Non-suicidal Self-injury and Suicide Risk Among Young Adults:

An Examination of the Role of Perceived Burdensomeness

A thesis presented in partial fulfilment of the requirements for the Degree of Doctor of Clinical Psychology

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For Aunty

I carry your heart with me; I carry it in my heart.

Abstract

Background: Non-suicidal self-injury (NSSI) is defined as direct, self-inflicted damage of body tissue in the absence of the intent to die, and outside of that which is socially sanctioned (Nock, 2009). The Interpersonal-Psychological Theory of Suicide (IPTS; Joiner, 2005; Van Orden et al., 2010) posits that serious suicide attempts occur when an individual experiences both *thwarted belongingness* and *perceived burdensomeness* (leading to the desire to die) and the capability to act upon that desire (*acquired capability*). **Current Study**: The current research suggests the possibility that in addition to the role played in suicidal behaviours, perceived burdensomeness (PB) also plays a role in NSSI and conceivably in the transition between NSSI and a suicide attempts. The aims of the current study were to gain further insight into the role of PB and its relationship with NSSI and to explore themes, narratives and meaning making of PB amongst those who have engaged in NSSI. The study hypothesised that higher levels of PB will be present amongst individuals who have engaged in NSSI compared with those who have not. **Methods**: A mixed methods approach was utilised, consisting of an anonymous online survey completed by 159 young New Zealanders (18 – 24 years of age). **Results**: A total of 36.9% of participants endorsed perceiving some degree of burdensomeness towards significant others in their lives, while over half of participants (51.6%) endorsed having engaged in NSSI. Question responses were combined to produce an overall PB score to be used for comparison between groups. An interpretative phenomenological analysis (IPA) was conducted consisting of six in-depth semi-structured interviews with individuals who had engaged in NSSI and made at least one suicide attempt. Study findings include the following, in a sample of individuals who engaged in self-injurious behaviours, scores on a measure of PB increased as self-injurious behaviour moved from NSSI to suicidal behaviour. **Findings**: Findings suggested that emotional regulation or reducing internal distress was a major driver for engaging in NSSI. Regression analysis

suggested that scores on a screening measure for Major Depressive Disorder, scores on a screening measure for Borderline Personality Disorder, frequency of NSSI and number of NSSI methods used were independently predictive of PB score, accounting for 39.8% of the variation in PB scores. However Major Depression scores were most significantly predictive, accounting for 34.2% of the variation in PB scores. A model of the interaction of PB, guilt and shame has been proposed from the IPA findings. Major conclusions were that higher levels of PB are present in individuals who have engaged in NSSI compared to those who have not engaged in any self-injurious behaviours; that there is evidence to suggest that a continuum of PB may exist moving from NSSI behaviours to suicidal behaviours and finally that PB is an important construct both clinically and for research into NSSI and suicide prevention. Study limitations are discussed and suggestions for future research made.

Acknowledgments

Those individuals who have taken on a project of substantial size such as this, will know, that very little is achieved in isolation; rather, there are many amazing people who help us along the way. Whether they are there for a single step of the journey, or for the entire marathon, their assistance is invaluable in order to achieve success. This thesis was no exception, it was a challenging journey of many steps that I could not have completed without the love and assistance I was lucky enough to have along the way. As with any journey worth travelling, there were good times, tough times and a number of unexpected obstacles along the way. All of these experiences have contributed to the person I am and the Clinical Psychologist I am becoming, and for this I am hugely grateful.

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"There is more in us than we know; if we can be made to see it, perhaps for the rest of our lives we will be unwilling to settle for less."

- ***Kurt Hahn (Founder of Outward Bound)***

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Glossary

Definitions of Self-Injurious Terms used in this Thesis

- ***Death by Suicide***: Death caused by an act undertaken with the specific intention to end one's life

- ***Non-Suicidal Self Injury (NSSI)*** : Direct, self-inflicted damage of body tissue in the absence of the intent to die, and outside of that which is socially sanctioned (Nock, 2009).

- ***Suicide Attempt*****:** An act undertaken with the specific intention to end one's life but not resulting in death

- ***Suicidal Ideation*****:** Thinking about, considering, or planning dying by suicide (Klonsky, May, Saffer & Boaz, 2016)

CHAPTER ONE: INTRODUCTION TO THESIS

Impetus for this Research Study

The New Zealand youth suicide rate is now one of the highest amongst developed countries and suicide in young people is a significant public health problem worldwide (Snowdon, 2017). This thesis began from a desire to make a contribution to understanding these high rates of suicide in the New Zealand youth population and provide some assistance in reducing these rates. While many years of research on the risk factors for suicide (both in New Zealand and abroad) are available, the situation has not improved, perhaps due to the focus of this research being predominantly on investigation of suicide epidemiology, rather than treatment or intervention research (Coppersmith, Nada-Raja, & Beautrais, 2018). At this time it appears evident that while significant research funding has been invested into suicide research, our current knowledge is not enough to curb the rising suicide rates in this country.

Training to be a clinical psychologist involves repeated instruction and practice at risk assessment (both theoretical training and practical training). Assessing the risk that a client will engage in suicidal behaviour in the imminent future, action can then be taken to attempt to lessen this risk. Preventing clients from getting to this stage is not easy to teach. Again most of the common risk factors that can influence an individual's likelihood of engaging in suicidal behaviours are known, and psychologists and other clinicians do their best to make use of this knowledge. However, the fact remains that we are still unable to determine which clients will make a suicide attempt and which will not. Risk factors are not enough; deeper knowledge is required.

During the early stages of my study of psychology and through to the beginnings of formulating this thesis I became aware that anecdotal evidence suggested that non-suicidal self-injury (NSSI) was a growing problem in New Zealand, especially amongst the

adolescent and youth populations, however little research data was available. The international research tells us that NSSI is a significant risk factor for future suicide attempts (e.g., Victor & Klonsky, 2014), stronger even than past suicide attempts (Asarnow et al., 2011; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011), but what determines who moves from NSSI to a suicide attempt, who continues to engage in NSSI repeatedly, and who ceases to engage in NSSI with no further self-injurious behaviours?

It became apparent that determining the answers to these questions is of great clinical importance for those working with individuals who engage in self-injurious behaviours, not only to address the harmful NSSI behaviours but also to use as a suicide prevention tool. Elucidating the links between NSSI and suicidal behaviours, and the mechanisms which inform a transition from NSSI to suicidal behaviour could perhaps provide a better understanding of which individuals will and which individuals will not make a future suicide attempt. As I continued to analyse the literature the link that is evident between NSSI and suicidal behaviour led to an understanding that models of suicide may well be useful for understanding both NSSI and/or the link between NSSI and suicidal behaviour. It was clear that NSSI was an important area requiring research both in and of itself, but also as a risk factor for suicide.

One well supported model of why people die by suicide - the Interpersonal Theory of Suicide (IPTS Joiner, 2005;Van Orden et al., 2010) appears to fit well with NSSI literature in parts, however a relatively small amount of research had been conducted into the construct of perceived burdensomeness (PB; Cha, Franz, Guzm, Glenn, Kleiman, & Nock, 2017; Ma, Batterham, Calear, & Han, 2016), which is one of the specific components of the IPTS model. The extent to which an individual perceives that they are burdensome on others or on society is reflected by self-hatred as well as the presence of the belief that others would be better off without them. If PB increases over time, could this construct contribute to the link

between NSSI and suicidal behaviour? It was these questions that eventually grew into the current research and form the basis of this thesis.

The thesis which follows is an exploration of NSSI and the construct of PB with the overarching goal of looking deeper than a correlation or risk factor, in order to assist in better enabling prevention of both NSSI and suicide in New Zealand youth.

Overview of Thesis

While the major focus of this research project was to explore and investigate non-suicidal self-injury (NSSI), it was necessary to spend time investigating and exploring suicide, so that the link between the two behaviours could be better understood, making sense in light of the overall research aims. While the thesis is focused on NSSI, it investigates these behaviours in light of a model which aims to explain death by suicide. It was therefore considered that to order the discussion of suicide and the associated literature before that of NSSI would work to create greater ease of understanding for the reader, and more sound positioning of the argument the thesis aims to make. The thesis therefore begins with an in-depth review of the suicide literature prior to moving towards a more in-depth review of the NSSI literature. Suicide literature and NSSI literature are then brought together, presenting the reasoning behind the current research.

The methodology utilised in the current study is then discussed, with some attention given to the decision to include both qualitative and quantitative methods, the reasoning behind this and the advantages of a mixed methods approach. Results for each of the qualitative and quantitative studies are first presented and discussed separately, prior to being discussed together as a whole study. Key findings drawn from all data gathered, relevance to current clinical practice, and limitations of the current research are then presented, followed by recommendations for further research drawn from the outcomes of this study.

CHAPTER TWO: SUICIDE

Suicide occurs in all areas around the globe, and across the lifespan. The World Health Organisation (WHO) has described suicide as being a "major public health concern in every country and every community worldwide" (World Health Organisation, 2014b, p.22), and was stated to be the 15th leading cause of death worldwide in 2012, making it the cause of approximately 1.4% of all deaths globally. The WHO considers suicide to be such a significant global health concern (affecting not only those who make suicide attempts but many others who are left behind experiencing long-lasting effects following a suicide), that it published the first World Suicide report in 2014 (World Health Organisation, 2014b). The World Suicide Report is focused on suicide prevention, and the acquisition of evidence-based interventions to lower suicide rates on a global scale.

Much of what we currently know about predicting suicidal behaviour has been gained through epidemiological studies with a focus on suicidal ideation and attempts, and the message that suicide is preventable (Glenn & Nock, 2014). Nock, Borges and Ono (2012) examined suicidal behaviours across 17 countries, and found that approximately 9.2% of adults had considered suicide, 3.1% had made a suicide plan and 2.7% had made at least one suicide attempt in their lifetime.

Research discussing the differences in suicide prevalence amongst different populations is beginning to shed further light on this global issue, however despite the literature on suicide continuing to grow, suicide rates remain a major issue with increasing rates every year (World Health Organization, 2014b). Despite the scale and gravity of this issue, relatively little is known about how to predict who will make a suicide attempt and who will not (Nock et al., 2012). There is currently no instrument or scale that is able to accurately determine

which individuals will go onto make a suicide attempt and which will not (Carter, Milner, McGill, Pirkis, Kapur & Spittal., 2017), and further, the current NICE Clinical Guidelines suggest that future self-injurious behaviour should not be predicted by use of a scale alone (National Institute for Health and Care Excellence, 2011).

What Factors Lead to Suicidal Behaviour

What leads to a person making a suicide attempt? What are the factors that contribute to such a large number of people taking their own lives each year? There have been many suggestions as to the answer to these questions including poverty, relationship breakdowns, job loss, depression or other mental disorders, impulsivity, and substance abuse. There are no well-defined pathological pathways that result in an individual making a suicide attempt and therefore predicting which individuals will make a suicide attempt and when this attempt might be made is currently almost impossible.

Research shows that vulnerability factors for suicide include peer bullying, exposure to violence, alcohol and drug intake, interpersonal relationship problems (both family and peer), low self-esteem and presence of a psychiatric disorder (Fortune, Stewart, Yadav, & Hawton, 2007; Hawton, Saunders, & O'Connor, 2012; McKinnon, Gariépy, Sentenac, & Elgar, 2016) as well as a range of static factors such as gender, sexual orientation and ethnicity (Gutierrez, Rodriguez, & Garcia, 2001). The increased risk of suicide associated with mental disorders has been known for some time (e.g., Borges et al., 2010; Nock et al., 2015). However, some authors suggest that looking to mental disorders and their association with suicide to make predictions of suicide attempts provides limited illumination about the processes leading to suicide attempts (Hjelmeland & Knizek, 2017; Nock et al., 2009; Pridmore, 2015).

Strong evidence has been reported showing that childhood maltreatment, especially sexual abuse during childhood increases the risk of suicidal ideation, and suicide attempts (Dunn, McLaughlin, Slopen, Rosand, & Smoller, 2013; Gomez et al., 2017). The effect of physical abuse during childhood also appears to act as a vulnerability factor for suicidal ideation and suicide attempts, however these effects appear to be somewhat dependent on social context (such as paternal education and family standard of living) compared to sexual abuse (Fergusson et al., 2008). Emotional abuse, while less frequently the subject of suicide research, has also been shown to increase the likelihood of suicidal ideation in young people (Miller et al., 2016). While knowledge of these vulnerability factors is helpful in providing a more thorough understanding of suicidal behaviour, looked at in isolation, they do not allow for the prediction of which individuals will engage in suicidal behaviour. Despite a knowledge of risk factors, there still exists a significant lack of understanding of how to predict suicide attempts and a limited understanding of the most effective strategies for the prevention of suicide in this population (Fortune et al., 2007). A more thorough understanding of the mechanisms and interactions of different correlates and risk factors is critical if we are to identify which individuals are at greatest risk of making a future suicide attempt, and also acts to inform the case conceptualisation, treatment plans and safety planning of those health professionals working with individuals at risk of suicide (May, Klonsky, & Klein, 2012).

Suicide in New Zealand

While consideration of current research is key for gaining a better understanding of the factors which drive suicide, it is important to recognise that the characteristics of suicide and suicide attempts vary significantly between different countries, communities and demographic groups (World Health Organisation, 2014b). Differences are also seen across

time; therefore current New Zealand research is paramount in order to reduce suicide rates in this country.

Suicide is a significant problem in New Zealand[1], with an average of 11 people dying by suicide in New Zealand each week, equating to more than 500 New Zealanders taking their own lives every year (Ministry of Health, 2015). According to the Annual Provisional Suicide Statistics for deaths reported to the coroner for the year ended 30 June 2018, 668 deaths in New Zealand are suspected suicide deaths, (official ruling on cause of death subject to final Coronial findings), a figure that represents approximately 13.7 deaths per 100,000 people (Office of the Chief Coroner, 2018). Figure 2.1 shows New Zealand's annual suicide rates per 100,000 population over the past decade.

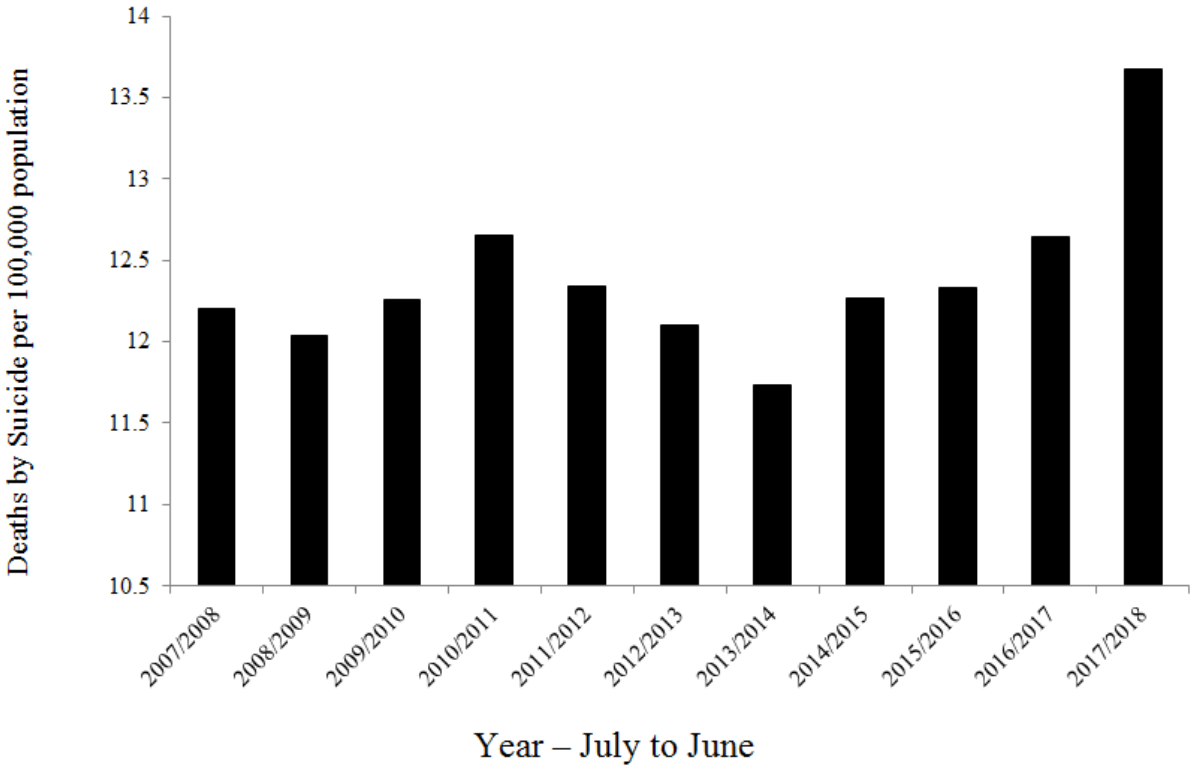

Figure 2.1. Total deaths by suicide per 100,000 population in New Zealand (Office of the Chief Coroner, 2018)

[1] Statistics New Zealand defines suicide as follows: "the act of intentionally killing oneself". Deaths are classified as suicide (or not) in accordance with chief coroner's findings.

Of 17 countries included in World Health Organisation mental health surveys, New Zealand had the highest rate for suicidal ideation (15.9%), and the second highest rates for suicide planning (5.6%) and suicide attempts (4.6%; Nock et al., 2012). Despite research into prevention strategies both in New Zealand and abroad, suicide remains an obvious health concern in New Zealand, especially amongst young people (Hatcher, Sharon, & Collins, 2009).

The suicide rate for those aged 10 – 24 years of age is reported as being approximately 40 per 100,000 (for the year ended 30 June 2018). During the years 2009 – 2013, the New Zealand youth suicide rates were compared to those in Australia and found to be approximately double the rate seen in Australia which is likely to account for the overall higher suicide rates within the New Zealand population compared to that of the Australian population (Snowdon, 2017).

