"My Scars are My Battle Wounds; I Made it Through": Non-Suicidal Self-Injury in a Gender Diverse College Population

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Abstract

Non-suicidal self-injury (NSSI) on college campuses is frequent, with one in five college students having reported engaging in self-injury. The impacts of childhood trauma and abuse are believed to play a role in NSSI behavior and elevate risk factors for individuals in adulthood. The purpose of this study was to explore the experiences of gender diverse college-aged individuals who have engaged in NSSI. Results indicated that most of the participants reported trauma influenced their NSSI behavior. Though there was not a significant report of family-based trauma, it was found that the traumatic experience that most of the participants shared was having a traumatic sexual experience (59% n = 46). Some clinical implications and directions for future research are discussed.

Keywords: non-suicidal self-injury, trauma, abuse, college populations, gender diverse

Introduction

Non-suicidal self-injury (NSSI) is the deliberate act of harming oneself without the intent to die (Hall & Place, 2010; Nixon et al., 2002). Young adults who are college age may be at particular risk for NSSI (Chia et al., 2008; Kaniuka et al., 2020). Given the rise of NSSI in this population, it is imperative to understand and address factors that may contribute to NSSI in college students. Specifically, it has been documented that NSSI plays an important role in coping with trauma symptoms and that trauma symptoms may mediate the relationship between occurrence of traumatic events and NSSI (Smith, et al., 2013). The purpose of this paper is to explore the experiences of young adults who have reported NSSI as well as a history of traumatic events and their perceptions of family support. Based on previous research, it is expected that those individuals who report engaging in NSSI also report a traumatic event such as abuse or violence in their past. Thus, the research questions for this paper are, "Do young adults who engage in NSSI have trauma in their history?" and "What is the support system for young adults who engage in NSSI?"

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Literature Review

What is Non-Suicidal Self-Injury?

NSSI is defined as the intentional destruction of one's body tissue without suicidal intent and for purposes not socially sanctioned (Klonsky et al., 2014). NSSI can occur in many ways but not limited to, cutting, burning, punching oneself, purposely breaking bones, and more. It is not the act that defines NSSI but the motivations behind it (Cornell University, n.d.). Specifically, NSSI has been associated with emotion regulation, self-punishment, and distress (Taylor et al., 2018).

There are several misunderstandings about NSSI, and correlation does not guarantee causation. In other words, mental health symptoms (e.g., depression and anxiety) and NSSI may be related, but does not mean one phenomenon necessarily causes the other. Initially, NSSI was seen as a symptom of borderline personality disorder (BPD); although NSSI can be a symptom of BPD, it also stands alone outside the comorbidities of other psychiatric diagnoses. It was previously believed that childhood sexual abuse can solely influence a person to participate in NSSI. Studies have shown that childhood sexual abuse influences NSSI, but only moderately (Klonsky et al., 2014).

Suicidal vs. Non-Suicidal Self-Injury?

Despite most NSSI participants' motives not being suicidal, that does not mean there are no individuals who self-injure in attempt to commit suicide. It is not uncommon for an NSSI participant to idolize suicide or death (Nock et al., 2006). NSSI and suicide attempts typically co-occur for self-injuring individuals, and NSSI is a risk factor for future suicide attempts (Nock et al., 2006). Researchers have theorized these links; however, future research is needed in this area. One of the many theories researchers have postulated is that individuals who participate in NSSI are less fearful of pain or death, so suicide is not as difficult for them to try (Wilkinson & Goodyer, 2011). NSSI individuals may make conscious decisions to commit suicide, too. It was reported that 70% of adolescents in the study who recently engaged in NSSI reported one suicide attempt in their lifetime (Nock et al., 2006).

Mental Illness, Personality, & Non-Suicidal Self-Injury

Mental illnesses are not rare in people who engage in NSSI. The two most common types of mental illness that NSSI individuals report having are anxiety and depression (Robertson et al., 2013). The most studied personality traits that commonly occur for NSSI individuals are neuroticism, low openness to experience, lower extraversion, conscientiousness, and agreeableness.

Reinforcement Sensitivity Theory (RST) is another personality theory that could apply to NSSI individuals. People with RST have two traits: sensitivity to punishment or sensitivity to reward. RST is also linked to individuals with anxiety or depression (Robertson et al., 2013). A 14-day study (Ose, Tveit, and Mehlum, 2021), found that individuals with personality disorders were more likely to participate in

NSSI. Individuals in the study who have had recent suicide attempts were the most common to partake in NSSI. This is not surprising data since one of the diagnosis criteria of self-injury is experiencing symptoms of BPD. Individuals who live with the effects and symptoms of eating disorders are also susceptible to engage in NSSI; however, Bulimia nervosa is the most common type of eating disorder in terms of NSSI engagement (Ose et al., 2021).

