SELF-INJURY: IMPROVING NURSING PRACTICE AND ASSESSMENT

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ABSTRACT

**Aim:** This paper is a report of a retrospective longitudinal study which examined the prolonged experiences of using self-injury, described by 25 adults from a community sample.

**Background:** There is a lack of research which advances nurses’ knowledge and understanding of self-injury. Few studies explored the prolonged use of self-injury and how it develops over time. Furthermore, the majority of studies have recruited participants from clinical populations with in-patients in psychiatric hospitals being the most frequently studied population. The purpose of this study was to investigate how self-injury is used by people in the community and how this use can change over time in order to improve nursing practice in relation to the assessment of self-injury.

**Method:** Informal interviews were used to obtain retrospective narrative accounts of adults’ experiences of using self-injury from its onset during childhood or early adolescence, throughout adolescence and into adulthood. These verbatim accounts formed a corpus of data which was analysed using a grounded theory method.
Results: The data analysis generated the substantial theory that self-injury develops as a versatile multi-functional behaviour which was/is governed by the individuals’ intentions and needs. The grounded theory process of analysis established a wide and complex range of variables involved in the use of self-injury, which form a suitable framework for assessing self-injury.

Conclusions: The findings of this study contribute towards developing our understanding and assessment of self-injury which can improve nursing practice. These objectives can help nurses to provide better care for people who use self-injury.

Keywords: Self-injury, deliberate self-harm, self-inflicted injury, non-suicidal self-injury, self-injurious behaviour.

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INTRODUCTION

Research and official studies have reported that there has been a notable increase in the occurrence of self-harm amongst adolescents. Brophy (2006), who led the ‘National Inquiry into Self-Harm amongst Young People’, stated that up to 1 in 10 young people in the United Kingdom self-harm during their adolescent years, 1 million adolescents have thought of self-harm and more than 800,000 adolescents had self-injured. Between 1 in 12 and 1 in 15 adolescents self-injure and around 4% of adolescents in the community cut themselves over a period of 12 months. Consequently there has been a growing need for rigorous qualitative research to explore the experiences of those who self-harm in particular the sub-category of self-injury. This research is required in order to more fully understand the dynamics involved in this alarming and complex human phenomenon which has been highlighted in official reports, such as National Institute for Clinical Excellence (2004) guidelines for self-harm. Also, the continued demand for research has been clearly stated by concerned leading researchers in the field such as Sutton (2007) who has written widely on the subject of self-injury and states that the need for progressive research to develop our understanding of self-
injury is “…enormous...”. Brophy (2006) concluded that the phenomenon is notably under-researched and the need for more comprehensive research is paramount to explore the dynamics involved in this specific form of self-harm.

In order to be clear about this directive it is important to understand self-injury within the spectrum of self-harm behaviours. The National Self-Harm Network (2010, p.1) defines self-harm as:

“...the act of deliberately causing harm to oneself either by causing a physical injury, by putting oneself in dangerous situations and or self neglect.”

In essence self-harm includes a wide range of behaviours, e.g. substance abuse, eating disorder, dangerous risk taking, etc, and includes self-injury. To be precise in contrast to other forms of self-harm, self-injury as defined by Sutton (2007, p. 23) is:

“...a compulsion or impulse to inflict physical wounds on one’s own body, motivated by a need to cope with unbearable psychological distress or regain a sense of emotional balance...carried out without suicidal, sexual or decorative intent.”

Self-injury typically involves direct, or immediate, short or long term physical damage to one’s own body by use of a variety of means, including cutting, burning, branding, scratching, picking, biting, head banging, hair pulling, hitting, bone breaking, repeated bruising, stabbing and reopening wounds (Murray, et al. 2007). Importantly, self-injury which is not a ‘norm’ or cultural practice of our society (Woldorf, 2005), provides the means to cope with (relieve or reduce) high levels of emotional and cognitive distress. The intent is for the person to remain conscious and change their state of consciousness through using self-injury e.g. superficial cutting of skin tissue. In addition, there are those who self-injure to relieve episodes of dissociation. During these disturbing states of detachment from thoughts and feelings, self-injury as a way of altering the feeling of profound numbness or deadness in order to feel more in touch with reality, in a cognitive and emotional context, regarding their physical and social environments.

