnaire

INVENTORY OF STATEMENTS ABOUT SELF-INJURY (ISAS) – Part I

This questionnaire asks about a variety of self-harm behaviors. Please only endorse a behavior if you have done it intentionally (i.e., on purpose) and without suicidal intent (i.e., not for suicidal reasons).

1. Please estimate the number of times in your life you have intentionally (i.e., on purpose) performed each type of non-suicidal self-harm (e.g., 0, 10, 100, 500):
   - Cutting ______
   - Severe Scratching ______
   - Biting ______
   - Banging or Hitting Self ______
   - Burning ______
   - Interfering w/ Wound Healing (e.g., picking scabs) ______
   - Carving ______
   - Rubbing Skin Against Rough Surface ______
   - Pinching ______
   - Sticking Self w/ Needles _____
   - Pulling Hair ______
   - Swallowing Dangerous Substances ______
   - Other ___________

**************************************************************************  
**Important: If you have performed one or more of the behaviors listed above, please complete questions 2-46. If you have not performed any of the behaviors listed above, please skip questions 2-46 and proceed to question 47.**
**************************************************************************

2. If you feel that you have a main form of self-harm, please circle the behavior(s) in question 1 (above) that you consider to be your main form of self-harm.

3. At what age (approximate date – month/date/year) did you:
   - First harm yourself? ____________
   - Most recently harm yourself? ____________

4. Do you experience physical pain during self-harm?
   Please circle a choice: YES    SOMETIMES    NO

5. When you self-harm, are you alone?
   Please circle a choice: YES    SOMETIMES    NO

6. Typically, how much time elapses from the time you have the urge to self-harm until you act on the urge?
   Please circle a choice: < 1 hour    1-3 hours    3-6 hours    6-12 hours    12-24 hours    >1 day

7. Do/did you want to stop self-harming?
   Please circle a choice: YES    NO
**Instructions**

This inventory was written to help us better understand the experience of non-suicidal self-harm. Below is a list of statements that may or may not be relevant to your experience of self-harm. Please identify the statements that are most relevant for you:

- **Circle 0 if the statement not relevant for you at all**
- **Circle 1 if the statement is somewhat relevant for you**
- **Circle 2 if the statement is very relevant for you**

**“When I self-harm, I am …”**

<table>
<thead>
<tr>
<th>Response</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2</td>
<td>8. Calming myself down</td>
</tr>
<tr>
<td>0 1 2</td>
<td>9. Creating a boundary between myself and others</td>
</tr>
<tr>
<td>0 1 2</td>
<td>10. Punishing myself</td>
</tr>
<tr>
<td>0 1 2</td>
<td>11. Giving myself a way to care for myself (by attending to the wound)</td>
</tr>
<tr>
<td>0 1 2</td>
<td>12. Causing pain so I will stop feeling numb</td>
</tr>
<tr>
<td>0 1 2</td>
<td>13. Avoiding the impulse to attempt suicide</td>
</tr>
<tr>
<td>0 1 2</td>
<td>14. Doing something to generate excitement or exhilaration</td>
</tr>
<tr>
<td>0 1 2</td>
<td>16. Letting others know the extent of my emotional pain</td>
</tr>
<tr>
<td>0 1 2</td>
<td>17. Seeing if I can stand the pain</td>
</tr>
<tr>
<td>0 1 2</td>
<td>18. Creating a physical sign that I feel awful</td>
</tr>
<tr>
<td>0 1 2</td>
<td>19. Getting back at someone</td>
</tr>
<tr>
<td>0 1 2</td>
<td>20. Ensuring that I am self-sufficient</td>
</tr>
<tr>
<td>0 1 2</td>
<td>21. Releasing emotional pressure that has built up inside of me</td>
</tr>
<tr>
<td>0 1 2</td>
<td>22. Demonstrating that I am separate from other people</td>
</tr>
<tr>
<td>0 1 2</td>
<td>23. Expressing anger towards myself for being worthless or stupid</td>
</tr>
<tr>
<td>0 1 2</td>
<td>24. Creating a physical injury that is easier to care for than my emotional distress</td>
</tr>
<tr>
<td>0 1 2</td>
<td>25. Trying to feel something (as opposed to nothing) even if it is physical pain</td>
</tr>
<tr>
<td>0 1 2</td>
<td>26. Responding to suicidal thoughts without actually attempting suicide</td>
</tr>
<tr>
<td>0 1 2</td>
<td>27. Entertaining myself or others by doing something extreme</td>
</tr>
<tr>
<td>0 1 2</td>
<td>28. Fitting in with others</td>
</tr>
<tr>
<td>0 1 2</td>
<td>29. Seeking care or help from others</td>
</tr>
</tbody>
</table>
30. Demonstrating I am tough or strong
31. Proving to myself that my emotional pain is real
32. Getting revenge against others
34. Reducing anxiety, frustration, anger, or other overwhelming emotions
35. Establishing a barrier between myself and others
36. Reacting to feeling unhappy with myself or disgusted with myself
37. Allowing myself to focus on treating the injury, which can be gratifying or satisfying
38. Making sure I am still alive when I don’t feel real
39. Putting a stop to suicidal thoughts
40. Pushing my limits in a manner akin to skydiving or other extreme activities
41. Creating a sign of friendship or kinship with friends or loved ones
42. Keeping a loved one from leaving or abandoning me
43. Proving I can take the physical pain
44. Signifying the emotional distress I’m experiencing
45. Trying to hurt someone close to me
Beck's Depression Inventory – Part II