Peer or Family Support

In addition to links between mental health and NSSI there is also the importance of social support. There are also several risk factors that could influence an individual to self-injure, including, but not limited to, childhood maltreatment, physical abuse, sexual abuse, psychological abuse, physical neglect, low self-esteem, and traumatic life events. Having peer or family support can reduce the risk of a person participating in NSSI, especially among women (Christoffersen et al., 2015). Furthermore, social support was noted as especially helpful for individuals with post-traumatic stress disorder (PTSD) and low self-esteem. For example, individuals with trauma from combat or disaster who have social support lessened their distress with PTSD symptoms. Social support is considered a mediator between NSSI and traumatic experiences.

Influence from Friends

According to Syed and colleagues (2020), adolescents may self-injure because their friends also engage in NSSI. NSSI contagion is a phenomenon that can occur when an adolescent is aware of their friend participating in NSSI and then self-injure due to this influence. NSSI can become a trauma bonding experience between peers which can then cause the self-injuring to become more frequent (Syed et al., 2020). Another theory this study presented was that adolescents experience a phenomenon called assortative relating, which is when similar individuals form friendships because of their shared qualities, attitudes, or behaviors. NSSI can become normalized within a friend group, and adolescents who are vulnerable or at-risk may begin to self-injure and participate in NSSI.

Abuse, Trauma, & Neglect

Physical abuse, sexual abuse, psychological maltreatment, physical neglect, and being bullied are just some of the reasons why one may self-injure (Christoffersen et al., 2015). According to Martin et al., (2016), individuals were more likely to participate in NSSI if they have experienced maternal maltreatment rather than paternal. Divorce, inter-parental violence, and low socio-economic status were more contributing factors as to why the individuals self-injured. The odds of engaging in NSSI are increased if a person experiences unfavorable family-life events (Martin et al., 2016).

Family Therapy and NSSI

Much of the treatment for NSSI has focused on prevention or reducing physical harm to oneself (Smithee et al., 2019; Weissman, 2009) and has been individually and symptom focused. In other words, treatments such as cognitive behavioral therapy, dialectical behavior therapy, and psychopharmacological medication management—while important and empirically validated—have focused primarily on treating the symptom and behavior, as opposed to looking at the larger family context where symptoms manifest. Understanding environmental factors which may contribute to NSSI behaviors is important in terms of sustaining long-term remission of NSSI and reducing the risk of repetition (Miner et al., 2016). Even if a college student lives outside of the home in which they were raised, family environment can still greatly impact and contribute to the young person's sense of support around them and the understanding of their experience.

Hypotheses

Based on previous research (Suyemoto & Macdonald, 1995) indicating that female-identifying individuals were more likely to engage in certain types of NSSI (e.g., cutting), it was hypothesized that the sample would be predominantly female identifying. Due to research findings reporting links between NSSI and underlying trauma/abuse in families-of-origin (Miner et al., 2016), it was also hypothesized that individuals who engaged in NSSI would also have a history of trauma and/or abuse, including possible sexual trauma prior to the age of 17 years.

Method

Participant Recruitment and Description

Participants for this study were recruited through the following methods: (1) social media sites (e.g., Women's Advice Group and Mental Health Support) and (2) an email listserv focused on female-identifying students at a Midwestern university. To participate in the study, participants had to report having engaged in NSSI and be at least 18 years old. This resulted in a total sample of 61 participants who completed the survey who ranged in age from 18-42 years with a mean age of 24.26 years (SD = 6.01). Most of the sample identified as female (68.9%, n = 42), White/Caucasian/of European descent (65.5%, n = 40), bisexual (31.2%, n = 19), and having at least some college (70.5%, n = 42). It is important to note that while we aimed to recruit a female-identifying population, given the research that shows females are at increased risk of participating in NSSI (Suyemoto & Macdonald, 1995), our participants represented diverse gender identities, including gender queer and gender nonbinary.

Additionally, 70.5% (n = 43) reported living in the United States with representation from various regions throughout the U.S. (Iowa, Minnesota, Missouri, Wisconsin, Tennessee, and Connecticut) and five individuals reporting from outside the United States (United Kingdom, Malaysia, and Canada). Fifty-four percent of participants reported residing in a suburban or urban area, with 21% reporting living in a rural area. It is important to note that within our demographics, 15-18 participants

did not respond to demographic questions asking about race, sexual orientation, gender, and age. We attribute this missing data to survey fatigue or the desire of the participants to remain anonymous, even though participants were informed that their responses would not be identified. Moreover, participants reported that the family structure in which they were raised consisted of nuclear families (e.g., two parents/caregivers) (49.2%, n = 30), step/blended families (8.2%, n = 5), single parent families (3.3%, n = 2), grandparent families (1.6%, n = 1), chosen families (e.g., not biological or legal) (1.6%, n = 1), other (4.9%, n = 3), and 19 participants did not respond. When asked with whom participants identified as supportive persons in their lives, a majority responded family members, friends, and romantic partners.