In the context of existing nursing practice there is a need to develop a more comprehensive understanding of why people use self-injury, in order to improve clinical practice and nursing care offered to those presenting with self-injury. This is due to the recognition that many people present themselves to nursing staff, in accident and emergency
departments, etc, requiring medical attention for self-inflicted injuries and without a history of mental illness (Alder and Alder, 2007). A number of researchers indicate that nurses should acknowledge the existence of the multiple meanings of self-injury (McAllister, 2003). This is essential if nurses are to accurately assess and provide a nursing diagnosis on which to plan and implement individualised nursing interventions (aimed at enabling the patient to achieve cessation in using self-injury). Without this applied knowledge, as pointed out by Orlando (1961 cited by McQuiston and Webb 1995) nurses are likely to fail in understanding the patient’s condition and consequentially provide inadequate care. Therefore research that increases nurses’ understanding and awareness of self-injury could provide a basis for work to improve nursing practice. In an applied context, this information should enable nurses to learn about self-injury and to acquire the knowledge necessary to achieve improvements in their clinical practice.

BACKGROUND

Researchers such as McAllister, et al. (2002), have measured the attitude of nurses working with clients who self-harm and have highlighted the need to improve professional attitudes, knowledge and understanding of self-injury in order to provide better practice and clinical services offered to this patient group. Friedman, et al. (2006) and McCann, et al. (2006), have investigated the attitudes of accident and emergency department staff towards patients who self-injure and noted a deficit in nurses’ understanding of self-injury. This lack of understanding has a detrimental impact on the nurse’s capacity to communicate with and acknowledge the patient’s perspective, and importantly to offer empathy – an elemental part of the therapeutic process in nursing (Mercer and Williams 2002). Being able to empathise is core to the patient / nurse relationship because it facilitates the capacity to understand the patient’s condition. The nurse in attempting to apply the nursing process and responding to a self-injuring person, without understanding the nature of self-injury with genuine empathy, will continue to heighten the risk of mis-diagnosis and consequentially deliver inadequate patient care. Smith (2002) found that health professionals generally perceive self-injury as being the patient’s problem and emphasised the need for health professionals to provide a care approach that views the person who self-injures from a wider holistic perspective. Therefore, specific self-injury research is required in order to develop and improve nurses’ knowledge, understanding and practice in working alongside patients who use self-injury.
Procter (2005) completed a literature review, which included an examination of the impact of patients’ self-harm upon mental health nursing practice and concluded that there is a need to develop an improved nursing service for people who use self-injury. In order to achieve this, nurses must fully acknowledge the social, biological, emotional and psychological features of a person’s use of self-injury. Thus the dynamics involved in the presentation of self-injury can be properly understood and improvements made to nursing practice accordingly. If this is to be achieved research that increases our understanding and knowledge of self-injury is required.

THE STUDY

Aims

In order to contribute towards fulfilling the shortfall in our knowledge and understanding of self-injury, this study examined the broad spectrum of variables involved in and associated with the manifestation of self-injury, whilst capturing the development and span of self-injury as a human experience.

Design

Audio recorded informal interviews (Nichols, 1991) provided the means for the researcher to obtain the participants’ retrospective narrative accounts (Sandelowski, 1991) detailing their prolonged experiences of using self-injury. These narratives were explored using a grounded theory method, which as described by Strauss and Corbin (1998) provided a structured analytical process for examining data and developing an explicit grounded theory.