Suicide Prevention in New Zealand

Suicide prevention has been a national mental health priority in New Zealand for some time, with the New Zealand Suicide Prevention Strategy (Ministry of Health, 2006) published 12 years ago. The aim of the strategy was to provide a structure to direct suicide prevention in New Zealand over the following decade, and one of the principles was that it should be 'evidence based'. Since the strategy was published, the overall suicide rates in New Zealand have not reduced significantly, and could perhaps be rising (Office of the Chief Coroner, 2018).

The Suicide Prevention Action Plan, a three year plan, was introduced in 2013 (Ministry of Health, 2013) with a number of actions to reduce the New Zealand suicide rates. Despite these initiatives, a recent review of the suicide research literature published in New Zealand and suicide prevention projects funded in New Zealand during the years that the

suicide prevention strategy was in place (2006 – 2016), has shown that while the prevalence of suicidal behaviours has been studied, there have been few intervention studies or research evaluating the suicide prevention initiatives (Coppersmith, et al., 2018). A new suicide prevention strategy is currently in the draft stage with the New Zealand Ministry of Health, however, the date that the strategy will be published (or if it will be published at all) is currently unknown.

Theories to explain death by Suicide

Suicide has been the focus of many studies and publications over many years and consequently a large number of theories as to why people die by suicide and factors that convey additional risk for suicide have been posited. Despite this, there is still a significant lack of understanding in how to determine who is likely to make a suicide attempt and who is not. Theories allow sense to be gained from the statistics about risk factors, as they either allow for the confirmation of predictions made from that theory, or not (Gunn & Lester, 2014). A sound theory for suicide would provide at least a partial explanation of the many unanswered questions about death by suicide and increase our understanding of the etiology of suicidal behaviour. Currently one of the most well empirically supported theories of why people die by suicide is the Interpersonal-psychological theory of suicide.

The Interpersonal-Psychological Theory of Suicide

The Interpersonal-Psychological Theory of Suicide (IPTS; Joiner, 2005; Van Orden et al., 2010) posits that serious suicide attempts occur when an individual has both the desire to die and the capability to act upon that desire (Joiner, 2005). The desire to die is thought to develop in the presence of two interpersonal constructs occurring concurrently – *thwarted belongingness* and *perceived burdensomeness*. The IPTS postulates that TB and PB

represent proximal predictors of suicidal ideation and as such, may account for (i.e., statistically mediate) the relations between various suicide risk factors and suicidal thoughts and behaviours (Van Orden et al., 2010). However, in order for an individual to engage in serious suicidal behaviour, they must also acquire the *capability for suicide* (Hill & Pettit, 2014; Van Orden et al., 2010). The IPTS therefore distinguishes between the desire for death by suicide and the ability to take action on this desire as separate components of death by suicide (Ribeiro & Joiner, 2009). The fundamental understanding of this theory is that possessing the capability to end one's life does not necessarily mean there is the desire to die, and the desire to die does not automatically mean and individual possesses the capability (Joiner, Van Orden, Witte & Rudd, 2009). Figure 2.2 shows a simplified illustration of the IPTS model, illustrating how the three constructs suggested as being central to suicidal behaviour combine, resulting in a relatively small proportion of individuals who make a serious suicide attempt (Van Orden et al., 2010).

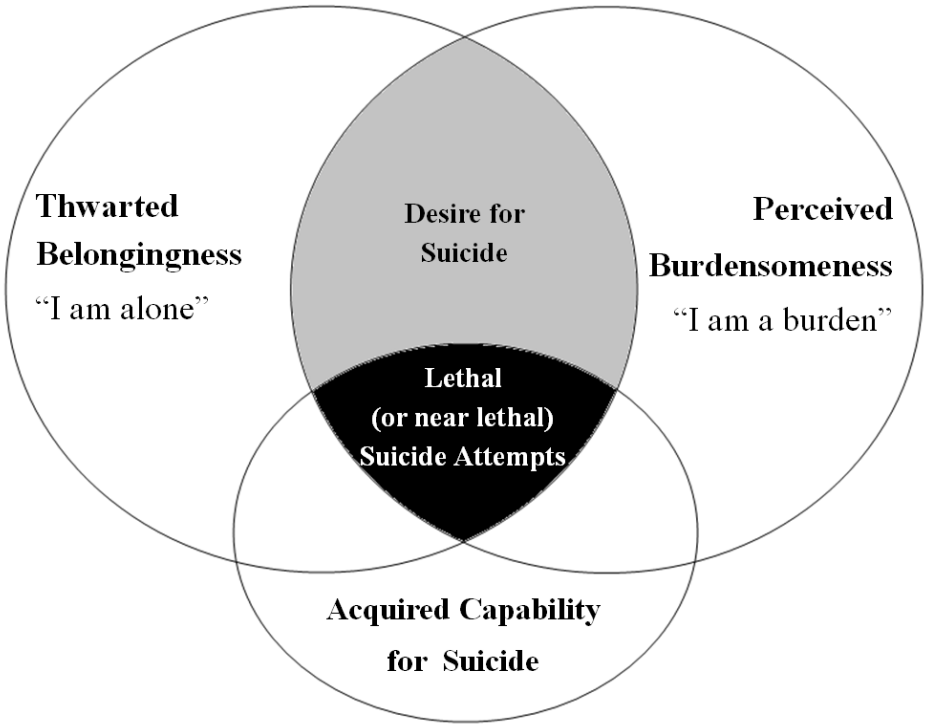

Figure 2.2. Assumptions of the Interpersonal-Psychological Theory of Suicide (adapted from Van Orden et al., 2010).

Acquired Capability

The IPTS suggests that the desire to die is not alone adequate to result in serious suicidal behaviour. Individuals must also eliminate some of the fear related to making a serious suicide attempt in order to engage in self-injury with lethal intent (Joiner, 2005; Van Orden et al., 2010). It has been proposed that humans are equipped with an innate fear of behaviours likely to result in their own injury or death (Willoughby, Heffer, & Hamza, 2015), including suicidal behaviour, and a desire to avoid exposure to painful and fear-inducing stimuli (Ohman & Mineka, 2003).

The IPTS proposes that the construct of acquired capability is made up of two major dimensions – lowered fear of death and increased physical pain tolerance (Van Orden et al., 2010). Acquired capability is thought to develop through recurrent exposure and habituation to physically painful experiences, resulting in a greater pain tolerance and a loss of fear or concern about death (Ribeiro & Joiner, 2009). The more painful or aggressive an experience is, the greater the degree of acquired capability it confers. Therefore the IPTS predicts that previous suicide attempts are the most immediate and effective means of acquiring capability for suicide (Ribeiro & Joiner), a suggestion that is well supported in the current literature (e.g., Bolton, Pagura, Enns, Grant, & Sareen, 2010; Christiansen & Jensen, 2007; Limosin, Loze, Philippe, Casadebaig, & Rouillon, 2007; May et al., 2012; Zonda, 2006). There are however, other ways in which the capability for suicide can be acquired, such as engaging in non-suicidal self-injury, especially if multiple methods of self-harm are employed (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006).

Acquired capability is believed to be a static risk factor[2] (Joiner, 2005). Emotional dysregulation has also been suggested to influence behaviours. A study investigating emotional regulation found that in terms of acquired capability for suicide, high negative urgency (a component of emotional dysregulation defined to be the degree to which rash action is taken in order to reduce negative emotion) was predictive of acquired capability, while high distress tolerance (the ability to accept negative psychological states that are experienced and to function in spite of these) was reported to reduce acquired capability (Anestis, Bagge, Tull, & Joiner, 2011).

NSSI is a risk factor for suicide attempts (e.g., Klonsky, May & Glenn, 2013), and thus the relationship between NSSI and suicide attempts suggests that these three factors are also related to NSSI, for example acquired capability for suicide may be gained through NSSI. Research investigating NSSI supports a link between NSSI and acquired capability (e.g., Willoughby et al., 2015), with one study finding that individuals who engaged in NSSI frequently reported an inability to feel pain during NSSI episodes (Nock & Prinstein, 2005). Cross-sectional studies show that those individuals with a history of NSSI demonstrate increased acquired capability compared to those who have no history of NSSI (Bender et al., 2011; Franklin et al., 2010). Willoughby and colleagues conducted a longitudinal study, reporting that higher frequency of NSSI behaviours over the past year conveyed an increase in acquired capability for suicide which remained at follow up one year later (Willoughby et al., 2015).

[2] A static risk factor is a feature of an individual's history that remains constant over time, or cannot be changed.

Thwarted Belongingness (TB)

Social isolation is one of the strongest risk factors for suicidal behaviours across the lifespan (Van Orden et al., 2010). The psychological need to belong is a powerful human motivator and when an individual experiences failure in their desire to belong, negative outcomes (both to mental and physical health) may occur (Baumeister & Leary, 1995). TB is focused on social isolation and alienation from valued social circles such as family, friends or other valued groups, an area of research that has produced much data supporting a correlation between lack of belonging and suicidality (Joiner, Van Orden, Witte, & Rudd, 2009). Van Orden et al. (2010) described TB as a higher order variable with two subordinate components – loneliness and the lack of reciprocally caring relationships.

TB is proposed to contribute to the development of passive suicidal ideation (or the desire for death). Rather than a stable trait, thwarted belongingness has been described as a dynamic cognitive–affective state that exists on a continuum from low TB to severe TB. At the most severe end, TB involves a complete absence of meaningful and mutually supportive relationships (or the perceptions that this is so), it is this most severe TB that the IPTS is concerned with.

Perceived Burdensomeness

To feel that one is a burden or a liability on significant others has been shown to be a key variable in the development of suicidal ideation and behaviour, and correlated to both hopelessness and levels of depression (Teismann et al., 2016; Van Orden, Lynam, Hollar, & Joiner, 2006). PB is a mental state comprising two components – self-hate and a belief that others would 'be better off without me', that is to say, that the individual considers themselves to be so defective as to be a liability on others which is fostered when the need for social capability is unmet (Van Orden et al., 2010). PB is a dimensional construct, described

as a dynamic cognitive-affect state and events such as family conflict, unemployment, illness or functional impairment can all contribute to an individual's perceived burdensomeness on those around them, and as such may also contribute to the desire to die (Joiner, 2005).

The relationship between PB and suicidal ideation is well supported (e.g., Assavedo & Anestis, 2016; Hollingsworth et al., 2018; Jahn, Van Orden, & Cukrowicz, 2013; Kanzler, Bryan, Bryan, Ray-Sannerud, Etienne, & Morrow, 2014; Ma et al., 2016; Hill & Pettit, 2014; Swanell, Martin, Page, Hasking & St John, 2014; Teismann, Forkmann, Rath, Glaesmer, & Margraf, 2016). Correlations between PB and suicidal desire have been found in a number of studies including in military personnel (Bryan, 2011; Monteith, Menefee, Pettit, Leopoulos, & Vincent, 2013), Bhutanese refugee populations (Ellis et al., 2015), individuals suffering from chronic pain problems (Wilson, Kowal, Henderson, McWilliams, & Péloquin, 2013) and community dwelling outpatients (Van Orden et al., 2006).

In a review of 27 studies focused on PB and suicidal behaviour (ideation, attempts and death by suicide), Hill and Pettit (2014) reported a statistically significant bivariate association between PB and both suicidal ideation and suicide attempts, suggesting that PB may in fact be a possible target for suicide intervention within clinical populations. Chu, Rogers and Joiner (2016) conducted a study looking at both PB and thwarted belongingness, and found that while both constructs were found to significantly account for the relationship between a history of NSSI and suicidal ideation at baseline, only PB mediated suicidal ideation at follow-up. One study focusing on the relationship between cyberbullying and suicidal ideation found that PB and depressive symptoms were significant direct positive predictors of suicidal ideation (Mitchell et al., 2018).

Baams et al. (2015) conducted a study looking at the association of PB with sexual orientation victimisation, coming-out stress, depression and suicidal ideation in lesbian, gay

and bisexual (LGB) youth. The findings of this study were that PB mediated all of these factors, therefore the authors concluded that feelings of burdensomeness towards others in their lives is a critical mechanism in explaining elevated levels of depression and suicidal ideation in this population.

PB and suicidal ideation have also been found to have an association in LGB university students (Hill & Pettit, 2012) and sexual minority adults (Woodward, Wingate, Gray, & Pantalone, 2014). Findings such as this have significant implications for those individuals or groups who support LGB communities, as decreasing social isolation is one of the major focuses for LGB communities, especially youth, however this study suggests that PB should be addressed in order to ultimately reduce depression and suicidal ideation amongst this population. Previous research has also discussed the coming-out process as producing feelings of being a burden on loved ones as (Hilton & Szymanski, 2011; Oswald, 1999).

Research on maladaptive perfectionism has also been shown to have a relationship with PB, with one study showing that PB acted as a mediator between maladaptive perfectionism and suicidal ideation, suggesting that PB is partially responsible for the psychological distress experienced as a result of maladaptive perfectionism that acts as a predictor for suicidal ideation (Rasmussen et al., 2012). The authors of this study propose that individuals struggling with maladaptive perfectionism experience a perceived ineffectiveness which leads to feelings of burdensomeness on those around them and a perception that others are burdened simply by the individual's existence, leading to suicidal ideation. Another study focused on maladaptive perfectionism in Asian international students in the USA, reporting that maladaptive perfectionism (as well as discrimination) was positively associated with suicidal ideation. Family discrepancy (tendency to perceive that family standards have failed to be met) was found to strengthen the relationship between PB

and thwarted belongingness with suicidal ideation (above and beyond depression; Wang, Fu, & Wong, 2013). Personal discrepancy (the tendency to perceive that personal standards have failed to be met) did not strengthen this relationship. The authors of this research suggest that feelings of shame about being unable to meet their family standards may play a role in the findings here. The experience of shame involves the negative evaluation of oneself (Lewis, 1971; Tangney, 1996), feelings of inadequacy and the desire to escape (Blum, 2008; Tangney & Dearing, 2002).

Other authors have also suggested that PB (and thwarted belongingness) may have an indirect influence on suicidal ideation via feelings of shame, or alternatively that shame may have an indirect influence on suicidal ideation via PB (and thwarted belongingness; Wong, Kim, Nguyen, Cheng & Saw, 2014). Another study investigated how shame might be related to social anxiety and the interpersonal suicide risk factors. The findings reported that shame was able to fully explain the relationship between social anxiety and PB. This indirect effect of PB was most prominent among individuals with high rates of comorbid depression (Arditte, Morabito, Shaw, & Timpano, 2016).

Anestis et al. (2011) concluded that elevated levels of emotional dysregulation (particularly low distress tolerance and high negative urgency[3]) predicted elevated levels of suicidal desire (which included high levels of PB). PB has been shown to act as a mediator in the relationship between suicidal ideation and a number of other suicidal risk factors, including perceived social support and social connectedness in college students (Hollingsworth et al., 2018), and perceived social problem-solving (the ability of an individual to identify problems and generate appropriate solutions (Chu et al., 2018).

[3] Negative urgency is defined by Anestis et al. (2011) as the extent to which an individual tends to act in a rash or impulsive manner with the goal of reducing negative affect.

PB has also been shown to mediate the relationship between depression and suicidal ideation amongst older adults (Jahn, Cukrowicz, Linton & Prabhu, 2011) as well as the relationship between maladaptive perfectionism and suicidal ideation (Rasmussen, Slish, Wingate, Davidson & Grant, 2012). All of these studies reflect the importance of this construct in improving our overall understanding of the mechanism by which NSSI increases the likelihood to die by suicide and the overall aetiology of death by suicide.

A study looking at the presence of PB in suicide notes reached conclusions contrary to the IPTS, suggesting that relatively few notes contained indications of PB (10.3%), with notes written by women being more likely to contain themes of PB. A limitation of this study however, was that just 33% of the suicide sample (1,091 suicides) actually wrote notes that could be included in the study. The authors thus suggest that perhaps suicide notes are not typical of suicides in general (Gunn et al., 2012) and therefore the conclusions drawn may not be entirely accurate.

Why is Perceived Burdensomeness Important?

There are many known risk factors for suicidal ideation, suicide attempt and death by suicide, many of which are shared risk factors for engagement in NSSI (e.g., Andover, Morris, Wren, & Bruzzese, 2012; Klonsky, Brausch, & Gutierrez, 2010; May & Glenn, 2013). NSSI itself is a robust risk factor for suicidal behaviours (Andover & Gibb, 2010; Asarnow et al., 2011; Klonsky et al., 2013; Klonsky & Muehlenkamp, 2007; Muehlenkamp & Gutierrez, 2007; Nock et al., 2006; Wilkinson et al., 2011).

Models for death by suicide can be helpful; however knowledge of how risk factors interact with and influence these models is required to gain greater insight that can be used in the treatment and prevention of suicidal behaviour. The correlation observed between NSSI and suicidal behaviour suggests that there is much overlap between NSSI and suicidal

behaviours, however as many individuals engage in NSSI without making a suicide attempt, crucial differences must also exist between the two. A relationship between NSSI and acquired capability for suicide has been reported previously (Joiner et al., 2012). These authors suggested that repeatedly engaging in NSSI behaviours acts to diminish the fear of death, while the pain caused by NSSI increases the overall pain tolerance over time. This link between NSSI with the IPTS, and consequently death by suicide suggests that perhaps PB may warrant further investigation within the context of all self-injurious behaviours.

Chapter Summary

Suicide is considered to be a major public health problem worldwide and New Zealand is no exception. Although initiatives that aim to assist in reducing the suicide rate in New Zealand have provided insight into behaviours related to suicide, we still lack knowledge on effective prevention initiatives. Research continues to reflect the notion that suicide is preventable, however despite the growth in literature on suicide, the problem continues. There currently exists much knowledge of vulnerability factors for death by suicide, however despite this knowledge, the ability to predict suicide attempts is still lacking, and thus the knowledge and ability to initiate effective suicide prevention strategies is also lacking. It is suggested that a more thorough understanding of the mechanisms by which these factors convey their risk for death by suicide is therefore required. This knowledge will assist with a greater ability to identify those at risk as well as informing case conceptualisation and treatment planning. The IPTS is currently the most well supported theory of why people die by suicide, suggesting that individuals die by suicide when they have both the acquired capability for suicide and the desire to die (resulting from thwarted belongingness and PB). While the IPTS is focused on death by suicide, it is likely that it may be useful in gaining a wider understanding of how and why known risk factors for death by

suicide lead to suicide attempts and death by suicide in some cases, but not in others. NSSI is known to be a significant risk factor for suicidal behaviour (e.g., Asarnow et al., 2011; Cox et al., 2012; Guan, Fox, & Prinstein, 2012; Kimbrel et al., 2015; Klonsky, May, & Glenn, 2013; Victor & Klonsky, 2014; Whitlock et al., 2013; discussed below), however the overlaps and the differences between NSSI behaviours and suicidal behaviours are not yet fully understood. A better understanding of these overlaps and differences may be useful in reducing both NSSI and suicidal behaviours.