Measures

The Non-Suicidal Self-Injury Assessment Tool (NSSI-AT) (Whitlock et al., 2013) was used to assess functions, frequency, age of onset, initial motives, practice patterns, disclosure, and treatment experiences. Participants responded to items using the scale's 7-point Likert measure ("Strongly agree" to "Strongly disagree"). Sample items included "I hurt myself to feel something," "I hurt myself because my friends hurt themselves," "I hurt myself to deal with frustration," and "I hurt myself in hopes that someone would notice that something is wrong or that so others will pay attention." It is important to note that test-retest reliability of NSSI-AT scores in the Whitlock et al. (2013) study was based on a small population (n = 25) and thus, more information using larger samples is needed. Participants were also asked to choose all that apply to the following question, "Have you ever done any of the following with the purpose of intentionally hurting yourself?" and were given a list of 15 examples of NSSI actions (e.g., cut wrist, bitten self, punched oneself, etc.).

Procedures

After receiving Institutional Review Board (IRB #20210387) approval from a Midwestern university, data for this study were collected using a variety of recruitment methods. Emails and electronic announcements informed potential participants about the study and included a link to an electronic copy of the survey. Social media announcements were posted on sites that individuals (female identifying) frequented for support around mental health, some of which included NSSI topics. Of the 74 participants who clicked the link and consented to participate, only 61 were eligible to participate and completed nearly most or the entire survey. Upon starting the survey, participants were presented with informed consent followed by a description of the study. If participants agreed to terms and met criteria, they were then provided with primary and secondary NSSI characteristics, NSSI functions, NSSI frequency, trauma scale questions, and a series of demographic questions. Participants were informed that their participation in the study was entirely voluntary and that they could stop the survey at any time. They were also informed that there was no way of identifying their anonymous answers after the survey was submitted. Upon completion of the survey, participants were provided with local and national mental health resources, as well as the opportunity to provide their email address to receive a copy of the survey's results.

Results

The findings of this study report frequencies and descriptions from the Non-Suicidal Self-Injury Assessment Tool (NSSI-AT; Whitlock et al., 2013) as well as demographics about the sample. Overall, we found that most of the participants who reported a trauma history consequently reported that this history influenced their NSSI behaviors. The traumatic experience that most of the participants shared was a traumatic sexual experience. Out of 46 respondents, 59% of the participants answered "yes" to having a sexual trauma history and 41% answered "no." The least shared traumatic experience of the participants was being a victim of violence, including child abuse, being mugged or assaulted. With this question, 24% reported "yes" and 76% reported "no." The study also offered a section for the participants to self-report a major upheaval in their life that could have shaped their personality or experiences. Within the sample, 69% self-reported traumatic events, while 33% self-reported no other traumatic events. Self-reported traumatic events included cutting off from immediate family members, being cut off due to coming out, parental conflict, emotional neglect, involvement of a parent with drugs/addiction, parental unemployment, and experiences of bullying.

In the last set of questions, the survey asked participants to reflect on how NSSI impacted their life, whether positively or negatively. A majority of the respondents reflected on how NSSI impacted their lives by indicating "the lasting marks / scars are constant reminders of bad / rough times in [their] life" and "in thinking / discussing [their] experience[s] around intentionally hurting myself, [they] have learned a lot about [themselves] and because of it have mentally / emotionally grown." One participant reflected that "[my] scars are my battle wounds – I made it through."

We found that while a majority of participants reported self-harming more than two years ago, others reported a range as recent as one week ago (n = 8) to one to two years ago. It is important to note that the researchers of this study provided participants with a list of both local and national resources at the end of the survey to seek out support should they find anything in the survey to be triggering or find that after taking the survey (whether they completed or not) they are considering counseling/therapy support.

Finally, participants were asked what description best describes the family structure in which they were raised. A majority of participants (57%) reported being raised in a nuclear family (e.g., two parents/caregivers; n = 30), while just under 30% of participants (n = 15) reported being raised in a step/blended (17%) or single parent family (12%). Two participants reported being raised by grandparents, one by chosen family (i.e., not biological or legal), and four others chose "other." Specifically, one participant shared, "I took care of myself and raised my two younger siblings. The extent of my parents involvement was a roof over our heads some of the time." Another participant stated that their living situation was fluid as they went from their mother's boyfriend's place to their grandma's place as well as their dad and stepmom's places.