The participants

Participants were recruited from the members of the general public and were accessed through a wide network of specialist self-injury organisations and support groups, such as FirstSigns (www.firstsigns.org.uk) and the Sirius Project (www.siriusproject.org.uk). They fulfilled the following inclusion criteria; had self-injured during adolescence, were aged between late 20s and early 50s, and living independently within the community. The fact that the participants were recruited from the members of the general public – the community at large - is a unique feature of this study. The 25 participants who participated provided demographic information which is consolidated in Table 1, below.
Table 1. The participants’ demographic information.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Occupation</th>
<th>Qualifications</th>
<th>Continues using self-injury</th>
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<tbody>
<tr>
<td>Jane</td>
<td>F</td>
<td>30</td>
<td>Human Resources Manager</td>
<td>BSc/MSc</td>
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<tr>
<td>Suzanne</td>
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<tr>
<td>Lauren</td>
<td>F</td>
<td>45</td>
<td>Own business</td>
<td>A levels</td>
<td></td>
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<tr>
<td>Kiron</td>
<td>M</td>
<td>37</td>
<td>Chef</td>
<td>Catering Qualifications</td>
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<tr>
<td>Susan</td>
<td>F</td>
<td>38</td>
<td>Advertiser</td>
<td>BA/MA</td>
<td>Yes</td>
</tr>
<tr>
<td>Ralph</td>
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<td>32</td>
<td>Building business</td>
<td>Building qualifications</td>
<td></td>
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<tr>
<td>Cindy</td>
<td>F</td>
<td>28</td>
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<td>A levels</td>
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<tr>
<td>Tracy</td>
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<td>31</td>
<td>Music Graduate</td>
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<tr>
<td>Paul</td>
<td>M</td>
<td>43</td>
<td>Support Worker</td>
<td>NVQ</td>
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<tr>
<td>Alex</td>
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<tr>
<td>Rachel</td>
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<td>Psychologist</td>
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<td>Yes</td>
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<tr>
<td>Tina</td>
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<td>PGCE student</td>
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<td>Yes</td>
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<tr>
<td>Laura</td>
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<td>BSc/MSc</td>
<td>Yes</td>
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<tr>
<td>Matt</td>
<td>M</td>
<td>32</td>
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<td>NVQ 2 IT</td>
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<tr>
<td>Faith</td>
<td>F</td>
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<td>Counsellor in training</td>
<td>BSc</td>
<td></td>
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<tr>
<td>David</td>
<td>M</td>
<td>47</td>
<td>Volunteer Care Assistant</td>
<td>NVQ 2 / Care</td>
<td></td>
</tr>
<tr>
<td>Jean</td>
<td>F</td>
<td>52</td>
<td>Audio-Visual Technician</td>
<td>Foundation Degree</td>
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<tr>
<td>Tamara</td>
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<td>34</td>
<td>Unemployed</td>
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<tr>
<td>Alex</td>
<td>F</td>
<td>43</td>
<td>Hairdressing business</td>
<td>City and Guilds</td>
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<tr>
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<tr>
<td>Lucy</td>
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<td>BA H Nursing</td>
<td></td>
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<tr>
<td>Nick</td>
<td>M</td>
<td>33</td>
<td>Insurance broker</td>
<td>BA</td>
<td></td>
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<tr>
<td>Zoe</td>
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<td>Personal Assistant</td>
<td>Secretarial</td>
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<tr>
<td>Gabby</td>
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<td>46</td>
<td>Houseparent</td>
<td>BA</td>
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<tr>
<td>Vince</td>
<td>M</td>
<td>30</td>
<td>Professional Actor</td>
<td>BA Performing Arts</td>
<td></td>
</tr>
</tbody>
</table>

Total 25 F – 18
M – 7 Age range 28-52

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In summary, this information confirmed the following key points:

- Gender ratio 2.6 women to 1 man
- The majority of participants were aged between 28 and 35 years
- 96% of the participants had gained qualifications (56% University degrees)
- The participants came from wide range of occupations (mainly professional)
- 44% of the participants were using self-injury at the time of being interviewed
- Additionally, it was confirmed by the participants that their use of self-injury remained or remains their own ‘secret’ and that they have no contact with health or social care professionals, or agencies regarding their use of self-injury.

**ETHICAL ISSUES**

The main ethical concern was that an individual may put themself forward to participate knowing that in recollecting their experiences of self-injury they are likely to ‘trigger’ or induce an episode of self-injury. Therefore, as agreed with the ethics committee, the participants were asked whether they had read and agreed with the condition for participation which specified that: “…you must be able to agree that by taking part and describing your experiences of self-injury you will not knowingly place yourself in a situation whereby you will induce an episode of self-injury”. This condition was stated in the invitation to take part and the screening process, and reiterated in the Participant Information and Briefing Pack and also when they completed the Informed Consent Procedure. After gaining ethical approval from the university research ethics committee the researcher conducted the study according to the committee’s guidelines. The participants were presented with written and oral information regarding the study procedure and details of how the ethical aspects of their participation would be met, including: maintaining confidentiality, preserving anonymity and the participant informed consent procedure.
DATA COLLECTION AND ANALYSIS