Please read each group of statements carefully, and then pick out one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements seem to apply equally well, select the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 62 (Changes in Sleep Pattern) or Item 18 (Changes in Appetite).

47. Sadness
   0  I do not feel sad.
   1  I feel sad
   2  I am sad all the time and I can't snap out of it.
   3  I am so sad and unhappy that I can't stand it.

48. Pessimism
   0  I am not particularly discouraged about the future.
   1  I feel discouraged about the future.
   2  I feel I have nothing to look forward to.
   3  I feel the future is hopeless and that things cannot improve.

49. Past Failure
   0  I do not feel like a failure.
   1  I feel I have failed more than the average person.
   2  As I look back on my life, all I can see is a lot of failures.
   3  I feel I am a complete failure as a person.

50. Loss of Pleasure
   0  I get as much satisfaction out of things as I used to.
   1  I don't enjoy things the way I used to.
   2  I don't get real satisfaction out of anything anymore.
   3  I am dissatisfied or bored with everything.

51. Guilty Feelings
   0  I don't feel particularly guilty
   1  I feel guilty a good part of the time.
   2  I feel quite guilty most of the time.
   3  I feel guilty all of the time.

52. Punishment Feelings
   0  I don't feel I am being punished.
   1  I feel I may be punished.
   2  I expect to be punished.
   3  I feel I am being punished.
53. **Self-Dislike**
   0  I don't feel disappointed in myself.
   1  I am disappointed in myself.
   2  I am disgusted with myself.
   3  I hate myself.

54. **Self-Criticalness**
   0  I don't feel I am any worse than anybody else.
   1  I am critical of myself for my weaknesses or mistakes.
   2  I blame myself all the time for my faults.
   3  I blame myself for everything bad that happens.

55. **Suicidal Thoughts or Wishes**
   0  I don't have any thoughts of killing myself.
   1  I have thoughts of killing myself, but I would not carry them out.
   2  I would like to kill myself.
   3  I would kill myself if I had the chance.

56. **Crying**
   0  I don't cry any more than usual.
   1  I cry more now than I used to.
   2  I cry all the time now.
   3  I used to be able to cry, but now I can't cry even though I want to.

57. **Agitation**
   0  I am no more irritated by things than I ever was.
   1  I am slightly more irritated now than usual.
   2  I am quite annoyed or irritated a good deal of the time.
   3  I feel irritated all the time.

58. **Loss of Interest**
   0  I have not lost interest in other people.
   1  I am less interested in other people than I used to be.
   2  I have lost most of my interest in other people.
   3  I have lost all of my interest in other people.

59. **Indecisiveness**
   0  I make decisions about as well as I ever could.
   1  I put off making decisions more than I used to.
   2  I have greater difficulty in making decisions more than I used to.
   3  I can't make decisions at all anymore.
60. **Worthlessness**
   0  I don't feel that I look any worse than I used to.
   1  I am worried that I am looking old or unattractive.
   2  I feel there are permanent changes in my appearance that make me look unattractive
   3  I believe that I look ugly.