Discussion

The current study explored the experiences of young adults who have engaged in NSSI, as well as a history of traumatic events and their family support. Overall, we found that most of the participants who reported a trauma history consequently reported an influence on their NSSI behaviors. The traumatic experience that most of the participants shared was having a traumatic sexual experience. Prior research reinforces our findings that certain types of risk factors, such as childhood sexual abuse and interpersonal dysfunction underlie NSSI behaviors (Cheasty et al., 1998; Christoffersen et al., 2014). Researchers postulate that one of the reasons individuals who engage in NSSI can be attributed to a physical, emotional, and sexual abuse history (Zetterqvist, et. al., 2015).

Some individuals in the study compared sex involving physical pain to cutting themselves. Moreover, there are both direct and indirect forms of NSSI, such as cutting and binge eating. According to research, the most common type of NSSI reported for female identifying individuals is cutting (59.2%), while the second most reported behavior is burning and hitting, which is most common for male identifying individuals (Freeman et al., 2017). Previous studies have shown that an individual can participate in up to ten ways of self-harming (Cornell University, n.d.), which is consistent with the findings in the study. NSSI is most likely to occur on the hands, wrists, stomach, or thighs of the individual's body. The severity of the act can vary from superficial injury to lasting scars or disfigurement. In two separate college studies, 33% of participants who reported engaging in NSSI indicated that they should have gone to see a doctor due to the significance of their physical wounds,while only 6.5% in the other study were treated professionally for their self-inflicted injuries (Cornell University, n.d.). The findings in this study reinforce the bulk of research of severity and frequency of NSSI.

Given the finding that approximately one-third of individuals who participated in the study identified as bisexual, it is important for future research to explore additional factors related to discrimination of sexual orientation and links to NSSI. Indeed, minority related stress (Meyer, 1995) impacts individuals living in a heterosexist society who are subjected to chronic stress related to the stigmatization of their identity. This same sentiment can be offered for individuals identifying as gender queer and gender non-binary. Thus, future research might explore the impact of minority-related stress on sexual and gender minority populations in the context of NSSI.

Family Therapy as Early Prevention

As stated earlier in the results section, some of the self-reported events were related to bullying, parental drug addictions, parental conflict, mental health concerns, neglect from caregivers, low social economic status, and emotional trauma. Given that the occurrence of NSSI is likely to continue and that the family is serving a significant role in a young person's life, it is important for couple/marriage and family therapists to consider this mental health phenomenon in context to the family. The inclusion of NSSI in the 2013 Diagnostic Statistical Manual has brought more awareness around the prognosis, symptoms, and duration of NSSI. While research has reported other influences, such as media and peer influences and biological and

psychological vulnerabilities (Schade, 2013), the family can be both a source of strength as well as a source of vulnerability and adaptation of maladaptive behavior patterns. Thus, addressing the function and the family from a systemic perspective can help shift the perspective of clinicians from an individual focus to looking at the relationship NSSI has with the larger family system.

Limitations and Future Research

Since this study was focused on female-identifying populations, the study was limited. However, it is noted that a number of our participants for this study identified as non-binary and/or gender queer. It is also noted that the data were collected from a mostly White sample. Thus, it is possible that data from a more racially and ethnically diverse sample would illustrate divergent or variant findings.

Study participants were also self-selecting, and it also possible that they had strong views about NSSI. Additionally, the findings of the study represent cross-sectional data. In other words, their responses are a snapshot in time and participants were not able to elaborate on their findings in person. Future studies should seek to collect longitudinal data and consider focus groups or in-person interviews to gather more detailed, rich data.

Finally, a next step in this research is analysis of quantitative findings to identify possible correlations between specific types of abuse (e.g., sexual) and type of self-injury; it would be good to conduct qualitative, open-ended interviews with participants to gather rich narratives, which can further our understandings of the complexities of NSSI and inform future treatment/therapy practices.

Conclusion

The results of this study provide important insights into young individuals' experiences who have engaged in NSSI. A majority of participants who engaged in NSSI reported that trauma influenced their NSSI behaviors and that they had experienced at least one traumatic event in their lifetime. These findings suggest that individuals who engage in NSSI do so as a means to cope with trauma from their past, which suggests the need for early intervention (e.g., individual and/or family therapy) to lessen the effects of NSSI. The hope is that this study will serve as a catalyst to encourage mental health clinicians (i.e., family therapists) to screen for NSSI in addition to considering ways that the family might be involved in treatment, especially in young adult populations. Additionally, we hope that this study illuminates the effects of trauma on young adults and adolescents. A next step in this research is analysis of quantitative findings to identify possible correlations between specific types of abuse (e.g., sexual) and types of self-injury, conducting qualitative, open-ended interviews with participants to gather rich narratives, which can further our understanding of the complexities of NSSI and inform future treatment/therapy practices.

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