Pilot study

Between April and May 2008, a pilot study was completed using the draft materials with two individuals, one adult man and woman, who met the participation inclusion criteria (see section above titled: The participants, for details). The primary purpose of the pilot study was to evaluate, amend, and subsequently develop and refine the materials and informal interview process for use in the main study. These materials included: an invitation to participate in the research, a participant screening checklist and risk assessment, a participant information and briefing pack, a participant informed consent form, a participant debriefing and participant feedback form. Evaluation of the participants’ and researcher’s pilot study feedback raised no issues, concerns or suggestions that indicated the necessity to amend the research documentation or interview procedure. Therefore the materials were prepared for use in the main study.

Additionally, regarding rigour and reliability, before the researcher proceeded with the main study, the pilot study interviews were transcribed (to form a corpus of pilot study raw data) and an inter-rater reliability test was carried out. This test was conducted to objectively measure the reliability of the researcher’s initial interpretations of the corpus of data. On the premise of strictly independent rating, two raters (the researcher and a skilled discourse analyst) interpreted and labeled the corpus with the initial basic themes they identified. The raters’ interpretations were then transferred onto a confusion matrix where the agreed ratings were combined and differences were established. The result of the inter-rater reliability test provided a Cohen’s Kappa (K) score of 0.70. The significance of this K score according to Fleiss’s (1981) ‘rule of thumb’ was a score that established the researcher’s interpretations were ‘good’. Therefore, as agreed with the University Research Ethics Committee: “…if a score of above 0.60 is obtained that confirms my interpretations are good to excellent and therefore reliable, the main study will proceed…” Subsequently, the researcher conducted the main study.

Main study

Data was collected by conducting informal interviews (between April 2008 and October 2008), with a community (non-clinical) sample of 25 adults, to obtain reflective, retrospective
narrative accounts of their experiences of the prolonged use of self-injury. This amounted to over 45 hrs of recorded interview time, which was transcribed to form a corpus of raw data for analysis.

Firstly an open coding process was applied to the corpus of interview data. This process of constant comparison established a complex and wide-ranging number of coded category concepts, which described aspects of the participants’ use of self-injury. Overlapping with this open coding was the process of axial coding of the data, which involved closely examining the properties and dimensions of the concepts and how they were connected or related to each other. Intersecting with axial coding, a process of selective coding was utilised to further analyse these components of self-injury. During this process, the relationships, patterns, meanings and dynamics involved within and between these interwoven components were further examined, in the context of the participants’ prolonged use of self-injury. This deeper level of processing and coding generated a central or core category concept, which unified all the components of self-injury on a pathway (or story line) reflecting developments in the participants’ use of self-injury as a grounded theory.

RESULTS

Overview

It was found that the use of self-injury developed, from its onset in childhood or early adolescence, throughout adolescence and into adulthood. The components involved in this development consisted of the participants’ behavioural, cognitive, emotional, social, communications, occupational and physiological experiences. Through applying the process of constant comparison, between and within these components, the core category that self-injury develops as a versatile multi-functional behaviour was generated. Fundamental to this overarching theory were the interlinked themes and patterns, which showed similarities in the evolving components of the participants’ continued use of self-injury. This evidence confirmed that the use of self-injury progressed to become a behaviour that could be adapted in its use, to serve a number of functions. This involved the generalisation in the use of self-injury according to the individual’s intentions for using it and changing personal needs.
The development of self-injury as a versatile multi-functional behaviour

Primary functions:
- Regulate, reduce or relief from high levels of emotional and cognitive distress
- Reduce / induce dissociative states of mind
- Control / stabilisation of a vacillation between high levels of distress and dissociation

Secondary functions – for example:
- A form of self-care
- Gaining a sense of control and empowerment
- Relieving day to day encounters with distress / generalised emotional distress
- Enabling a persona in a social context
- Focussing on examinations or performance at work without the distraction of thoughts and feelings
- Gaining a euphoric sensation
- The use of overt types of self-injury as a form of non-verbal communication