CHAPTER THREE: NON-SUICIDAL SELF-INJURY

As noted earlier, non-suicidal self-injury (NSSI) is defined as direct, self-inflicted damage of body tissue in the absence of the intent to die, and outside of that which is socially sanctioned (Nock, 2009). Thus, while NSSI may present similarly to suicide attempts (SA) in hospital Accident & Emergency departments, the difference is in an individual's intent – to injury and not to end one's life.

Research suggests that both interpersonal (e.g., social interaction and family relationships; Brausch & Gutierrez, 2010), and intrapersonal factors (e.g., regulation of emotion and perceptions of self-worth; Baetens, Claes, Willem, Muehlenkamp, & Bijttebier, 2011) can contribute to NSSI (Nock, 2009; Zetterqvist, Lundh, & Svedin, 2013). NSSI is considered to be a maladaptive behaviour by many, however it is utilised as a method for coping with strong emotions, assisting individuals to temporarily feel better (Bresin, Sand, & Gordon, 2013; Franklin et al., 2010; Nock & Prinstein, 2005; Tatnell, Kelada, Hasking, & Martin, 2014; Weinberg & Klonsky, 2012).

Defining Self-Injurious Behaviours

Self-injurious behaviours have been known by many names, and this lack of consensus has led to some confusion when attempting to understand these behaviours. This limits the ability to compare research studies focused on self-injury, hindering the development of a greater understanding of these behaviours. Self-injury is a topic discussed within the academic literature, by mental health and medical practitioners, within self-help materials and generally within the population in the popular press, across social media and in

person. Such wide discussion of self-injurious behaviours often sees inconsistent use of a number of terms, describing a variety of behaviours, a precise definition of which particular behaviours are being discussed is often not included, at times leading to confusion or misinformation.

A number of different terms have been used to describe self-injury, including self-mutilation (Favazza, 1998), self-injurious behaviours, parasuicide, self-harm (Harris, 2000), deliberate self-harm (DSH; Hawton, 2004) and as will be used in the current study non-suicidal self-injury (Jacobson & Gould, 2007).

Parasuicide, self-harm and DSH include all self-injury no matter what motives may be present (suicidal or non-suicidal) and therefore will include suicide attempts as well as self-injury with no suicidal intent. The definitions of each of these terms can differ, depending who is making use of them, at times including deliberately reckless behaviours, substance abuse, and eating disorders, and sometimes referring to self-injury alone (Chandler, Myers, & Platt, 2011). The definition of these terms can also differ between countries. For example, Jacobson and Gould (2007) explained that the DSH is usually considered to refer to NSSI in the USA, however in the United Kingdom this term encompasses any self-injury that does not result in death.

The current study is focused on non-suicidal self-injury and therefore will use the term NSSI wherever possible. As mentioned above, as many studies have used different terms to describe the self-injurious behaviours they are exploring, some discussion of the literature includes terms other than NSSI, however in all cases (other than those noted) the population the authors were focused on was individuals engaging in self-injury without suicidal intent (that is to say NSSI, despite not necessarily using this nomenclature). At times

it was appropriate to discuss literature that was focused on a different self-injurious population, when this has been done it has been clearly noted.

History of NSSI

Self-injurious behaviours have been documented for centuries, with the earliest papers on this topic published in the 1960s, and the first epidemiological study that of Ross and Heath (2002), discussed the difficulty with differences in naming of self-injurious behaviours, and whether or not each definition included both suicidal and non-suicidal self-injury. These authors used the term 'Self-Mutilation' and included all self-injurers in their study (that is to say, those individuals who had engaged in suicidal behaviour and/or non-suicidal self-injury), but reported on NSSI separately to suicidal behaviours – concluding that there was a high prevalence of self-mutilation in non-clinical adolescent populations (13.9% of the population examined).

Since 2002, the body of literature examining self-injurious behaviours has begun to grow. However, despite research findings suggesting that NSSI behaviour is prevalent, and for some individuals, may become clinically and functionally impairing (Hawton & James, 2005; Wilkinson, 2013), NSSI was generally only considered to be a symptom of Borderline Personality Disorder (BPD) and little importance was given to this behaviour. The focus on NSSI changed following the publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association. 2013). It is now well known that the majority of individuals who engage in NSSI do not meet the criteria for a diagnosis of BPD (De Leo, 2011).

Predominantly in North America, it has been proposed that NSSI be recognised as a separate clinical disorder (Favazza & Rosenthal, 1990; Graff & Mallin, 1967; Kahan & Pattinson, 1984; Muehlenkamp, 2005) and much discussion has occurred around how to

better characterise or describe individuals who engage in self-harming behaviours in the absence of suicidal intent or other emotional disorders (De Leo, 2011; Herpertz, 1995; In-Albon, Ruf, & Schmid, 2013; Muehlenkamp, 2005; Shaffer, & Jacobson, 2009). Common to all of these proposals has been the alleviation of strong distress in the absence of the intention to die (Klonsky, 2007). Kahan and Pattinson (1984) analysed 56 published case reports of self-harm and described the clinical characteristics of a deliberate self-harm syndrome (including the inability to resist injuring oneself, increased sense of tension prior to self-harming, and a feeling of release or relief after self-harming). Despite use of the term 'deliberate self-harm', these authors were focused on NSSI and differentiated between self-harming without suicidal intent and suicidal behaviour. Kahan and Pattinson, proposed that a separate diagnostic syndrome be included in the fourth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Some years later, Favazza and Rosenthal (1990) proposed the inclusion of an impulse disorder in the DSM, described as Repetitive Self-Mutilation Syndrome. The description of this syndrome complemented that which had been proposed earlier, however, these authors also included the symptom of having a preoccupation with harming oneself.

Muehlenkamp (2005) also proposed the inclusion of a NSSI as a distinct disorder in the DSM (she named this 'Deliberate Self-Injury Syndrome'). Muehlenkamp made clear in the proposed criteria that the syndrome was focused on non-suicidal self-injury only, lacking any suicidal intent, discussing the area using the term 'superficial/moderate self-injurious behaviours' (SIBs). Muehlenkamp argues that research shows that most individuals who engage in NSSI are able to make a clear distinction between NSSI and suicidal behaviours, and do not consider death to be a likely outcome as a result of NSSI. Significant differences have been found between those adolescents who engage in NSSI and those who engage in suicide attempts in levels of depression, suicidal ideation and general attitudes towards life

(Muehlenkamp & Gutierrez, 2004). In addressing the question of whether NSSI itself constitutes a psychiatric disorder (and thus warrants inclusion in the DSM), Muehlenkamp suggested that indeed NSSI could constitute a psychiatric disorder due to the notable symptom pattern and what she describes as a "clear presentation of biological and associated features (e.g., age of onset, precipitants, course)" (Muehlenkamp, 2005, p. 327). Despite this, she also acknowledges that NSSI is common in both psychiatric and non-clinical populations, suggesting that other differentiations (outside of engaging in NSSI) are required to determine if a psychiatric diagnosis is warranted or not. Overall, Muehlenkamp's proposal highlighted the absence of conscious suicidal intent and described the phenomenological and empirical data supporting adoption of this distinct syndrome but did not address the fundamental question of whether NSSI itself constitutes a psychiatric disorder in and of itself.

Since that time research studies have increasingly suggested that while NSSI can be seen in many mental disorders (including BPD), it is also possible for individuals to exhibit NSSI in the absence of any other psychiatric comorbidities, (Glenn & Klonsky, 2009; In-Albon et al., 2013; Jacobson, Muehlenkamp, Miller, & Turner, 2008) perhaps providing some evidence that NSSI may be a psychiatric disorder in and of itself or not a psychiatric disorder at all. However, NSSI is a complex behaviour, and this lack of diagnostic delimitation (due to NSSI occurring outside that which is represented by NSSI Disorder, such as BPD and Pervasive Development Disorders) currently acts to prevent validation of NSSI Disorder. There is also a need to gain empirical evidence as to the frequency threshold of NSSI that would constitute a diagnosis of a psychiatric disorder (that is to say, how many episodes of NSSI over what timeframe is clinically meaningful, and what of the severity of these episodes), as well as which methods of NSSI should be included in the disorder and an accurate understanding of what the implications may be for introducing NSSI Disorder, both positive and negative (Selby, Kranzler, Fehling, & Panza, 2015).

Non-suicidal Self-injury as a distinct Psychiatric Disorder

Shaffer and Jacobson (2009) proposed the inclusion of a NSSI disorder in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013). The clinical criteria proposed was similar to that which had been proposed by earlier studies, identifying several explanations for the inclusion, such as the clinical and functional impairment caused by such symptomology and the evidence against NSSI being exclusively a symptom of BPD or suicidality. It is difficult to see how this fits with current literature, which suggests that a substantial proportion of people who engage in NSSI do not seek help, either medical or psychiatric, a fact that has been supported in the deliberate self-injury literature (Evans, Hawton, & Rodham, 2005; Hawton, Saunders, & O'Connor, 2012; Nixon, Cloutier, & Jansson, 2008). The authors also suggested that without this research and intervention studies, knowledge of ways to assist individuals struggling with NSSI will be impeded (Shaffer & Jacobson, 2009). The fifth edition of the DSM was released in 2013 and included as a 'Disorder Requiring Further Research' the new diagnostic classification Non-suicidal Self-injury Disorder (NSSID). Since this time research studies have shown support for NSSID as a distinctive clinical disorder, often present with one or more psychiatric comorbidities (In-Albon et al., 2013; Zetterqvist, 2015). While there is some evidence to suggest that NSSI should be recognised as a unique clinical disorder, there is also concern about labelling individuals who engage in NSSI as having a psychiatric disorder.

It is argued that labelling individuals as having a psychiatric disorder as a result of engaging in NSSI also poses a number of disadvantages, specifically rejection and stigmatisation by the general public, peers and the individual's against themselves (De Leo, 2011). It can be argued that defining NSSI as a psychiatric disorder would be to pathologise behaviour. Following such a trend, are we then to assign every problematic behaviour its

own specific disorder? Selby and colleagues pose the question – is this a behavioural disorder, or a disordered behaviour? (Selby, Kranzler, Fehling, & Panza, 2015).

There are arguments for and against the inclusion of NSSID as a distinct clinical disorder. In the absence of any guidelines to distinguish between a behavioural disorder and a disordered behaviour significant improvement in assisting people struggling with NSSI is urgently needed (Selby et al., 2015). The etiology of NSSI is currently far from understood, and the heterogeneity of NSSI is so broad, that it is difficult to see how fitting this behaviour into one disorder may result in a better understanding of the how treatment of NSSI may be improved; further research into NSSID is therefore required.

Epidemiology of Non-suicidal Self-Injury

Research focusing on the prevalence and characteristics of NSSI within the community has produced somewhat varied results. While research into NSSI is increasing worldwide, currently the majority of NSSI research has been conducted within the North American population. Most community-based findings conducted within North America have shown that between 14 and 24% of adolescents have engaged in NSSI at least once (e.g., Hankin & Abela, 2011; Jacobson & Gould, 2007; Laye-Gindhu & Schonert-Reichl, 2005; Muehlenkamp & Gutierrez, 2007; Nock, 2009; Swannell, Martin, Page, Hasking, & St John, 2014). Therefore, if NSSI was to be classified as a diagnosable psychiatric disorder, 14 – 24% of North American adolescents would potentially gain a psychiatric diagnosis.

Outside of North America research suggests that the lifetime prevalence of NSSI in adolescents varies significantly across countries, ranging from as low as 5.5% in Hungary (Csorba, Szelesne, Steiner, Farkas, & Nemeth, 2005) to as high as 65.9% reported in Sweden (Lundh, Karim, & Quilisch, 2007). Studies conducted in Turkey (Zoroglu et al., 2003), Germany (Plener, Libal, Keller, Fegert, & Muehlenkamp, 2009) and Belgium

(Muehlenkamp, Williams, Gutierrez, & Claes, 2009) suggested the prevalence among adolescents to be 21.4%. 25.6% and 30.7% respectively. A recent Chinese study reported a prevalence of 23.2% among Chinese students (Liang et al., 2014). A study conducted by Plener and colleagues (2013) that measured and compared prevalence rates of NSSI amongst adolescents from Austria, Germany and Switzerland found that while the overall six month prevalence rate was found to be 18.8%, significant differences were found in the prevalence rate for each country with adolescents from Germany reporting the highest prevalence rate (14.6%) and adolescents from Switzerland reporting the lowest (7.6%).

Plener et al. (2013) speculated on why significant differences in NSSI rates may be seen across neighbouring German speaking countries, where it might be hypothesised that similar rates would be seen. One suggestion for having a lower rate of NSSI in Switzerland was that the sample of adolescents was taken from private Grammar Schools; however one study conducted in the USA showed that NSSI is still very prevalent in middle and upper class schools (Yates, Tracy, & Luthar, 2008). Another study using a German sample reported that financial income and type of schooling were not associated with DSH (the focus of this study was DSH, not NSSI; Brunner et al., 2007). The higher rates seen in the German sample, do not correspond to higher suicide rates, with Germany having the lowest suicide rates across the countries included in the study according to the WHO statistics (Plener et al., 2013).

Comparison of prevalence rates for NSSI can be difficult due to methodological differences across studies, such as measures used, definitions of self-harm, age ranges included and large differences in sample size and the heterogeneous nature of NSSI. The majority of individuals who engage in NSSI do not seek assistance (either medical or psychological) and therefore it is difficult to ascertain the prevalence of NSSI behaviours with accuracy (Whitlock, Eckenrode, & Silverman, 2006). When focusing on the frequency,

or number of times an individual has engaged in NSSI, research results are once again varied, ranging from just one incident to hundreds of incidents of NSSI (Hanania, et al., 2015; Jacobson & Gould, 2007; Martin, Swannell, Hazell, Harrison, & Taylor, 2010; Nock, 2010). Research has shown that the frequency of NSSI appears to influence both the severity of NSSI and psychopathology generally. For example You, Leung, Fu and Lai (2011) conducted a study focused on Chinese adolescents who engaged in NSSI. These authors concluded that those individuals who engaged in NSSI repetitively (defined to be six times or more over the previous 12 months) had greater levels of depression symptomology and dissociation as well as more behavioural impulsivity than episodic NSSI individuals (engaged in NSSI five times or less). Szewczuk-Bogusławska et al. (2018) conducted a study looking at frequency of NSSI and found that individuals who engaged in NSSI behaviours more frequently defined to be eight times or more over the previous 12 months, showed significantly higher depression symptomology and had an overall lower age of NSSI onset.

In addition to the frequency of NSSI, the number of different methods of NSSI has also been a focus of research. The number of different methods used for NSSI has been reported to be associated with greater psychopathology (e.g., Nock et al., 2006; Whitlock et al., 2008) and is therefore important to consider. One study (Klonsky & Olino, 2008) utilised latent class analysis with results divided their sample into four clinically distinct NSSI groups,, the most severe group (based on methods used and frequency of NSSI) was associated with a higher likelihood of endorsing multiple NSSI methods and higher levels of distress than other groups. Those groups with higher NSSI frequency also included individuals who reported higher suicidal ideation and other psychological difficulties, endorsing more risk factors for future suicidal behaviour (such as significantly more frequent use of alcohol). Glenn and Klonsky (2011) reported that life time frequency of NSSI is

significantly related to the number of NSSI methods used, therefore as methods increase we may conclude that the severity of NSSI is also increasing.

NSSI and Age

Studies focusing on the age of onset indicate that NSSI generally peaks between 11 and 18 years of age (Hankin & Abela, 2011; Jacobson & Gould, 2007; Muehlenkamp & Gutierrez, 2007; Nixon, Cloutier, & Jansson, 2008; Nock & Prinstein, 2005). Periods of transition tend to increase the chance of an individual engaging in NSSI, for example, the transition from primary school to high school, or the transition from high school to University (Taliaferro & Muehlenkamp, 2015).

Adolescence is a significant developmental period and it is often during this time that the first onset of NSSI occurs, with research suggesting that rates of NSSI are particularly high in adolescents and young adults (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Whitlock, 2006). It is also during the adolescent period that there is known to be an elevated risk of both suicide attempts and death by suicide (Somer et al., 2015). One study, a large cross-sectional study conducted with an Australian population revealed that self-injury peaked at an earlier age for males (between 10 and 19 years, compared to females where NSSI peaked between 15 and 24 years), suggesting that the age of onset may in fact be younger in males (Martin et al., 2010). Studies show that NSSI is significantly more common amongst adolescents and young adults, with research suggesting that while approximately 6% of community based adults endorsed currently engaging in NSSI (Klonsky, 2011), for community based adolescents this figure is approximately 17% (Muehlenkamp, Claes, Havertape, & Plener, 2012; Swannell, Martin, Page, Hasking, & St John, 2014). High rates of NSSI amongst the youth community have also been found in New Zealand, with Wilson et al. (2013) reporting that 18% of 13 year olds and 28% of 15 year

olds endorsed having engaged in NSSI and up to 50% of secondary school students report having engaged in NSSI at least once (Garisch & Wilson, 2015).

NSSI and Gender

The information that follows is based on binary definitions of gender, as most literature is focused only on the traditional binary definitions of gender. Studies have generally shown that NSSI is more prevalent amongst females than males, especially within the adolescent population and more so in clinical samples (e.g., Bresin & Schoenleber 2015; Xavier, Marina Cunha, & Pinto-Gouveia, 2017) with one study reporting females as almost twice as likely to report NSSI (18.9% vs 10.9%; Whitlock et al., 2011). Why women are more likely than men to engage in NSSI is not fully understood, however, it is evident that an interaction of several factors (environmental and biological) are likely contribute to this difference (Bresin & Schoenleber, 2015).