61. **Loss of Energy**
   0  I can work about as well as before.
   1  It takes an extra effort to get started at doing something.
   2  I have to push myself very hard to do anything.
   3  I can't do any work at all.

62. **Changes in Sleeping Pattern**
   0  I can sleep as well as usual.
   1  I don't sleep as well as I used to.
   2  I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
   3  I wake up several hours earlier than I used to and cannot get back to sleep.

63. **Irritability**
   0  I don't get more tired than usual.
   1  I get tired more easily than I used to.
   2  I get tired from doing almost anything.
   3  I am too tired to do anything.

64. **Changes in Appetite**
   0  My appetite is no worse than usual.
   1  My appetite is not as good as it used to be.
   2  My appetite is much worse now.
   3  I have no appetite at all anymore.

65. **Concentration Difficulty**
   0  I haven't lost much weight, if any, lately.
   1  I have lost more than five pounds.
   2  I have lost more than ten pounds.
   3  I have lost more than fifteen pounds.

66. **Tiredness or Fatigue**
   0  I am no more worried about my health than usual.
   1  I am worried about physical problems like aches, pains, upset stomach, or constipation.
   2  I am very worried about physical problems and it's hard to think of much else.
   3  I am so worried about my physical problems that I cannot think of anything else.

67. **Loss of Interest in Sex**
   0  I have not noticed any recent change in my interest in sex.
   1  I am less interested in sex than I used to be.
   2  I have almost no interest in sex.
   3  I have lost interest in sex completely.
Body Attitudes Scale (BAS) – Part III

This questionnaire concerns body integrity, attractiveness, health and effectiveness. Please write the appropriate number on the line next to each question.

1 - Strongly Agree   2 - Disagree   3 - Neither Agree Nor Disagree   4 - Agree   5 - Strongly Agree

_____ 68. Most people find me attractive.
_____ 69. I try never to do anything that threatens my health.
_____ 70. Sometimes I feel disconnected from my body.
_____ 71. Most days I physically feel sick.
_____ 72. I am good at most sports activities.
_____ 73. I often seem to damage my health without seeming to.
_____ 74. Everyone deserves to have sexual pleasure.
_____ 75. I am not a good-looking individual.
_____ 76. I have never had the experience of feeling outside of my body.
_____ 77. Good health is one of the most important things in my life.
_____ 78. Sometimes my body feels out of control.
_____ 79. I do not have physical endurance.
_____ 80. I take care of myself when I feel sick.
_____ 81. My body is sexually appealing.
_____ 82. Sometimes my body feels like an enemy.
_____ 83. I hate being touched by others.
_____ 84. I am currently at an attractive weight.
_____ 85. I like my looks just the way they are.
_____ 86. I can imagine having a satisfying sex life in the future.
_____ 87. Most of the time when I look in the mirror, I feel ugly.
_____ 88. I would prefer to live without a body.
_____ 89. I like the idea of having a physically mature body.
_____ 90. I enjoy being sexually aroused.
91. I liked my body much better before it matured.
92. I am not a physically coordinated individual.
93. I am presently at a healthy weight.
94. I have to work hard to make myself more attractive to others.
95. Sexual experiences give me pleasure.
96. My looks often disgust me.
97. People consider me a very good athlete.
98. I frequently wish I was more sexually attractive.
99. I often feel at war with my body.
100. I am physically ill more often than I am well
101. I prefer to avoid sexual experiences.
102. I feel that my body is strong.
103. I think of myself as sexually appealing.
Demographic Information – Part IV

Please circle the letter that best represents your answer.

104. What is your age?
   a. Younger than 18 years
   b. 18-25 years
   c. 25-30 years
   d. 30 years or older

105. What is your gender?
   a. Male
   b. Female

106. Circle the ethnicity/race that best represents you…
   a. American Indian or Alaskan Native
   b. Asian
   c. Black or African American
   d. Native Hawaiian or other Pacific Islander
   e. White
   f. Hispanic or Latino