Combinations of primary and secondary functions

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Figure 1. Diagram illustrating the features involved in GT process of analysis (open, axial and selective coding) and the generation of the substantial theory that self-injury develops as a versatile multi-functional behaviour.
Learning to use self-injury

Starting during childhood or early adolescence, all the participants learnt to use self-injury through experiential or social learning. Regarding experiential learning, the majority of participants either damaged their own body as an impulsive response to overwhelming distress or had an accident causing physical pain, which coincidentally reduced the high level of distress they were experiencing at the time, for example:

“...what triggered me to self-injure...was I...fell over and grazed my knee and at the time I was upset about something...and...hurting my legs took...my mind off the upset and that... triggered something in my head...there’s something...that worked for me...”
(Matt, 32)

In contrast, several participants described acquiring self-injury through learning from their social environments. This learning took the form of copying social role models, in particular father figures, from within their family unit, for example:

“...I would see my Dad banging his head up against the wall...that ...influenced me to self-injure...what else can you do as a child...to vent all the unrest... I’d...watched my dad and started doing it...him passing on all his uselessness...I banged my head against the wall...”
(Lauren, 45)

All the participants described repeating self-injury as a coping strategy.

Developing covert types of self-injury

All the participants’ practice in using self-injurious behaviours tended to be influenced by their motivation to develop covert types of self-injury. These covert types of self-injury provided them with the means to privately cope with high levels of emotional and cognitive distress, and dissociative states of mind, for example:

“...although people got to know – I used to just change where I would cut...they would think I had stopped – but I hadn’t...I became better at hiding it...better at self-injuring so...it wouldn’t notice...I changed the area...arms then ...legs...I kept my self-injury to places on my body I could hide – making it invisible to others...covered by what I wore...”
(Suzanne, 29)
Developing cognitive reinforcement for using self-injury

All the participants described their use of self-injury as being reinforced by the formation and development of robust beliefs and justifications. Fundamentally, these cognitions evolved alongside the prolonged use of self-injury, for example:

“...it helped me keep on track, keep stable, keep from being even more upset – so...it worked...I don’t think I could have managed without self-injury...it was my secret prop...it gave me...strength...it doesn’t poison your body – take away life – for me it gives back life...there was nothing that cut out the pain as well as self-injury...” (Gaby, 46)

Developing skills and proficiency in applying self-injury

Importantly over time, alongside these cognitive developments, the participants’ level of skill in applying self-injury developed. This culminated in the formation of complex and refined forms of self-injury which were applied to achieve the maximum effect whilst causing minimal bodily damage.

“…the cuts were only small...never deep – only surface skin...it was about getting...the right amount of pain – self-damage...to induce the process of pain relief...some surfaces of skin...like under your arm – inner thigh – can hurt more than other parts of the body...it is something you learn when you self-injure – especially if it needs to be done in such a way as to obtain a real physical pain – with limited body damage...” (Laura, 34)

Developing addictive or habitual needs to use self-injury

The majority of participants described developing addictive or habitual needs from their prolonged use of self-injury. Although reported in this study as behavioural and sensory effects, these findings are consistent with researchers who have identified that the repeated use of self-injury can cause the user to become addicted to endorphins or pain relieving neurotransmitters, which are opiate-based and released in the body when physical injury occurs (Sandman and Hetrick, 1995). Highlighting this aspect, the participants described
developing a focus on inducing the desired level of physical pain in order to relieve the high levels of distress, whilst inducing a state of calmness and tranquillity.

“... I would be feeling stressed, angry, irritated...annoyed... and running a carving knife down my legs relieved all that...everything...and as I press...the knife harder it becomes...painful and...I realised how good it felt...I enjoyed the feel of it...the sensation...it feels really nice...a little bit of pleasure...” (Alex, 38)

Developing primary and secondary functions in the use of self-injury

Primary functions

All the participants described the long lasting primary functions for which their self-injury was consistently used, including:

Relieving high levels of emotional and cognitive distress
All the participants described their prolonged use of self-injury to induce a state of relief from the unbearable high levels of emotional and cognitive distress they encountered, for example:

“...my emotions that become so big and overwhelming...cutting helps...release them to...create a balance between the overwhelming emotions and controllable emotions...reducing my... emotional distress...or pain...to a level I can cope with...it’s...the way I manage my thoughts and feelings that grow too big for comfort...”
(Rachel, 30)

Altering states of dissociation
In addition to encountering overwhelming distress, all the participants who experienced abuse and neglect during childhood and adolescence described encountering repeated and highly disturbing episodes of dissociation, for example:

“...I became...aware of the times that I would dissociate and this feeling of being not sure of my reality would be changed by self-injuring which would... make me feel real again...cutting was keeping me alive...” (Susan, 38)
In contrast, when encountering overwhelming distress, several participants describe developing the use of self-injury to induce a level of dissociation. This use of self-injury would enable them to ‘escape’ from their distressing thoughts and feelings, for example:

“... cut cut cut and it worked... stopping the overwhelming feelings and thoughts... dead in their tracks... and I couldn’t give a damn about anything – I felt completely numb (in thoughts and feelings) like somebody had hit me over the head with a iron bar – concussed... oblivious to it all...” (Jane, 30)

Reducing the vacillation between these high levels of distress and dissociation

Several participants described their use of self-injury developing as a means of coping with a vacillation between overwhelming distress and disturbing dissociation. They used self-injury to induce a level of dissociation when encountering overwhelming distress and on other occasions to alleviate encounters with disturbing dissociation, for example:

“... I was cutting... to bring my overwhelming emotions under control to calm me and yet, other times... I would cut myself for the opposite reasons... I used to... completely dissociate... I would cut because I needed to make myself feel alive again... it had that dual purpose....” (Faith, 40)

Secondary functions

Prompted by their established and prolonged use of self-injury, the participants learnt about the additional effects gained through using self-injury and became increasingly aware of the generalised functions self-injury could serve. On reflection, they recognised that the use of self-injury had wider implications for them personally and that its use extended to serve a range of secondary functions. These functions were formed according to the individual’s experiences and changing needs. The following examples illustrate these secondary functions:

A form of self-care
As a consequence of their frequent use of self-injury, several of the participants describe how they developed an emphasis of using self-injury to create a situation whereby they could engage in post self-injury self-care, for example:

“...cleaning up was very much part of the whole purpose of my self-injury... it certainly became part of it as time went by... gently clean my damaged skin... it was like someone
else was taking care of me cleaning and bandaging my injuries...it was self-care...I used to have lotions and creams – plasters and bandages – all in my own first aid box...” (Zoe, 38)

Gaining a sense of control and empowerment
Several participants described how they developed the use of self-injury to gain a sense of control and empowerment in their lives, in context to their social environments, where they were not affected by distressing thoughts and feelings, for example,

“...I was bullied...those day to day feelings about feeling different and not understanding why other kids didn’t like me...it (cutting) gave me relief and...empowerment...and this...secret was mine...it...gave me tranquillity and control in my life...and they (bullies) couldn’t hurt me (emotionally)” (Vince, 30)

Relieving day to day encounters with distress / generalised emotional distress
All the participants developed their awareness that self-injury was an effective method for coping with lower levels of distress encountered in their day-to-day lives. Importantly, this aspect of self-injury reflects a generalisation in the participants’ use and application of self-injury as a multi-functional behaviour, for example:

“...I was using self-injury...as a general coping mechanism...if life got difficult in terms of...having...three children under the age of four...and I was stressed then I would cut...I could feel tension...building up during the day and I would wait till the kids were in bed and then do it...sometimes I couldn’t wait...I would go to the bathroom and quickly cut...and relieve the tension a bit enabling me to live a normal life...to function...that’s what it did for me...” (Faith, 40)

Enabling a persona in a social context
The majority of participants described developing the use of self-injury to enable and maintain a persona within their social environments. This function allowed them to hide their suffering and conceal their use of self-injury from others. Using self-injury for this purpose became established and increasingly important, for example,

“...I would ...keep injuring until I felt calm...had control of the emotion that was inside of me so I could be this normal person, on the outside, that everyone wanted...everyone expected...this outside persona...I was a good well behaved young lady...I didn’t want anyone to see the hurt...I just needed to keep it all hidden...” (Jean, 52)
Focussing on examinations or performance at work without the distraction of thoughts and feelings