Males tend to engage in forms of NSSI that present as outward-focused aggression, possibly causing damage to others, to objects or property but also to themselves. A study by Whitlock and colleagues reported that females were more likely to engage in NSSI due to feeling upset or with the desire to be noticed, while males were 1.6 times more likely to report anger as the trigger for NSSI (Whitlock et al., 2011). Females are more likely to engage in direct NSSI (damage directly to themselves) employing methods that produce blood, for example cutting or scratching the skin, whereas males are more likely to employ methods that result in unseen injuries, such as punching or burning themselves or banging their heads (Andover et al., 2010; Claes, Vandereycken, & Vertommen, 2007; Whitlock et al.). This tendency to engage in indirect forms of NSSI may act to disguise the self-injurious intent of the behaviour, and in this way the methods utilised by males may act to alter understandings of NSSI sex differences. These sex differences have been found in both adolescent (Sornberger et al.,

2012; Whitlock et al.) and adult populations (Andover, Primack, & Gibb., 2010), however some authors have suggested that the gender difference diminishes at least partially by adulthood (Lewis & Arbuthnott, 2012; Serras, Saules, Cranford, & Eisenber, 2010).

Studies focused on NSSI in males have suggested that males may engage in more severe forms of NSSI compared to woman, and that while women will care for their self-inflicted wounds, men are more likely to neglect to appropriately care for wounds, which may result in medical complications (Claes et al., 2007). This may be due to the fact that men are less likely than woman to view their NSSI as being a problem and to seek assistance for their NSSI behaviours (Whitlock, et al., 2008).

It is possible that the research may be somewhat reflective of findings that females are more likely to seek out treatment, help or support for mental health problems than males (Bresin & Schoenleber 2015; Nam et al., 2010), and the gender differences seen may be at least somewhat reflective of a reluctance of younger males to report NSSI compared with females (Bresin & Schoenleber, 2015).

Cessation of NSSI

For some individuals engagement in NSSI may be transient, minor and self-limiting (Whitlock, et al., 2008), therefore not necessarily requiring clinical intervention. According to some authors, this is possibly reflective of a normal developmental process (Bresin & Schoenleber, 2015) as opposed to experiencing a psychiatric illness (as the proposed NSSID would suggest). However, for some individuals long lasting injuries are incurred and non-suicidal acts can transition into suicide attempts (e.g., Asarnow et al., 2011). Emery, Heath, and Mills (2017) conducted a study focused on the basic need satisfaction in the onset, maintenance and cessation of NSSI in adolescents using Ryan & Deci's Self-Determination Theory (SDT; Deci & Ryan, 1985). The SDT is a theory concerned with human motivation

and personality that suggests that motivation exists on a continuum, one end being *amotivation*, then moving through four forms of *extrinsic motivation*, and ending at *intrinsic motivation*. Each level differs in perceived control and is focused on supporting natural or intrinsic behaviours that are effective and healthy (Jacobi, 2009). Emery et al., (2017) concluded that need satisfaction (specifically the needs of autonomy, competence, and relatedness) is significantly lower in individuals who engage in NSSI, compared with those with no history of NSSI, concluding that need satisfaction differs as a function of NSSI status (no history of NSSI, beginning NSSI, maintaining NSSI or stopping NSSI). These findings show some similarity to the findings of Whitlock, Prussien and Pietrusza (2015), who conducted a study into NSSI cessation and using qualitative data concluded that changes in the ability to regulate emotions, increased self-awareness and an increase in important relationships may act to bring about cessation of NSSI.

Non-suicidal Self-injury in New Zealand

As described above NSSI is considered to be a significant problem amongst adolescents worldwide (World Health Organization, 2014a) and New Zealand is no exception. NSSI has been found to be prevalent in New Zealand (Beautrais, Wells, McGee, & Oakley Browne, 2006; Larkin & Beautrais, 2008). NSSI research within the New Zealand population is still somewhat limited compared to research into suicidal behaviour or NSSI research from abroad (especially from North America) and the majority of research that has been conducted does not differentiate between self-injury with suicidal intent and NSSI. Despite this, the data is still of importance in gaining some understanding within a New Zealand context. Garisch & Wilson (2010) conducted a study using De Leo and Heller's (2004) questions about deliberate self-harm (DSH); which covered self-injury with suicidal intent as well as NSSI. Participants were 300 New Zealand high school students residing in the Wellington region who were asked for motives for self-injury but not specifically about

intent. Results suggested that approximately 15% of high school aged individuals have engaged in DSH at least once, however the authors suggest there is some potential for underestimation of DSH behaviours due to participant non-disclosure of what may be viewed as an undesirable behaviour. A limitation of this study was that questions were very broad and provided no detail into the methods used, progression over time, or frequency or duration of engagement in DSH. Generalisability may also be limited as most participants were of New Zealand European decent and pupils attended a high socio-economic status school. This study also focused on bullying, depression and alexithymia and focused on DSH rather than NSSI alone.

A New Zealand based Dunedin longitudinal study found a similar figure, suggesting a lifetime self-harm prevalence of 13% (in a population of 26 year-olds), however as with many studies focused on deliberate self-harming behaviours (without questioning intent), this study was also limited by the fact that it did not differentiate between self-harming behaviours conducted with suicidal intent and self-harming behaviours conducted without the intent to die (Nada-Raja, Skegg, Langley, Morrison, & Sowerby, 2004).

Johnstone et al. (2015) conducted a study in New Zealand focused on childhood predictors of both SA and NSSI in depressed adults. They reported slightly higher life-time prevalence for NSSI of 21% within a clinical sample. A recent study, (Fitzgerald & Curtis, 2017) conducted with New Zealand university students using the Whitlock, Pietrusza, and Purington, (2013) *Survey of College Mental Health and Wellbeing* found a NSSI 12 month prevalence of 15.3%, a figure that is more than double that found in a similar USA based study.

The Auckland Youth 2000 Study conducted a survey of 8,500 New Zealand adolescents, and reported a prevalence of frequent NSSI (defined as having engaged in NSSI

behaviours three or more times in the past 12 months) as approximately 1 in 13 individuals (Tiatia-Seath & Fleming, 2012). NSSI in New Zealand may be a growing problem amongst young people (adolescents and young adults), with a more recent study by Garisch and Wilson (2015) finding that in a large sample of secondary school students from the Wellington region, 48% reported having engaged in NSSI at least once, compared to a figure of 15% in the same authors' 2004 study. These findings suggest that there is a need for NSSI to be addressed in New Zealand, and coupled with New Zealand's high suicide rates, the reduction of self-harming behaviours should remain a priority within New Zealand health strategies.

Cultural Considerations in New Zealand

While a substantial body of research into suicidal behaviour amongst New Zealand Māori exists, research into NSSI amongst New Zealand Māori is somewhat lacking. At least two New Zealand based studies focusing on rangatahi Māori (Māori youth) have reported prevalence rates for this population to be similar to those for non-Māori, suggesting that Māori youth are at no greater risk of NSSI (Fitzgerald & Curtis, 2017; Wilson et al., 2015). Official statistics from the Ministry of Health suggest that 18% of those individuals hospitalised for intentional self-harm (either due to NSSI or suicidal behaviour) identified as New Zealand Māori (14.9% of the New Zealand population identify as Māori, therefore this figure is consistent with what would be predicted), 3.6% identified as Pacifica (Ministry of Health, 2014; 7.4% of the New Zealand population identify as Pacifica, therefore this figure is lower than would be predicted). These figures do not give an indication of the exact prevalence rates, as they do not take into account the intention behind the self-injury (i.e., whether intention was suicidal or non-suicidal). Further, only a small percentage of those who engage in NSSI will present to hospital (Hatcher et al., 2009), and presentations to general practices, chemists, traditional healers or other health professionals are not taken into

account (Dash, Taylor, Ofanoa, & Taufa, 2017). Robinson et al., (2017) undertook a study focusing on the link between socio-economic status and NSSI, concluding that individuals of lower socio-economic status are at increased risk of engaging in NSSI, and as New Zealand Māori are more likely to be of lower socio-economic status, suggesting that they are at greater risk of engaging in NSSI. However, while a disproportionately high number of New Zealand Māori die by suicide, research suggests that they are at no greater risk of engaging in NSSI (Fitzgerald & Curtis, 2017).

CHAPTER FOUR: UNDERSTANDING WHY PEOPLE ENGAGE IN NSSI

Theories of Non-suicidal Self-Injury

NSSI is a complex and multi-dimensional behaviour, which likely results from a combination of biological, psychological and social influences (De Riggi, Moumne, Heath, & Lewis, 2017). Theories of NSSI generally fall into at least one of four types – intrapersonal or interpersonal negative reinforcement and intrapersonal or interpersonal positive reinforcement (Figure 4.1). Positive reinforcement includes the generation of feelings or stimulation that the individual may wish for (intrapersonal) or the facilitation of help-seeking (interpersonal). Negative reinforcement includes distraction from unwanted thoughts or feelings (intrapersonal) or facilitation of escape from uncomfortable social situations (interpersonal) (Nock, 2009; Nock & Prinstein, 2005). It is noted that research has suggested that there can at times be a distinction between the reasons reported for engaging in NSSI and the actual function served by NSSI behaviours (Nock 2009).

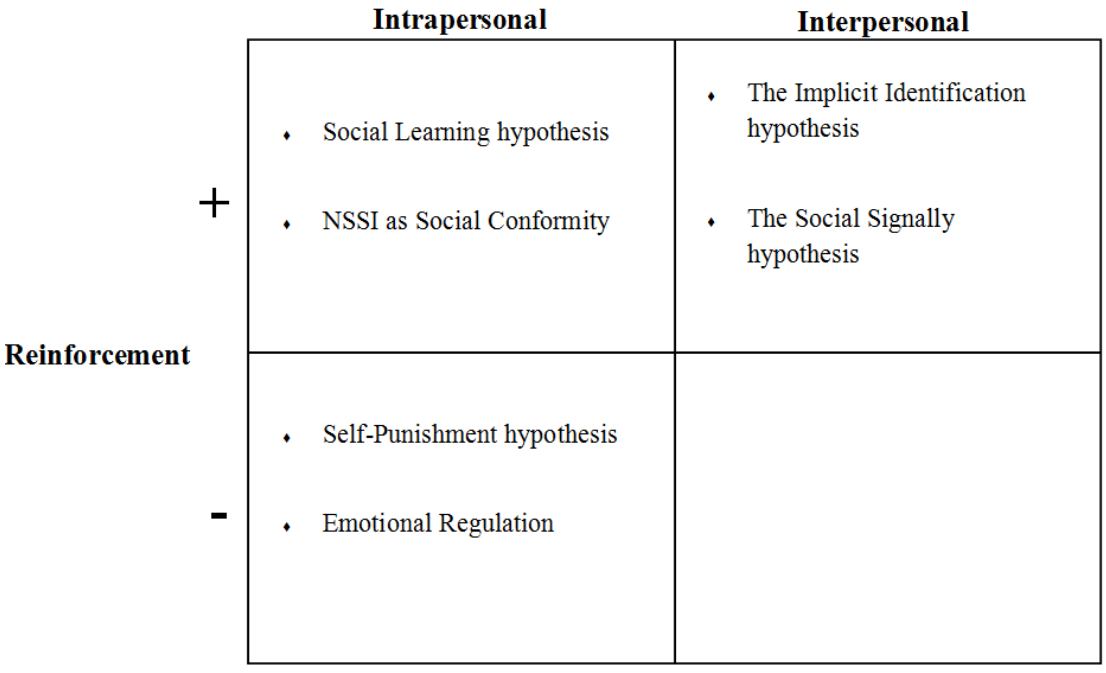

Figure 4.1. Intrapersonal and interpersonal theories of NSSI

Nock (2009) reviewed the differing functional models that have been suggested for NSSI (each with varying empirical support) and has proposed a number of hypotheses for the development and maintenance of NSSI:

- *The Social Learning hypothesis* suggests that engaging in NSSI is influenced by observation of similar behaviours being used by others. Purington and Whitlock (2010) reported that the significant increase in NSSI behaviour over the past decade has been paralleled by an equal increase in references to NSSI in movies, songs, and internet sites. However correlation does not necessarily indicate causation, references to NSSI may have increased due to the incidence of NSSI increasing first, or both NSSI and references to it may be influenced by one or more other factors.
- *The Self-Punishment hypothesis* suggests that individuals engage in NSSI as a form of self-directed abuse, learned through being a victim of repeated abuse by others. This hypothesis has been supported by research showing a link between childhood abuse and NSSI especially in females (Maniglio, 2011; Vaughn, Salas-Wright, Underwood, & Gochez-Kerr, 2015; Zoroglu et al., 2003).
- *The Social Signalling hypothesis* suggests that individuals may engage in NSSI as a method of communication when other means, such as verbal strategies have failed or not delivered the required effect (Nock & Mendes, 2008). However, this hypothesis is not supported in cases where individuals who engage in NSSI make attempts to hide their self-injurious behaviours from those around them.
- *The Implicit Identification hypothesis* suggests that once an individual has engaged in NSSI they may learn to rely on this behaviour as a valuable and efficient way of achieving the desired function. If the individual identifies with NSSI, they may learn to see themselves as a person who engages in self-harm and therefore continue to engage in NSSI (perhaps as a way to gain and maintain an internal locus of control).

Emotional Regulation

Engaging in NSSI has been reported by individuals who have discussed their experiences as an attempt at helping themselves, either by eliciting help from others, or by taking action to reduce their internal distress or providing grounding when in a dissociative space (Adler & Adler, 2007; Claes, Klonsky, Muehlenkamp, Kuppens, & Vandereycke, 2010). The use of NSSI for the reduction, escape from or tolerance of difficult emotions (intrapersonal negative reinforcement) is reported by those who engage in NSSI as the most common function or reason that these individuals engage in this behaviour (Bresin & Schoenleber, 2015; De Riggi, Moumne, Heath, and Lewis, 2017; Gratz & Chapman, 2007; Klonsky, 2007; Nock, Prinstein, & Sterba, 2009). The effect is temporary, but may last anywhere from several hours, to days or weeks (Adler & Adler, 2007; Favazza, 1998). This can be understood in light of evidence that has found that physical pain is able to reduce negative emotions temporarily suggesting that NSSI is somewhat adaptive short term, with the possibility of negative outcomes if it is employed long-term (Bresin & Gordon, 2013). While some studies focused on NSSI behaviours have reported that impulsivity is a risk factor for these behaviours (Baer et al., 2018; Glenn & Klonsky, 2010), it is important to note that studies where individuals have been directly interviewed have shown that NSSI can also be planned or fully intentional. Some individuals are even able to defer the NSSI to a chosen time and place or to when they felt ready (Adler & Adler, 2007).

Some forms of NSSI (scratching, bruising, cutting and burning) have been reported to be both positively and negatively reinforced, that is to say, these behaviours act to both increase positive affect and decrease negative affect (Claes et al., 2010). Delaying engagement in NSSI reportedly allows the individual more enjoyment in conducting the harming behaviours or provides more opportunity to hide the behaviours (Prus & Grills, 2003). In these delayed cases, the individual seems to be driven more by the sense of

enjoyment obtained through NSSI, rather than the reduction of difficult emotions in the moment (Adler & Adler, 2007) they are therefore able to weigh up the costs and benefits of engaging in NSSI (rather than engaging in NSSI due to a problem with impulse control), suggesting that NSSI occurs both due to psychological factors, as well as sociological factors, and for some individuals may be considered a significantly ordered behaviour, rather than disordered behaviour or a psychiatric disorder.

NSSI as Social Conformity

Individuals who engage in NSSI have reported that engaging in these behaviours can be a way to engage with particular social or friendship groups that may provide a sense of identity or belonging, and may sometimes be seen as a means to gain popularity amongst those the individual is affiliated with (Adler & Adler, 2007; Muehlenkamp, Hoff, Licht, Azure, & Hasenzahl, 2008; Nock & Pristein, 2005; Pristein et al., 2010). In this way NSSI may be described as a strategy for social conformity (Jarvi, Jackson, Swenson, & Crawford, 2013; Wilkinson et al., 2011; Purington & Whitlock, 2010). One study reported findings that approximately 50% of young people who identified with alternative youth subcultures such as 'emo', 'goth' or 'punk' engaged in NSSI, and overall were 4 – 8 times more likely to engage in self-harming behaviours (either non-suicidal or suicidal) compared to peers who did not identify with these subcultures (Young, Sproeber, Groschwitz, Preiss, & Plener, 2014).

For young people today, the pressure to conform or to fit in with their peers is not only present in a face-to-face context, but also present online through social media. One study focusing on the social media app Instagram reported that images of NSSI are posted frequently and suggested that the social reinforcement gained through this social media platform may act to encourage more severe NSSI pictures to be posted and act to contribute

to a social media contagion (Brown, et al., 2018). At times groups of peers may engage in NSSI together, possibly sharing the same tools and at times injuring each other further increasing the socially driven spread of NSSI by producing feelings of cohesiveness (Walsh & Muehlenkamp, 2013). NSSI that begins for these reasons may or may not lead to long-term engagement in NSSI; the risk for repeated NSSI behaviour varies for each individual (Whitlock et al., 2015).

It is likely that the reasons that an individual has for engaging in NSSI alter over time, moving between intrapersonal and interpersonal functions (Ministry of Health, 2008). What appears to hold true is that all individuals who engage in NSSI are struggling in some way (Adler & Adler 2007; McKenzie & Gross, 2014).

NSSI as a Suicide Risk Factor

As mentioned previously, NSSI and suicide attempts are related and some individuals who engage in NSSI also engage in suicidal behaviours (ideation, planning and attempts to end their life). This relationship was illustrated by a recent Australian community study that found almost half (48.1%) of individuals who had engaged in NSSI had also experienced suicidal ideation during the period they were self-injuring. This number is 12 times that found in individual's who had never engaged in NSSI - despite the fact that these self-injuring behaviours were not associated with an intention to die (Martin et al., 2010). Evidence suggests a substantial number of individuals who engage in NSSI undergo compelling suicidal impulses, and may use NSSI as a suicide avoidance strategy (Klonsky, 2007), suggesting that NSSI may act to protect against suicide, but in the longer-term may be a link between suicidal ideation and making a suicide attempt, indicating that NSSI is a complex behaviour that needs to be understood by practitioners working with individuals engaging in these behaviours.

Chan et al. (2018) in a study examining NSSI in New Zealand high school students, found that individuals who had repeatedly engaged in NSSI behaviours had a significant overlap with those who had made a suicide attempt, suggesting that for some individuals, NSSI may sit on the same continuum as suicidal ideation and death by suicide. The authors noted that this trend was not seen in Pasifika students, who were least likely to engage in repeated NSSI, but most likely to report a suicide attempt in the past year, the reasons for this difference were unclear. A recent study conducted with data from the Avon Longitudinal Study of Parents and Children in the UK found that many of the risk factors for suicide commonly cited were not associated with individuals transitioning from suicidal ideation or engagement in NSSI to making a suicide attempt (by age 21), suggesting that these common risk factors were in fact associated with the suicidal ideation of NSSI itself – not the transition to suicide attempts. These authors demonstrated that NSSI is associated with the transition from suicidal ideation to making a suicide attempt. Results obtained suggested that a number of factors should be taken into account when attempting to learn who will transition on to make a suicide attempt and who will not, including history of NSSI as well as exposure to self-harm (Mars et al., 2019).

While NSSI can be hazardous in its own right, previous or concurrent NSSI has been reported to be a major risk factor for suicidal behaviour (e.g., Asarnow et al., 2011; Cox et al., 2012; Guan, Fox, & Prinstein, 2012; Kimbrel et al., 2015; Klonsky, May, & Glenn, 2013; Victor & Klonsky, 2014; Whitlock et al., 2013). It is estimated that a history of NSSI is present in approximately 50-60% of individuals who die by suicide (Foster, Gillespie, & McClelland, 1997); while individuals who engage in NSSI are estimated to be 100 times more likely than the general population to make a suicide attempt (Hatcher et al., 2011; Figure 4.2). Having previously engaged in NSSI is described by some authors as a clinical marker for the risk of future suicide attempts. NSSI has been found to be more strongly

associated with suicide attempts than other recognised risk factors for suicide, such as depression, anxiety, impulsivity, and Borderline Personality Disorder (Andover & Gibb, 2010; Klonsky, May, & Glenn, 2013 Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011). Wilkinson et al. (2011) reported that NSSI was a stronger predictor of future suicide attempts than past suicide attempts were, finding that those adolescents with a history of NSSI had 10-fold greater risk of a suicide attempt during treatment than those individuals who had not engaged in NSSI (independent of depressive symptoms).

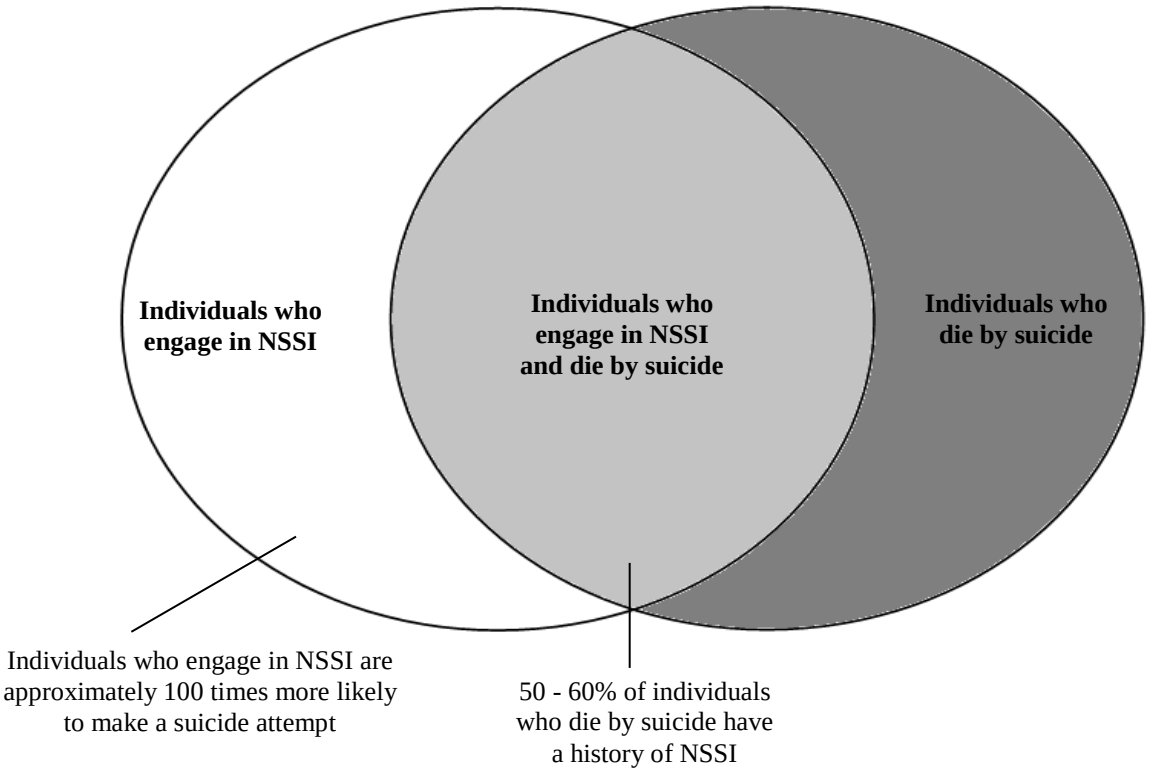

Figure 4.2. Schematic diagram illustrating the overlap between individuals who engage in NSSI and individuals who die by suicide

Further to NSSI acting as a risk factor for future suicide attempts, Brackman, Morris and Andover (2016) found that the frequency of NSSI was a significant modifier for the

association between suicidal ideation and suicide attempts, with an increase in suicidal ideation being associated with an increase in suicide attempts only for individuals who engaged in NSSI at either an average or high frequency. Suicidal ideation and suicide attempts did not share a significant association in the absence of NSSI, this finding is consistent with what we might predict using the IPTS, with NSSI acting as a means to acquire the capability for suicide. Of note was that individuals' self-reports of fearlessness of death and also objectively measured pain tolerance levels (by use of a pain sensitivity task), two components of acquired capability, did not moderate the relationship between suicidal ideation and suicide attempts as NSSI did (Brackman et al., 2016). This finding may suggest that NSSI plays a more complex role in suicide risk than is currently understood.

The relationship between NSSI and suicide attempts (SA) is complex and remains far from fully understood (Paul, Tsypes, Eidlitz, Ernhout, & Whitlock, 2015), while NSSI and suicide attempts are phenomenologically different, episodes of NSSI, with or without a history of suicide attempts are of paramount clinical importance in suicide interventions and prevention strategies (Boxer, 2010).

Risk factors such as depression serve to increase the risk for suicide, while ensuring access to lethal means serves to increase the capability for suicide, however unlike most other risk factors, NSSI is somewhat unique as it not only serves to increase the desire for suicide through its association with increased emotional and interpersonal distress (Klonsky & Olino, 2008; Klonsky & Muehlenkamp, 2007) acting to increase suicidal ideation (or desire to die), but also enhances the capability to make a suicide attempt through multiple events of self-inflicted harm and pain (Nock et al., 2006; Klonsky et al., 2013)

Transition from NSSI to Suicide

Only a small proportion of individuals who engage in NSSI go on to make one or more suicide attempts, the relationship between these behaviours is complex. It is not possible to predict which individuals engaging in NSSI will transition onto suicide attempts, which individuals will continue to engage in repeated NSSI or cease further self-injury. If however, primary care and mental health clinicians were able to more accurately anticipate which individuals were likely to transition from engagement in NSSI to making a suicide attempt; work to reduce suicide rates may be more successful.

Elucidating the relationship between NSSI and SA has important clinical implications in suicide prevention interventions and risk management (Klonsky et al., 2013). Recent studies have found that NSSI rates prior to intervention are a stronger predictor of a future SA than previous SAs in both clinical adolescent samples (Asarnow et al., 2011; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011) and community adolescent samples (Guan et al., 2012).

Dickstein et al. (2015) conducted a study with psychiatric inpatients focusing on the difference between individuals who engage in SA and individuals who engage in NSSI. This study focused on implicit associations between NSSI, death, and suicide across three mutually exclusive homogeneous groups of adolescents (one group consisting of individuals who have engaged in a suicide attempt, one group of individuals who have engaged in NSSI and one group of typically developing control individuals). The authors hypothesised that individuals would have stronger implicit identification (forming an association without conscious awareness) with cutting if they were in the NSSI group or death and suicide if they were in the suicide attempt group. The study used the SI-IAT (self-injurious implicit association task), a performance-based computerized reaction task in order to measure

implicit associations (Nock & Banaji, 2007). The authors reported findings that partially agreed with their hypotheses, with those individuals who engaged in NSSI having stronger implicit attitudes towards self-cutting (compared to those who had made a SA without a history of NSSI and the control group). However contrary to their hypothesis, the NSSI group also had stronger self-identification with suicide/death (compared to those in the SA group and the control group). Further analysis revealed that this group difference appears to be independent of comorbid depression and suicidal ideation (although the authors note that further research and statistical analysis is required).

The reasons why NSSI participants had not made a suicide attempt despite having stronger identification with death/suicide and access to lethal means (for example sharp objects) require further research, however the authors suggest that perhaps NSSI-only participants had not yet acquired all of the necessary elements to make a suicide attempt. Thus this data suggest that understanding the mechanism of the relationship between NSSI and identification with suicide/death would likely be useful in working towards preventing suicide attempts. This was the first study to look at homogeneous sample groups (groups of individuals that are engaged in either SA or NSSI, not both), providing further elucidation of Joiner's IPTS model. Individuals' who only engaged in NSSI demonstrated acquired capability as well as greater levels of social isolation (compared to other participant groups), suggesting that perhaps PB (which was not specifically assessed for) may be associated with the transition from NSSI to a suicide attempt.

Factors contributing to thwarted belongingness (such as loneliness) have been the subject of research into suicide attempts for many years (Van Orden et al., 2010). Further, a number of studies have looked at the link between repeated NSSI and the construct of acquired capability, concluding that the capability for death by suicide may be adequately

acquired through repeated NSSI (e.g., Baer, 2018); however the relative contribution of PB in the transition to suicide attempts is still largely unknown.

Perceived Burdensomeness, Suicide and Non-Suicidal Self-Injury

While the IPTS is a model of suicide (not NSSI), as mentioned above, NSSI is a major risk factor for suicide attempts, and it is therefore possible that PB plays a role in both of these behaviours and perhaps in the transition between NSSI and a suicide attempt. PB was the subject of few empirical studies into the causation of suicidal behaviour until the IPTS was introduced in 2005, and research is still currently lacking on how PB differs between individuals who self-injure without suicidal intention and those who self-injure with the intention of ending their lives. Study results appear to vary in terms of the robustness of each of the constructs posited by the IPTS to bring about suicidal behaviour (Chu et al., 2017), however recent research has suggested that particularly suicidal ideation but also other suicidal behaviours may be more strongly correlated with PB compared to thwarted belongingness (Bryan, Morrow, Anestis & Joiner, 2010; Ma et al., 2016). The IPTS does not specifically make a link between NSSI and PB, however, Chu, Rogers and Joiner (2016) investigated the relationship between the two, in order to ascertain a better understanding of the mechanism by which NSSI is associated with suicidal behaviour. They found that the relationship between a history of NSSI and suicidal ideation is mediated by PB. This suggests that a greater understanding of PB and NSSI may enhance the ability to determine who will make a suicide attempt and who will not. Recent studies have shown that PB not only influences suicidal behaviours, but is also able to mediate a number of other suicidal risk factors. Carrera and Wei (2017) for example applied Joiner's (2005) IPTS model to Asian American students, focusing on experiences of depression and interpersonal shame. These authors found that PB was a contributing factor in higher interpersonal shame and likelihood of future depression. A recent study examining both PB and thwarted belongingness found

that only PB (not thwarted belongingness) was able to mediate the relationship between perceived social support and suicidal ideation, suggesting that PB may act to mediate particular relationships that together lead to suicidal ideation and attempts (Hollingsworth et al., 2018).

Buitron and colleagues (2016) focused on interpersonal stress and its association with suicidal ideation within a population of adolescent inpatients. These authors used structural equation modelling and reported a significant, indirect effect via PB, specifically highlighting the potential of PB as a suicide prevention intervention target. These results were congruent with another study that found the association between childhood emotional abuse and suicidal ideation was mediated by PB among University students (Puzia et al., 2014). A recent study focused on perceived social problem-solving deficit and its association with suicidal ideation, also found suicidal ideation to be at least partially explained by PB, these results were able to be replicated across a wide range of population groups who with regard to suicidality and general mental health were both demographically and clinically diverse (Chu et al., 2018). PB has been described as a socially based cognition important for gaining a fuller understanding of risk for suicidal behaviours (Miller et al., 2016). It has also been suggested that PB may act as an activating agent impacting on other suicidal risk factors and thus targeting this construct in interventions may impact not only PB but also more distal risk factors, assisting in reducing the rate of suicide attempts (Hill & Pettit, 2014).

Understanding Perceived Burdensomeness

Further understanding and elucidation of the construct of PB to determine if, in conjunction with other factors, PB facilitates the transition from NSSI to suicide attempts would be useful for practitioners working with individuals engaging in NSSI and at risk of suicide. The link between perceptions of being a burden and its contribution to suicidal

ideation, suicide attempts and death by suicide is far from fully understood, however, recent literature (as detailed above) suggests the possibility that PB may be a stronger predictor of which individuals currently engaging in NSSI may transition to suicidal attempts that those currently considered. In this way, PB may act as a moderator for the transition between NSSI and suicidal behaviour (thereby directly contributing to the capability to make a suicide attempt).

A focus on this construct and how it relates to NSSI may allow for further elucidation of the link between perceptions of burdensomeness, NSSI and suicidal behaviour, perhaps allowing for a critical threshold to be determined, assisting with better risk management and providing a successful point of intervention for the treatment of NSSI and better prevention of suicide attempts. While psychometric analysis is able to provide a quantitative expression of the construct of 'burdensomeness', for practitioners working with clients who are engaging in self-harming behaviours, a knowledge of how this construct is understood and made sense of by those engaging in this behaviour would be especially helpful in case conceptualisation and intervention strategies, suggesting that both quantitative and qualitative data would be of use.

Therefore, gaining further insight into subjective perceptions of burdensomeness to others may also be of use to practitioners working with individuals who are engaging in NSSI or suicidal behaviours, in order to gain a better understanding of how individuals think about 'burdensomeness' and how it manifests. Figure 4.3 shows the IPTS Model with the additional relationship between PB and suicidal attempts that is suggested as a focus for research.

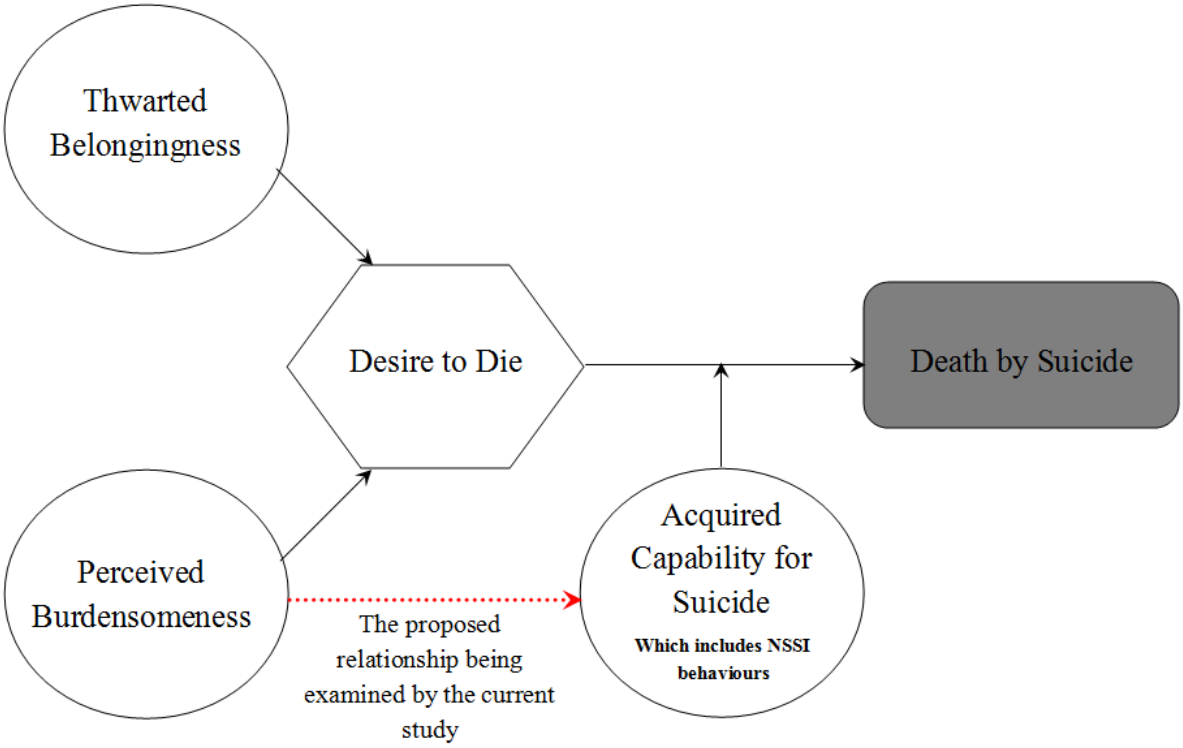

Figure 4.3. IPTS model illustrating the additional relationship that the current study is proposing to explore (adapted from Van Orden et al., 2010).