Several participants describe developing the use of self-injury as a means of coping with the challenges they encountered with examinations. These difficulties intensified or added to the high levels of distress they were already experiencing in their personal lives such as emotional abuse, for example:

“...my GCSEs were coming up...and teachers were saying I’m going to fail...I...worked myself into the ground...studying...and I self-injured...I cut...to keep myself going...it...became a way of coping with all that...I didn’t want to feel...anything...because if I did - I might fall apart and the only way to not get upset was to cut...and...it became this vicious cycle...it continued right the way through my exams but after my exams it stopped...” (Tracy, 31)

Moving into adulthood, several participants describe how this secondary antecedent or source of distress shifted to become ‘distress caused by difficulties encountered with work demands and expectations’, as opposed to school and / or college in adolescence.

Gaining a euphoric sensation

Highlighting the addictive features of self-injury, during adulthood the majority of participants describe developing the use self-injury to gain a euphoric sensation. Gaining this effect, for several, became a primary function or objective for using self-injury, for example:

“...my self-injury is no longer associated with my emotions...when I burn myself and the pain...as it goes up in an arch – a wave and at the top there is a moment when...you can’t think of anything...feel anything...like being blinded by sunlight...I...find that...really nice...it’s a moment of not experiencing anything other than that one specific – fssssh!!!...” (Cindy, 28)

The use of overt types of self-injury as a form of non-verbal communication

Several participants described developing overt, or unconcealed, usage of self-injury. On occasions, they would find that using self-injury was not enough to relief the very high levels of distress they encountered– it became ineffective. Subsequently, its use shifted to become a salient non-verbal form of communication, which signalled their desperate need for support, for example:
“...the cutting was severe...not to die – to kill myself...I wanted others to know the distress I was feeling...the self-injury...was me... communicating how bad I felt – how much I was in turmoil inside - yes...my ‘cry for help’... I needed some help...” (Tamara, 34)

Combinations of primary and secondary functions
Combinations of the primary and secondary functions of self-injury were presented or used according to the individual’s personal needs and circumstances, and were ultimately influenced by the individual’s intention for using self-injury. Demonstrating this, several participants increasingly needed to hide their use of self-injury from others, due to the high value it had for them as a coping strategy. Accordingly, they describe becoming increasingly proficient at using covert types of self-injury, to regulate high levels of emotional distress and reduce states of dissociation, whilst providing them with a sense of control over their thoughts and feelings and enabling them to present a persona to others that they were not suffering. They explained how this use of self-injury was carried out in private and without others knowing or being aware of their continued use. They took planned measures to protect their valuable ‘secret’.

A framework for assessing the functions of self-injury

Using the findings of this research in an applied context, to improve clinical practice and introduce a way forward in the assessment of self-injury, the processes of open and axial coding (involved in the grounded theory process of analysis) established a wide range of category concepts, e.g. victim of bullying, which were directly involved in the use of self-injury. When the properties and relationships between these category concepts were examined, it was found that they merged to form seven robust components that expressed the core features involved in the individuals’ use and development of self-injury, e.g. behavioural and social. On reflection and in the context to the assessment of self-injury, these components and their properties provide a framework or checklist (Klonsky and Glenn, 2008), upon which a holistic assessment of self-injury can be constructed and developed. The following figure 2, illustrates this applied use of the findings.
**Figure 2.** Showing the variables used to construct an assessment of self-injury.
This framework provides a comprehensive set of variables which form a checklist for nurses assessing an individual’s use and functions of self-injury. It extends or advances many of the checklists available, which are inadequate for holistically (or globally) assessing self-injury and or are restricted in their use (Nixon and Heath, 2008). Using the proposed checklist will involve examination and clarification of the extent and relevance of the 86 variables involved in the use and maintenance of an individual’s self-injury (including 7 main areas and 79 properties of these areas incorporated into the assessment). Identification of these aspects of self-injury will support the nurses to confidently apply the nursing process based on a thorough assessment of an individual’s use of self-injury. Additionally, this framework provides the components upon which the development of a standardised assessment of self-injury can proceed. This will involve further research and psychometric testing of the framework, with larger samples from a range of settings.