Chapter Summary

NSSI is a complex behaviour, reported to be a major risk factor for suicidal behaviour (e.g., Asarnow et al., 2011; Cox et al., 2012; Guan, Fox, & Prinstein, 2012; Kimbrel et al., 2015; Klonsky, May, & Glenn, 2013; Victor & Klonsky, 2014; Whitlock et al., 2013), and a stronger predictor of future suicide attempts than past suicide attempts are (Wilkinson et al., 2011). Literature has shown that NSSI may act as a link between suicidal ideation and making a suicide attempt (e.g., Klonsky, 2007; Martin et al., 2010), with some suggestion that for some individuals, NSSI may sit on the same continuum as suicidal ideation and death by suicide (Chan et al., 2018).

Despite NSSI acting as a major risk factor for suicidal behaviours, only a small proportion of individuals who engage in NSSI will go on to make one or more suicide

attempts, it is not possible to predict which individuals will do this. While focusing on NSSI behaviours and suicidal behaviours is useful, a greater understanding of the relationship between NSSI and suicide attempts is required, as this relationship has important clinical implications in suicide prevention and risk management (Klonsky et al., 2013), as well as NSSI interventions.

The transition from NSSI to suicide is not yet understood, however recent research suggests that PB may be associated with the transition from NSSI to a suicide attempt (Dickstein et al., 2015). The relationship between NSSI and factors contributing to thwarted belongingness (such as loneliness) as well as acquired capability for death have been the focus of a many studies (Van Orden et al., 2010), however the relative contribution of PB in the transition from NSSI to suicide attempts is still largely unknown.

There is currently a lack of empirical research on how PB differs between individuals who self-injure without suicidal intention and those who self-injure with the intention of ending their lives. PB has been shown be a contributing factor to a number of suicidal risk factors, such as interpersonal shame and future depression (Carrera & Wei, 2017), as well acting as a mediator in the relationship between social support and suicidal ideation (Hollingsworth et al., 2018) and interpersonal stress and suicidal ideation (Buitron et al., 2016). It has been suggested that PB may act as an activating agent impacting on other suicidal risk factors (Hill & Pettit, 2014), it is thus possible that PB may act as a moderator for the transition between NSSI and suicidal behaviour (thereby directly contributing to the capability to make a suicide attempt).

The relationship between NSSI and PB is therefore a useful area of focus to gain knowledge contributing to improved assessment, case conceptualisation, and intervention strategies for both NSSI and suicide prevention.

CHAPTER FIVE: THE CURRENT STUDY

The Current Study

In spite of the many hundreds of studies that have been conducted globally on suicide and NSSI behaviours, the incidence of death by suicide has not declined substantially in 50 years (Action Alliance for Suicide Prevention, 2014). Empirical research suggests there are a number of common risk factors associated with suicide attempts and NSSI, however, in order to gain meaningful and useful outcomes, it is now essential that research goes further than simple correlations and concentrates on integrative causative mechanisms (Brent, 2011; Nock, 2009; O'Connor, 2011).

This study looks to assist in addressing the gap that currently exists in our understanding of the relationship between NSSI, a significant risk factor for suicidal behaviour, and perceived burdensomeness (PB), a construct shown to contribute to death by suicide as part of the Interpersonal-Psychological Theory of Suicide (IPTS). Further elucidating our understanding of this relationship is likely to provide learnings that are useful both for increasing our understanding of why NSSI acts to increase likelihood of suicidal behaviour, and through this learning, also provide a better understanding of NSSI. Only a relatively small quantity of research had been conducted into the construct of PB, and this construct and its relationship to NSSI is far from fully understood. A greater understanding of perceived burdensomeness, especially in the context of NSSI, is currently missing from the literature on both NSSI and suicide prevention.

It is suggested that gaining a better understanding of NSSI and its relationship with PB will allow practitioners to better assist individuals struggling with NSSI, and also to better determine which individuals engaging in NSSI will go on to make a suicide attempt and which will not. Knowledge gained may allow for better, more targeted suicide prevention

strategies (by addressing the risk factor, rather than taking action after a suicide attempt) as well as more knowledgeable assistance for individuals struggling with NSSI.

Gaining a greater understanding of the links between PB, NSSI and suicidal behaviour, will allow for a fuller understanding of self-injurious behaviours and thus contribute to the development of sound theoretical models to inform clinical assessment strategies with the aim of contributing to suicide prevention and highlighting the need for new interventions for both NSSI and suicidal behaviour.

The current study will be focused on the experience of PB in young adults aged 18 – 24 years who have engaged in non-suicidal self-injury (with or without a history suicide attempts). This study will utilise both quantitative and qualitative methods (explained in detail below) in order to gain as in-depth an understanding of this construct as possible.

Research Aims

- To gain further insight into the role of perceived burdensomeness and its relationship with non-suicidal self-injury.
- To explore themes, narratives and meaning making of perceived burdensomeness amongst those who have engaged in non-suicidal self-injury.

Hypotheses

- That higher levels of perceived burdensomeness will be present amongst individuals who have engaged in NSSI compared with those who have not.
- That levels of perceived burdensomeness exist on a continuum with the intent of self-injurious behaviours. Therefore, PB for those not engaging in self-injurious behaviours will be lowest, those engaging in NSSI only having higher levels, those

engaging in NSSI and suicide attempts having higher levels again and those engaging in suicide attempts only having the highest levels of perceived burdensomeness.

- That levels of perceived burdensomeness will increase as frequency and number of methods of NSSI increase
- That higher levels of symptoms of depression will result in higher level of perceived burdensomeness and increased engagement in NSSI
- That individuals who endorse behaviours commonly associated withborderline personality disorder will have higher levels of perceived burdensomeness compared with individuals who don't meet this criteria.

Research Question

The qualitative aspects of the current study are not designed to test a specific hypothesis, but rather as exploratory research in order to gain further understanding of PB and the association of this construct with non-suicidal self-injury. The following exploratory research question will be used for the current study:

- What is the lived experience of perceived burdensomeness for individuals who engage in NSSI, suicide attempts or both?

Possible Outcomes

- To make recommendations for assessment and intervention components that may assist therapists working with individuals struggling with non-suicidal self-injury

- To make recommendations for assessment and intervention strategies for individuals who engage in NSSI (which may assist in halting the transition from NSSI to suicide attempts ultimately working to reduce suicide attempts)
- To provide data on perceived burdensomeness within a New Zealand population, that may lead to a better understanding of self-injurious behaviours amongst young adults in Aotearoa New Zealand.

CHAPTER SIX: METHODOLOGY

Methodology

This study was approved by the Massey University Human Ethics Committee: Southern A – 15/50 on 25 September 2015 (MUHEC 15/50)

The choice was made to include a mixed methods approach utilising both nomothetic and idiographic methods to collect both quantitative and qualitative data. This decision was made as it was hoped that the two types of data would complement each other. The research project aimed to gain an understanding of what perceptions of burdensomeness were like for the individuals who were experiencing them. Use of the mixed methods approach is useful in psychological research as it allows for a person-centred approach to research, making space for the participant's voice and decisions as to what they perceive to be important. A mixed methods approach allows for a more comprehensive and complete understanding and utilisation of the data. It was hoped that a mixed methods approach for the current research project would gain results that are able to be of more use to meeting the aims of the current study.

Part One – Survey

Design

A survey design was utilised for the first part of the research, in order to assess group differences across a number of areas focused on perceptions of burdensomeness, non-suicidal self-injury (NSSI) and suicide attempts (Appendix A). Participants were recruited via a number of methods. Firstly, course coordinators at Massey University were provided with the survey link and information sheet. Course coordinators who were willing to assist with

recruitment then made the details available to their students via the online Massey University site for that particular paper (the 'Stream' site). A total of 87 course coordinators from Massey University were approached (from the schools of Psychology, Design, Health, Business, Accounting and Music). Eleven of those approached agreed to assist with student recruitment (4 coordinators of psychology papers, 4 coordinators of design papers, 3 coordinators of health papers). A number of course coordinators were not comfortable with the area of research (NSSI and suicide attempts) and didn't feel it was appropriate to recruit students for this research area, others did not reply when approached for assistance by email. Secondly the survey information and a link to the online survey were shared on various closed Facebook pages and were emailed to a group of approximately 400 Massey University postgraduate students. A total of 204 individuals began the survey, with 159 completing the survey.

The survey took between approximately 15 and 30 minutes to complete (depending on which group each particular participant self-selected into) and explored the following areas: depression, borderline personality disorder, self-injurious behaviours (including suicide attempts) and PB. Raw survey data remained anonymous, with the researcher having no access to any identifying information for either those who had received the invitation email, or those who have completed the survey (except for in the case of participants contacting the researcher to indicate willingness to participate in Part Two of the study, explained below). The responses to the survey were collected from October 2015 until June 2016. The survey was generated using Qualtrics Survey software (a web-based survey tool to conduct survey research, evaluations and other data collection activities).

Participants

Respondents were New Zealand residents aged between 18 and 24 years of age. Depending on a participant's particular responses they were directed to appropriate question sets, for example, those individuals who endorsed self-injurious behaviours were directed to the survey questions related to NSSI and suicide attempts and were asked a further question to determine if they engaged in NSSI, suicide attempt(s) or both. If an individual did not endorse ever having engaged in self-injurious behaviour, they did not see these question sets. Appendix A provides a breakdown of which questions each group of participants received. Participants fell into four distinct questionnaire groups:

- **Group One** - individuals who have engaged in NSSI only, either currently or historically (no suicide attempts). Individuals were asked which behaviours they had engaged (without the intention to end one's life) from the list included in the Non-Suicidal Self-Injury–Assessment Tool (NSSI-AT; Whitlock, Exner-Cortens, & Purington, 2014):
    - Severely scratched or pinched skin with fingernails or other objects to the point that bleeding occurs or marks remain on the skin
    - Cut wrists, arms, legs, torso or other areas of the body
    - Carved words or symbols into the skin
    - Bitten own skin to the point that bleeding occurs or marks remain on the skin
    - Attempted to / successfully broken own bones
    - Ripped or torn skin
    - Burned any area of the body

- Rubbed glass into skin or stuck sharp objects such as needles, pins, and staples into or underneath the skin (not including tattooing, body piercing, or needles used for medication)
- Banged or punched objects or oneself to the point of bruising or bleeding
- Intentionally prevented wounds from healing
- Engaged in fighting or other aggressive activities with the intention of getting hurt
- Pulling out hair, eyelashes, or eyebrows with the intention of hurting oneself
- Ingested a caustic substance(s), or more than the recommended dose of painkillers, medication or other drugs (self-poisoning)
- Ingested sharp object(s) (such as pins or staples)

The above list of behaviours was used in this study as a means of operationalising NSSI. However, the participant themselves made the decision as to whether they had engaged in NSSI, thus while the above behaviours were specifically included in the survey, each participant was also invited to list any NSSI behaviours they had engaged in that were not included on the list. Questions asking about specific NSSI behaviours were also separate to an initial question that asked if the individual had engaged and self-injurious behaviours and a question that asked if these self-injurious behaviours were with (or without) suicidal intent.

- **Group Two** – individuals who had in the past or currently, engaged in NSSI and who had made at least one suicide attempt.
- **Group Three** - individuals who had made at least one suicide attempt but had never engaged in NSSI. Participants in this group had engaged in self-injurious behaviours where the intention was to end their life.
- **Group Four** - individuals who have never engaged in any deliberate self-injurious behaviour (either NSSI or a suicide attempts). Group Four was a control group.

The Survey

The survey created was between 45 and 100 items long (depending on which group an individual self-selected into, determined by specific item responses). The items making up the survey were selected from existing measures of depression, borderline personality disorder, self-injurious behaviours and PB (as discussed below) possessing good reliability and validity, and some additional questions focused on PB. The following measures were used either in part or full:

Interpersonal Needs Questionnaire (INQ; Van Orden, Cukrowicz, Witte, & Joiner, 2012), a measure designed to assess thwarted belongingness and PB. The INQ consists of 15 items (6 items pertaining to PB and 9 items pertaining to thwarted belongingness), and asks ask "How true are each of the following statements for you?", using a 7 point Likert scale (ranging from 1 – *Not at all true for me* to 7 – *Very true for me*). It can be scored as one total score, or broken into two subscales. The PB subscale of this measure, conducted with a sample of young adults (aged 18 – 30 years) has yielded a Cronbach's alpha coefficient of .96 (Lutz & Fiske, 2016). Van Orden, Cukrowicz, Witte and Joiner (2012) conducted a study of the psychometric properties of the INQ using five independent samples (consisting of a variety of age and psychopathology levels). These authors reported that the INQ provides pure indicators of each of the distinct constructs it focuses on (thwarted belongingness and PB), thus it has high content validity, and high construct validity. The INQ also has high predictive validity for suicidal behaviour. Results confirmed invariance between clinical groups and good convergent validity was found (Van Orden, et al., 2012). The INQ has also been found to be psychometrically sound with good internal consistency reliability and acceptable convergent validity with a population of military veterans (Gutierrez et al., 2016). The INQ has been used widely in research into both thwarted belongingness and PB, and has been translated into at least three languages. A shortened version of the INQ (eight items)

has been used successfully in research with a military personnel population (Allan, Gros, Hom, Joiner, & Stecker, 2016). Another study conducted with Slovenian adolescents also used the INQ (modified slightly by removal of three questions) successfully for PB and thwarted belongingness (Podlogar, Ziberna, Postuvan & Kerr, 2016).

The six items (from the 15-item scale) that specifically assessed PB were included in the survey.

Self-Perceived Burden Scale (SPBS; Cousineau, McDowell, Hotz, & Hébert, 2003), is a 25-item self-report measure and asks ask "How true are each of the following statements for you?", using a 5-point Likert scale (ranging from *1 – Not at all true for me* to 5 – *Very true for me*). It does not contain multiple subscales, but has been used in shortened versions (eight, nine and 18 item versions). The SPBS was designed to assess burdensomeness experienced by an individual in relation to those people who help them in day-to-day life (such as friends and family members), specifically in chronic illness, and has been translated into a number of languages. The psychometric properties of the SPBS were assessed with a population of chronically ill adults and discriminant validity data suggested that burden scores were independent of age and education (however the current study did not include the SPBS in its entirety). The SPBS has yielded a Cronbach's alpha coefficient of .93 (Cousineau, McDowell, Hotz & Hebert, 2003) with shortened versions also yielding similar Cronbach's alpha coefficients (e.g., Wilson, Kowal, Caird, Castillo, McWilliams & Heenan, 2017).

The SPBS has been widely used for research in a variety of populations including individuals suffering from acute or chronic pain (Fishbain et al., 2016; Kowal, Wilson, McWilliams, Péloquin & Duong, 2012) and individuals suffering from a movement disorder (Dempsey, Karver, Labouliere, Zesiewicz & De Nada, 2012), however it is most commonly used (and validated with) with individuals who are diagnosed with cancer (e.g., Oeki,

Mogami & Hagino, 2012; Simmons, 2007). Much of the research conducted using the SPBS also has a focus on aspects of mental health, especially as a result of self-perceived burden. Fishbain et al. (2016) reported that in Chronic Pain patients, self-perceived burden significantly predicted suicidal ideation, planning and past attempts. Another study reported that functional impairment in patients with movement disorders was associated with depression and this relationship was mediated by self-perceived burden (Dempsey et al., 2012).

Fourteen items from this 25-item scale were included in the survey. Items in the SPBS use the term "caregiver", in the current study this term was replaced with "friends, family or partner". Examples of the SPBS items included are: "*I worry that my friends, family or partner to take time away from other things in order to help me*"; "*I am concerned that my demands have strained my relationship with my friends, family or partner*"; "*Sometimes I feel that my friends, family or partner might be better off without me*"; and "*I think that I make things hard on my family, friends or partner*". The items excluded were items that were inappropriate for the population participating, for example "*I am concerned that because of my illness, my caregiver is trying to do to do too many things at once*". It is noted that removal of some items may alter the validity of the SPBS (as it is no longer the standardised instrument), however it was considered that addition of a wider number of items may provide a broader range of information that may be useful in gaining a fuller understanding of how individuals understand perceptions of burdensomeness.

Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer & Williams, 2010), a shortened version of the full Patient Health Questionnaire, focuses on symptoms of depression. Reliability of this measure has been reported to be excellent, yielding a Cronbach's alpha coefficient of 0.89 (Kroenke, Spitzer & Williams, 2001). This measure was originally developed to assess for major depressive episode/disorder according to the

DSM-IV criteria, however it also corresponds to the DSM-5 criteria (American Psychiatric Association, 2013). The PHQ-9 is made up of a total of nine items, eight of which specifically measure depression and an additional item targeting suicidal ideation. The PHQ-9 provides a score pertaining to depression severity, providing a classification of depressive symptomology that is clinically meaningful. Psychometrics reported by Kroenke and colleagues show excellent test-retest reliability and internal reliability (Cronbach's α of 0.89), as well as excellent specificity and sensitivity. Strong construct validity and external validity were also reported as well as clear cut-off thresholds for different severities of depression (Kroenke et al., 2010). A number of studies with a focus on self-injurious behaviours across a variety of populations have included questions from the PHQ-9 (e.g., Dueweke, Rojas, Anastasia & Bridges; Horton, Dyer, Tennant & Wright, 2018). All nine items were included in the survey. The rationale for including the PHQ-9 was to ensure that the survey had a measure of depression. Research has shown that depression is important to consider when research is focused on PB, NSSI or suicide (and indeed most studies of this kind include a measure of depression). For example depression has been found to be commonly correlated with PB (e.g., Van Orden, Lynam, Hollar, & Joiner, 2006), and significant differences have been found in levels of depression in adolescents who engage in NSSI compared with those who engage in suicide attempts (Muehlenkamp & Gutierrez, 2004), suggesting that perhaps depression also increases as self-injurious behaviour worsen. Ensuring that data gathered can provide some knowledge of the depression rates in the participant sample will be useful in making comparisons, and allowing for further elucidation of the relationship between depression and PB.

Non-Suicidal Self-Injury Assessment Tool (NSSI-AT; Whitlock et al., 2014), a measure designed to assess both primary (form, function, frequency, recency and wound location) and secondary NSSI characteristics (such as the contextual and subjective

experience of the individual). This measure is useful for more than simply diagnostic purposes; it is also useful for intervention and prevention endeavours. The NSSI-AT includes questions with two response options (true or false) and questions that use a 4-point Likert scale (ranging from *1 – Strong Disagree* to 5 – *Strongly Agree*). The NSSI-AT has been shown to have good test-retest reliability for any NSSI behaviour (r = 0.74) and NSSI functions (r = 0.79). As well as good concurrent, convergent (r = .38, p < .001) and discriminant validity (Whitlock, Exner-Cortens, & Purington, 2014). The NSSI-AT has been used (either in its entirety or sections of the measure) for assessment of NSSI in a number of different research areas with young people, including the association between NSSI and family functioning in adolescence (Baetens, Andrews, Claes & Martin, 2015), NSSI among Israeli high school students (Madjara, Zalsmanb, Mordechaia & Shovalb, 2017), and NSSI among New Zealand university students (Fitzgerald & Curtis, 2017).

The decision to use the NSSI-AT was made for a number of reasons. Firstly at the time of deciding on methodology for the current study, to the knowledge of the researcher, this was the best supported and comprehensive measure for NSSI only (as opposed to all self-injurious behaviour) published. The NSSI-AT also includes items related NSSI characteristics which were not included in other measures available at the time methodology for the current was established. These items included questions on motivations for initiating NSSI, variation in NSSI severity and help-seeking for NSSI. The authors of the NSSI-AT created the measure with the view of covering a broad territory as well as using language that reflected the experiences of those individuals who engage in NSSI behaviours. Secondly, this measure is freely available in the public domain.

Strong reliability (as assessed by test-retest) of NSSI-AT scores and validity (as assessed using concurrent, convergent, and discriminant evidence) has been reported by Whitlock, Exner-Cortens, and Amanda Purington (2014). Twenty-four items were used from

this assessment tool, chosen to provide further information on the form, function, frequency, recency, wound location, age of onset and age of cessation (if NSSI has ceased) of NSSI. It is noted that removal of some items may alter the validity of the NSSI-AT; however items were included to be considered in isolation, rather than as an entire measure, in order to gain a better understanding of NSSI behaviours within the sample being examined. NSSI-AT items were also helpful for assisting individuals to consider the context and impact of NSSI behaviours.

Mclean Screening Instrument for Borderline Personality Disorder (MSI-BPD; Zanarini, et al., 2003), a 10-item true/false, questionnaire based on DSM-IV criteria for Borderline personality disorder (BPD). All 10 items were included in the survey. Total scores for participants were used for comparison and analysis.

In non-clinical populations, the MSI-BPD has been found have good internal consistency, moderate construct and concurrent validity, good reliability (Gardner & Qualter, 2009) and adequate criterion validity (Patel, Sharp & Fonagy, 2011). The rationale for including a measure for BPD was to allow for BPD symptomology to be included in the overall analysis of engagement in self-injurious behaviours, due to NSSI being considered to be a symptom of BPD.

Additional Questions - A number of additional questions focusing on PB that the researcher judged would add to the breadth of data being gathered were included for those individuals who endorsed engaging in NSSI. These questions became apparent to the researcher during a review of the literature and were not covered in the measures already included in the survey. Additional questions included the following:

- "Do you believe that you are more likely to self-injure or make a suicide attempt if you feel that you are a burden to others?"
- "Has anyone in your life explicitly told you that you are a burden/burdensome?"

- "Do you feel more of a burden than you did 12 months ago?"
    - Participants were also given the opportunity to write freely (open ended text box) about anything else they chose at the end of the survey as a response to the following question:
- "We are interested to know what you think is important for people who want to better understand and help those who intentionally hurt themselves to know?"

Additional questions were not included in the overall PB score, as once again not all participants were presented with these questions. In some cases these questions were used to inform the semi-structured interviews conducted in part two of the study.

Participants did not have to answer all survey questions; rather self-selection into a particular study group (on account of responses to particular items) dictated the number of questions that each participant group was presented with. Figure 6.1 provides an illustration of the screening questions used for allocation of participants to each group. Participants from Group One and Two were asked 55 - 60 items, those in Group Three were asked 35 items and those in Group Four (control group) were asked 20-25 items. The survey software used (Qualtrics) was able to ensure that each participant was only presented with those questions that related to their particular study group.

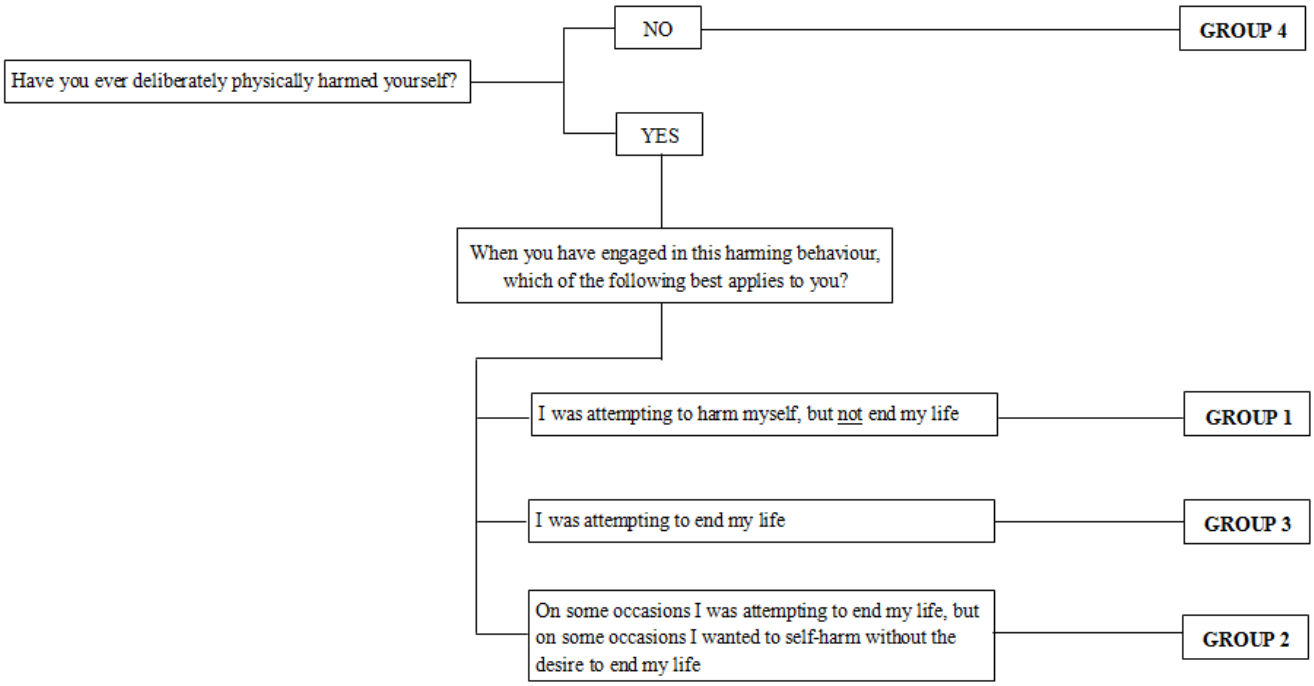

Figure 6.1. Illustration providing details of screening questions that allowed participants to be allocated to the different groups (to then be provided with a specific group of survey questions)

Overall Perceived Burdensomeness Score

An overall score reflecting responses to PB related questions was calculated for each individual from their responses to all questions from INQ and the SPBS. The score was calculated using the PB score from the INQ, calculated as suggested by the authors (taking each response score between 1 and 7 and summing for a total score), and following a similar procedure for the SPBS. One item in the SPBS required reverse scoring ("*receiving help from others makes me feel that they care for me*"). Scores from the INQ and the SPBS were then summed to provide a final score. Additional PB questions asked of those participants who engaged in NSSI did not make up part of this score, as they were not presented to those participants who did not engage in self-injurious behaviours. As the INQ and the SPBS were presented to every participant, regardless of their engagement in self-injurious behaviours, an overall PB score was able to be calculated for every participant.

Procedure

An information sheet (see Appendix B) outlining the details of the study and expectations of participants was included in both the original invitation email or Facebook post, and presented prior to beginning survey questions. Contact details for the researcher were also provided to allow participants to contact the researcher with any questions or concerns (via email or 0800 number). No such contact was made with the researcher regarding the survey. The study was advertised as being about NSSI and Suicide in young adults. Thus individuals knew what the focus of the study was from the outset. The construct of perceived burdensomeness was not mentioned as being a focus of the study.

Individuals interested in participating were able to follow the link to the online survey that could be completed at the convenience of the participant. Prior to being presented with the first survey question, all participants were asked to provide consent for participation in the study, and they were also provided with contact information for a number of helplines and face-to-face counselling services in order to seek assistance should they require it (see Appendix C). The same help sheet was provided again following submission of the survey.

The study details were 'shared' on Facebook three times over the duration that data collection was taking place; the postgraduate email list was sent two emails during this time. All individuals contacted were invited to share the details with any friends they considered may be interested in participating. Each participant from Group 1, 2 or 3 who completed the survey was then asked (via a survey question) if they would be interested in taking part in a follow-up interview for the next phase of the research. Those who answered in the affirmative were asked to provide a name and contact (email or phone number) and informed that the researcher would contact them with further information. All participants who

completed the survey were offered the opportunity to enter into a prize draw to win one of six Visa gift cards worth $50.

Data & Analysis

Once results were obtained, it was possible to determine if a significant difference in PB existed between study groups, allowing for further elucidation of the relationship between NSSI and suicidal behaviour and the extent of the role of PB in relation to both of these behaviours.

SPSS 25.0 for Windows (SPSS Inc., Chicago, IL) was used to conduct statistical analysis on the data collected. The completed survey responses were be put into a data set for analysis. Screens for normality, linearity and homoscedasticity were conducted prior to continuing with further analysis. Univariate analysis of variance was used to investigate whether there was a significant difference in PB scores between those individuals who engaged in NSSI and those who do not engage in any self-injurious behaviours (Group 1 and Group 2 as one group, compared with Group 4 the control group). A regression analysis was then performed to determine if the independent variables focused on in the survey are related to variance in PB score (dependent variable). Hierarchical regression was used to ascertain how much variance was seen as a result of each of the independent variables tested (producing a final model including all independent variables that act to alter the variance seen in PB scores. Finally an analysis of variance test was used to determine if this model determined by statistical analysis was statistically significant.

Right to Withdraw

Participants were unable to withdraw from the survey after submitting it online. However all data was completely anonymised. All participants were informed that they had

the choice to refuse to answer any question that they felt they did not want to provide an answer for (for any reason).

Safe Storage of Data

Data collected electronically was stored on computer under password protection. Any paper data collected was made electronic, with paper copies being securely destroyed. Massey has a 10 year policy for storage and disposal of data. After 10 years all the raw data will be destroyed.

Ethical Considerations

Due to the focus of the current study being self-injurious behaviours, including both non-suicidal and suicidal behaviours, it was important to consider the effects that participating in the study may have on individuals. While it is possible that answering survey questions concerning suicidal and self-injuring behaviours may trigger suicidal or self-injurious impulses for some individuals, recent studies suggest that this is uncommon. Whitlock et al. (2013) conducted a web-based survey with university aged participants looking at the impact of questions within the areas of self-injury, suicidal behaviour and psychological distress and found that just 2.7% of respondents reported negative survey experiences and found that rather than heightening behavioural risk, participants tended to think more deeply about their lives and experiences, leading the authors to suggest that surveys may in fact be beneficial in promoting self-reflection within individuals with a history of self-injurious behaviours. An earlier study looked into whether survey questions about suicidal ideation or behaviour caused distress or an increase in suicidal ideation in high school students. These authors concluded that immediate distress levels and suicidal ideation as well as levels two days following questions did not differ significantly between the control and experimental groups (Gould et al., 2005). This study also suggested that participation

may have been beneficial for high-risk participants, as distress levels for these individuals presented as less distressed than control participants.

It was anticipated that the risk for an increase in self-injurious behaviour in participants as a result of answering the current survey questions would be low. Despite this safety procedures were implemented in order to mitigate any risk. As mentioned above, at two points during the online survey, participants were provided with an information sheet that detailed a number of helplines and face-to-face counselling services that the participant could contact should they decide they needed to talk to someone about any issues raised during the survey. A 0800 number and an email address were also provided before a participant began the survey so they were able to contact the researcher should they have any questions or queries pertaining to the survey or participation in the survey.

Part Two – Interpretative Phenomenological Analysis

Design

Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith, Flowers, & Larkin 2009), a qualitative methodology, was utilised for the second part of the current study. IPA allows for the examination of how people make sense of their life experiences (Smith et al., 2009) and therefore aligns well with the third research aim. IPA is derived from phenomenology and symbolic interactionism (Flowers, Smith, Sheeran, & Beail, 1998). Rather than being concerned with objective experiences, IPA focuses on the subjective meanings that individuals assign to experiences. Other qualitative methods, such as discourse analysis focus on the reasons that individuals talk about events or experiences in particular

ways, IPA, however, is interested in the meaning that individuals give to the experiences they talk about. Smith (2011) explained this difference as follows:

> "While IPA researchers talk to participants and analyse what they say in order to try to learn about how they are making sense of their experience, discourse analysts examine what participants say in order to learn about how they are constructing accounts of experience" (Smith, 2011, p. 10).

IPA is also interpretative as the researcher must construct the analysis. This process utilises what is known as the 'double hermeneutic' – the researcher attempts to make sense of the individual making sense of their lived experiences (Smith & Osborne, 2008; Smith et al., 2009). Through this interpretative approach, the ways individuals' think about events can be revealed and thus it is possible to examine the relationship between cognition and behaviour allowing self-injury decision-making to become the focus of investigation.

IPA is guided by a strong idiographic responsiveness concerning certain occurrences in lived experiences, conducting a detailed analysis of each case individually. IPA aims to reveal experiences fully and thoroughly not only for each individual participant, but also to then analyse both convergence and divergence across the individual cases, illuminating in detail something about the entire group. This is in contrast to nomothetic methods. IPA is also a flexible approach and inductive by nature, making use of semi-structured interviews that allow for unanticipated themes to emerge and be explored. Smith (2011) identified the core characteristics that determine a high quality IPA study. These characteristics include, the study having a clear focus, collecting strong data and being rigorous in nature, the analysis of the data should be interpretative, deal with both convergence and divergence (with each being elaborated fully).

While IPA first began in the area of health psychology, a number of high-quality IPA studies have also been conducted in other areas of psychology, including clinical psychology (e.g., Chinello et al., 2018). Smith explains that IPA is especially valuable when the research being conducted is personal or idiosyncratic, dynamic, concerned with identity, and where sense-making is essential. The current study focusing on PB in NSSI and suicide attempts fits this description and thus IPA was considered an appropriate methodological choice.

Semi-structured Interview

Data collection for IPA is required to be flexible; as such Smith et al. (2009) suggests the best approach to data collection is use of a semi-structured interview. For this reason a semi-structured interview was used for this part of the study, allowing the researcher to follow up on areas of importance as they came to light. The interview was designed to focus on the extent of PB of the individual on others in their life and to explore any perceived relationship between this and NSSI or suicidal behaviours. A copy of the interview schedule used during each interview can be found in Appendix F.

Participants

Participants for this part of the study were recruited from those individuals who completed the survey (excluding individuals who fell into the control group or suicide only group, Group 3 or 4). All participants who completed the survey from Part One of the study and fell into either Group 1 or 2 (and therefore endorsed engaging in NSSI) were offered the opportunity to participate in a follow-up interview. All individuals who expressed interest in participating in an interview were provided with the participant information sheet which outlined full details of the study (Appendix D). Those individuals who wanted to participate made contact with the researcher via email (the option of a toll free phone number was also

provided, however no individuals made use of this option) and all questions or concerned were then addressed. Following this, a mutually convenient time was arranged for the interview to occur (either at the Massey University Psychology Clinic in Wellington or another location convenient for the participant).

All participants had engaged in NSSI, and made at least one suicide attempt. Twenty-eight individuals expressed an interest in participating in a follow-up interview. All of the potential participants were provided with full information and contact details for the researcher. Of this number, six agreed to participate in an interview and all six were subsequently interviewed. This number falls within the sample size of four to ten participants recommended for Doctoral research studies utilising IPA (Smith et al., 2009).

Participants were based in Wellington, Auckland or Palmerston North. The age range of participants was between 21 years to 23 years of age. One of the six participants was male, and the remainder were female. Gender appropriate pseudonyms were allocated to maintain anonymity.

Procedure

Prior to conducting any interviews, written consent was obtained (Appendix E), including consent to audio record the interview, consent to have a registered clinical psychologist supervise the interview in real time (for interviews that were conducted in the Wellington region) and consent to publish fully anonymised quotations. Interviews were held at the Massey University Psychology Clinic in Wellington or via an online video call (for those participants outside of the Wellington region).

A risk assessment was conducted prior to the interview commencing; including asking participants to complete a Beck's Hopelessness Scale (BHS) to ensure that each participant

was deemed safe to discuss the confronting topics that were covered in the interview. The BHS includes 20 items which are answered either true or false. The scale focuses on an individual's feelings about expectations, the future, and loss of motivation. For the general population the BHS yielded Cronbach's alpha coefficients of ranging from 0.82 to 0.93 (Beck & Steer, 1988). A score less than nine was deemed acceptable to move forward, if a participant had a score within the moderate or severe range on the Beck Hopelessness scale (score of nine or above), further risk questions were asked (e.g., "Are you feeling safe right now?") and the option of asking a registered clinical psychologist to assess the participant was always available. It was explained to participants that should they wish to terminate the interview at any time that this could be done immediately. Following each interview participants were also assessed (via risk assessment questions) to ensure they were safe to leave by asking some safety-based questions, and an information sheet was provided consisting of region-specific helplines and face-to-face support services. For those interviews that were conducted online, the same safety-based questions were asked, and the information sheet was emailed through (prior to and after the interview), support people that the participant felt safe to speak with were also identified and the participant was encouraged to speak with these people if they felt they needed too (support people depended on the participant, but included partners, parents and therapists).