**DISCUSSION**

**Study limitations**

The findings are potentially limited in generalisation due to the small sample size (25 adults), which was drawn from the community at large. The sample did not extend to include representation from the groups identified in previous research, such as Yates (2004), where the use of self-injury is a common occurrence, e.g. psychiatric hospitals. However, this present research study attracted a unique group of individuals who wanted to take part out of their own free will or volition. Further to this point, it was noted that those who decided to take part in this study consisted of a group of individuals who were at a stage in their lives where they could orally describe their experiences of using of self-injury. Arguably, this could mean that the findings are relevant only to those people who are willing to articulate their use of self-injury. Undeniably, the findings did rely on the retrospective self-reports of the participants’ memories of using self-injury and it is acknowledged that they may have been inaccurate or distorted over time. In addition, participants may have experienced difficulties in describing their experiences when involving mental processes that are directly related to episodes of using self-injury and involve a level of debilitation in the individuals’ cognitive functioning (Klonsky, 2009).
Advancing knowledge and understanding of the functions of self-injury in nursing

This study provides an account the prolonged use of self-injury and how, from its onset, it develops to become a versatile multi-functional behaviour. These functions were found to develop over time and were dependent on the individual’s intentions, personal circumstances and needs. This theoretical perspective makes an important contribution to advancing nurses’ knowledge and understanding and clinical practice regarding the care of people using self-injury. It advances the available body of literature describing the functions of self-injury and takes forward the recommendations of previous researchers which concluded that research clarifying the functions of self-injury is greatly lacking (Santa Mina, et al. 2006, Chapman, et al. 2006 and Nock, 2009). Developing this point, Suyemoto (1998) and Yip (2006) identified that self-injury is meaningful for individuals and recommends that this behaviour should be interpreted from a multi-dimensional perspective in order adequately to understand why individuals persistently use self-injury. The findings of this study confirm that self-injury is interpreted using a multi-dimensional perspective (Santa Mina, et al. 2006). This perspective essentially provides a platform from which nurses can develop greater insight and awareness of the meaning and purpose of self-injury. With a better understanding of the functions of self-injury, many nurses working in community and hospital settings may no longer struggle to interpret its presentation and can develop genuine empathy towards the user.

CONCLUSION

This study postulates a theory that self-injury develops as a versatile multi-functional behaviour, which is influenced in its use by the needs and intentions of the individual. It was established that primarily self-injury provided the participants with a means of coping with episodes of overwhelming distress and or dissociative states of mind. However, the participants’ prolonged use of self-injury led to its use for a number of secondary functions, e.g. a way of gaining a euphoric sensation. These findings contribute towards advancing nurses’ knowledge and understanding of how self-injury develops and is maintained.
SUMMARY

What is already known about this topic
• Causational factors and various primary functions associated with the use of self-injury (SI), e.g. using SI as method of coping with emotional distress, have been studied and acknowledged by nurses.
• There is a notable lack of applied research which contributes towards advancing the understanding of SI and the practice of nurses working alongside people who use SI.
• Researchers have developed a variety of assessments of SI, however, there are presently no standardised holistic assessments available for nurses (in the UK) who are required to assess individuals’ use of SI (in both community and hospital settings).

What this paper adds
• The study extended our knowledge and understanding of SI through examining the prolonged use of SI in a community sample. The findings add new dimensions to what is already known about the functions of SI, in particular the development of SI over time.
• The multiple functions of SI identified from this study consist of, long term, primary functions and the development of a range of secondary functions, which are governed by the individual’s needs and intentions.
• This study broadens our perspective of SI by showing how it exists and develops in the lives of those who use it.

Implications for practice and / or policy
• The findings contribute towards advancing nursing practice, by providing a holistic perspective of the functions of SI, which promotes nurses to genuinely empathise with those who use SI.
• Additionally, the findings of this study provide a comprehensive checklist or framework that can be used to assess individuals’ use of SI and from which a standardised assessment can be developed (this process could begin with a scale construction exercise).
• This study demonstrates how, in the context of improving nursing services, the mobilisation of resources should be gauged at including those using SI who are not necessarily suffering from a mental health condition, and may require a service.
REFERENCES