It was important that the researcher focused on empathic listening and establishing rapport with each participant. Skills common to clinical psychology such as active listening, validation and summarisation were also important to include throughout each interview. IPA calls for the researcher to attempt to understand the participant's sense-making, and as such they are required to work hard to see topics from the participant's viewpoint.

In accordance with the IPA methodology, participants were encouraged to share their own understandings and sense-making of their lived experience, sense of self and identity.

As proposed by the Massey University Human Ethics Committee, interviews conducted at the Wellington Campus were supervised in real time (from a separate room) by a registered clinical psychologist to ensure the safety of each participant. The supervising clinical psychologist was able to step in at any point where it was deemed that safety was an issue. For interviews conducted via online video calling, a registered clinical psychologist was available to the interviewer for assistance if required and interviewees had support people available to them if required.

Following the first interview, the interview schedule was reviewed by the research supervisor (a registered clinical psychologist) to ensure that the interviews obtained the information being sought. However, it was not deemed necessary to make any changes to the interview schedule at that time. The interviews ranged in length from 25 to 54 minutes (average of 43 minutes). All interviews were transcribed verbatim and fully anonymised by the researcher.

Data Analysis

IPA was used to analyse the transcripts both individually and together. Smith et al. (2009) has outlined a number of accepted stages for IPA methodology. Initially each transcript was read and re-read multiple times, allowing the researcher to engage deeply with the original data. The first time each transcript was read, the audio-recording was also played. Any notes taken by the researcher during or following each particular interview are also read and were added, where appropriate, during the initial stage of analysis. The next stage of analysis involved an investigative examination of the semantic content, language and contextual meaning throughout the transcript. As familiarity with the transcript grew it was possible to identify distinctive ways that the participant thought about, talked about and understood the topics of interest. During each re-reading, notes and comments were made

throughout the transcript exploring emerging patterns of meaning. Focusing on descriptive, linguistic and conceptual notes made throughout the transcript and mapping the interrelationships, associations and patterns between these exploratory notes, emergent themes were developed. Connections and patterns throughout these identified themes then became the focus of analysis, with a particular emphasis on those themes that mapped directly to the main research question. Abstraction and 'subsumption' (grouping like with like to form clusters of thematic patterns) were used in order to develop a list of super-ordinate and sub-themes that most precisely illustrated the participant's own narrative. This process was repeated for each of the interview transcripts. Finally themes across all transcripts were identified and analysed. Connections, patterns, similarities and differences among themes across narratives were all focused on during this part of analysis. A secondary rater (a qualified clinical psychologist with experience in qualitative research), also independently rated two of the transcripts in order to ensure inter-rater reliability was achieved. This resulted in a high level of agreement on emergent themes and thus the analysis was considered to be conducted to a high standard.

Right to Withdraw

Participants were informed prior to consenting to participate in the interview that they had the right to withdraw from the study up to two weeks after their interview. After this time all data would be completely anonymised, including use of pseudonyms. "

Safe Storage of Data

Data collected electronically was stored on computer under password protection. Any paper data collected was made electronic, with paper copies being securely destroyed. Massey has a 10 year policy for storage and disposal of data. After 10 years all the raw data will be destroyed.

Ethical Considerations

As mentioned above, there are particular ethical issues that needed to be considered for the study. Participants being interviewed had all engaged in NSSI and most had made a suicide attempt, as such interviewing these particular individuals about their experiences was at times distressing for them. It is therefore important that certain precautions were undertaken in order to maintain participant safety.

An initial risk assessment was conducted with each participant prior to the commencement of the interview, including but not limited to use of the Beck Hopelessness Scale. This risk assessment was conducted by the researcher, and had there been any concerns a registered clinical psychologist would have been asked to take further action. Each interview was also either supervised in real time by an experienced clinical psychologist as a further safety measure or the researcher had access to a registered clinical psychologist so assistance could be sought if required.

All participants were provided with an information sheet that detailed a number of helplines and face-to-face counselling services that the participant could contact should they decide they needed to talk to someone following the interview. In addition to this, both of the members of the research supervision team are registered clinical psychologists with extensive experience whom the researcher was able to discuss any problems or concerns with.

Researcher Reflexivity

The IPA process explicitly recognises the influence that the researchers own beliefs, values and assumptions will have on how they interpret and make sense of a participant's sense making. Thus the researcher is recognised as having an inherent part of both the

process and product of the IPA research (Horsburgh, 2003). Therefore while conducting IPA research (during both data collection and analysis stages) the researcher is encouraged to engage in self-appraisal and self-reflection on their own beliefs and values in order to increase their awareness of any sources of bias that may influence analysis and outcome (Smith, et al., 2009).

In order to ensure that the researcher was practicing reflexivity she kept a self-reflection journal throughout the IPA process, reflecting on beliefs, values, assumptions, thoughts and emotions – before, during and after every interview, and throughout the analysis phase of the IPA research. Working to be constantly reflective throughout the process allowed the researcher to maintain an open and balanced approach.

The supervising researcher was also available for regular discussion throughout the research, this allowed for further reflection and further assistance with identification of potential sources of bias. Further, the researcher worked to maintain constant mindfulness around treating each participant as a unique individual, providing empathy and validation, and making use of the IPA process to allow each participant to feel heard.

CHAPTER SEVEN - SURVEY RESULTS

This chapter describes the data obtained from the survey, investigating the relationship between perceptions of burdensomeness and non-suicidal self-injury (NSSI). Data is presented both from the entire sample (without consideration of whether participants have engaged in self-injurious behaviours) and some data is presented only from those participants who endorsed a history of, or current engagement in self-injurious behaviours. Details of which data is being analysed is noted throughout.

Results are presented in two sections; the first section includes descriptive statistics from all participants, followed by a more thorough examination of data gained from each section of the survey. The second section is focused only on data provided by those participants who endorsed engaging in NSSI. Data-screening procedures evaluating the assumptions of normality, linearity and homoscedasticity have been included in Appendix G. Covariate analysis and Hierarchical Regression analysis are then presented, to ascertain whether demographic variables (age, ethnicity and sex), depression, Borderline personality disorder traits and NSSI behaviours were independently predictive of PB scores.

Descriptive Statistics

Participants

As shown on Table 7.1, the final sample was made up predominantly of females (81.8%) of New Zealand European ethnicity (70.4%), in undergraduate education (69.8%), ranging in age from 18 – 24 years with a mean age of 21.09 years, (SD = 1.95).

Table 7.1

Participant Demographic Information

	Count (%)
Gender	
Female	130 (81.8%)
Male	24 (15.1%)
Not disclosed	5 (3.1%)
Ethnicity	
NZ European	112 (70.4%)
Māori	19 (11.9%)
Asian	12 (7.5%)
Pacific	5 (3.1%)
Middle Eastern/Latin American/African (MELAA)	2 (1.3%)
Other Ethnicity	9 (5.7%)
Student Status	
Undergraduate Student	111 (69.8%)
Postgraduate Student	30 (18.9%)
Not a Student	18 (11.3%)

The majority of the sample were University students (n=141, 88.7%) with almost 70% of the sample identifying as undergraduate students. Participants were not asked which university they were currently studying at, however it is likely that the percentage of males (15.1%) and female (81.8%) students is not reflective of the average seen in university populations in New Zealand. The Massey University Annual Report (2017) reported figures of 37% and 63% male and female students respectively while the Victoria University Annual Report (2017) reported figures of 56% and 44% male and female students respectively. A greater proportion of females compared with males participating in the survey may be due to a number of reasons, such as females being more open to participating in surveys about mental health and generally being over-represented in NSSI statistics.

A limited amount of ethnicity data was collected to ascertain if the sample gained was representative of the New Zealand population. Ethnicity data was coded in accordance with the recommendations from the Ministry of Health (Ministry of Health, 2017) and is detailed in Table 7.1. The ethnic distribution was somewhat under representative of individuals identifying as Pacific, but similar to New Zealand averages for people identifying as New Zealand European, Māori, Asian and Middle Eastern/Latin American/African (MELAA; Statistics New Zealand, 2017).

A total of 204 individuals completed the initial part of the survey (asking just one general question following demographic questions about engagement in self-injurious behaviours). As respondents progressed through the survey some individuals submitted their responses before completing all questions, therefore there were differing numbers of participants for different items included within the survey. Following this initial set of questions 190 individuals answered the next sets of questions focused on perceptions of burdensomeness (presented to all survey participants). A total of 171 individuals provided responses for the depression screening questions.

There were a number of question sets that were only presented to individuals who had endorsed engaging in NSSI (Groups 1 and 2). Of the 111 participants originally allocated into these groups, 89 individuals provided responses for these sections. Of the completed survey submissions, 72 individuals were allocated to Group One, 17 individuals to Group Two, 5 individuals to Group Three and 77 to Group Four. Figure 7.1 illustrates the survey break down.

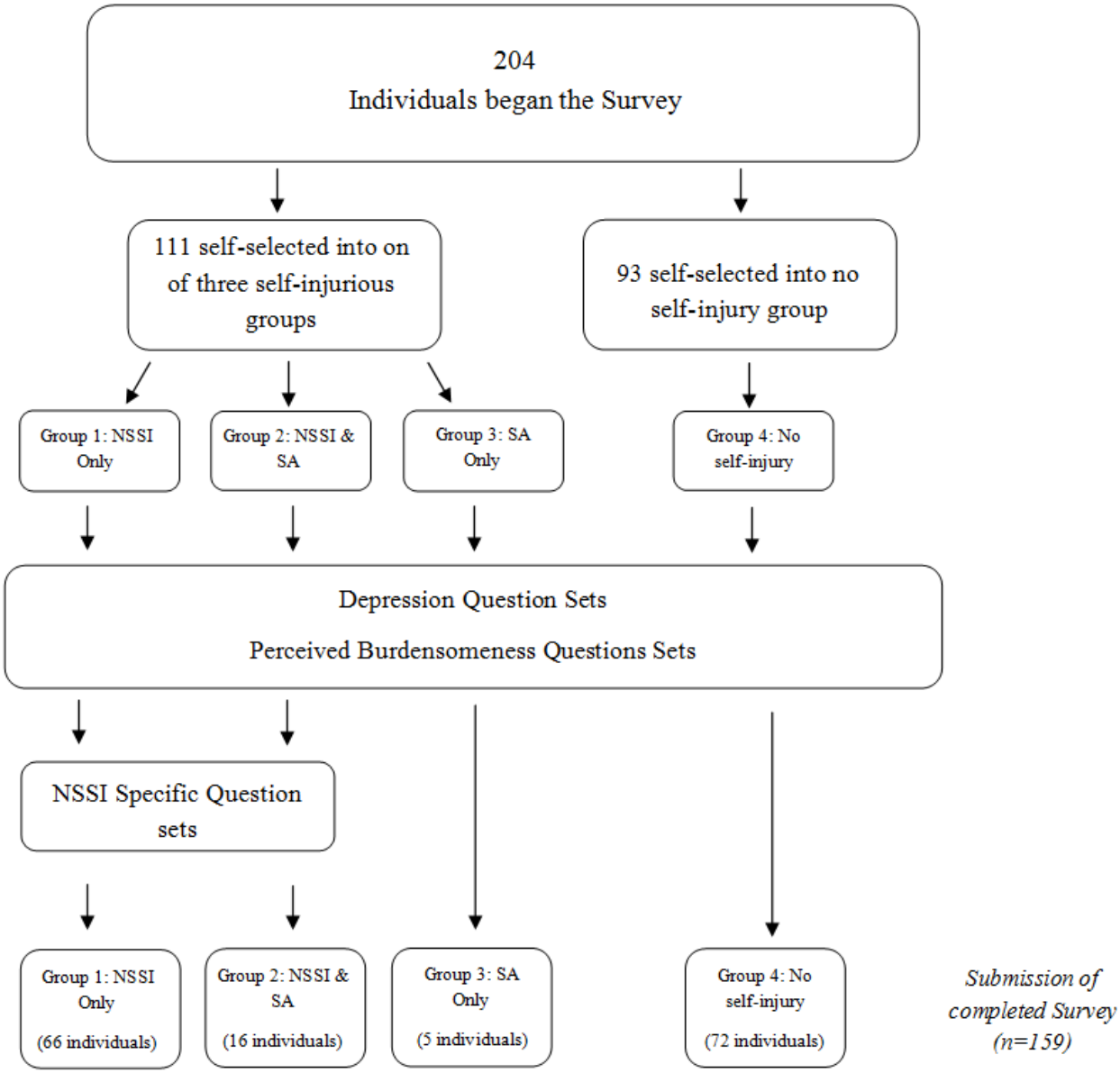

Figure 7.1. Illustration of the number of individuals who completed each survey section

Data from All Participant Groups

As mentioned above, the results that follow are taken from the entire survey response group, including all participants regardless of engagement in self-injurious behaviours.

Depression Measure - Patient Health Questionnaire-9 (PHQ-9)

Results obtained for those items that were included to gain a measure of depression within the participant sample indicated moderate or severe depression for approximately 35% of participants (based on total scores and guidelines for interpretation of the PHQ-9, Table 7.2). It is noted that the PHQ-9 is not a diagnostic instrument, and that while it does address symptoms outlined in the DSM-5 (American Psychiatric Association, 2013), a clinical interview would also be required to ascertain the exact number of individuals who may meet diagnosis for depression.

Table 7.2

PHQ-9, Depression Measure results – All Groups

Descriptor and Score Range*	**% of Participants**
No Depression Indicated (0 – 4)	31.7%
Mild Depression Indicated (5 - 9)	32.9%
Moderate Depression Indicated (10 – 14)	15.2%
Moderately Severe Depression Indicated (15 – 19)	12.2%
Severe Depression Indicated (20 – 27)	7.9%

* based on interpretation guidelines

Item analysis indicates that the items – *Feeling tired or having little energy; Trouble falling or staying asleep* and *poor appetite or over eating* were endorsed as being present more than half the days in a week or nearly every day, by 48%, 41% and 40% of participants respectively. All other items (anhedonia, low mood, feeling bad about self, trouble concentrating, catatonia or hyperarousal, suicidal ideation or self-injury) were rated as being a problem for them at least more than half the days in a week by 15 and 28% of participants.

Figure 7.2 shows the mean depression score for each of the survey groups. Overall depression scores showed a positive linear relationship, that is to say, depression scores increased from no self-injurious behaviours to NSSI behaviours and continued to increase from NSSI only to NSSI and Suicide Attempts, with the highest depression scores being seen in the Suicide Attempt only group. It is noted that the Suicide Attempt Only group was very small (n=5), and thus results should be interpreted with caution.

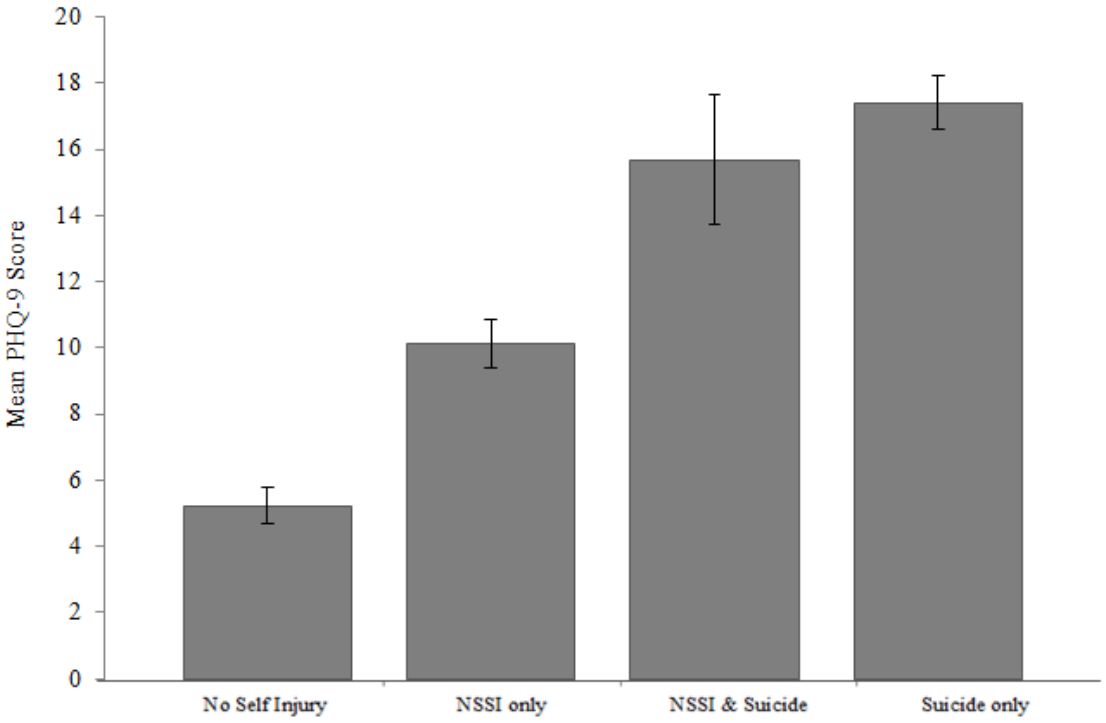

Figure 7.2. Group Mean Depression Scores

Borderline Personality Screen – McLean Screening Instrument (MSI)

As noted earlier, results obtained from the MSI were not analysed for the purposes of making a diagnosis of BPD, but rather to gain some idea as to whether higher rates of BPD traits are correlated to levels of PB and additionally to gain further insight into NSSI behaviour. While MSI responses alone would not be appropriate for making a BPD diagnosis, it is noted that 29 participants (17%) met the MSI diagnostic cut off score

indicating that they may meet criteria for BPD. Overall results from the MSI items are included in Table 7.3.

Table 7.3

McLean Screening Instrument results

Question	**Yes**
Do you experience periods of extreme moodiness?	59.6%
Have you often acted in an angry or sarcastic manner?	49.4%
Are you often distrustful of other people?	48.2%
Have you had at least two other problems with impulsivity (e.g. eating binges and spending sprees, drinking too much and verbal outburst)?	45.0%
Have any of your closest relationships been troubled by a lot of arguments or repeated breakups?	39.8%
Do you frequently feel unreal or as if things around you are unreal?	35.9%
Have you often felt that you had no idea of who you are or that you have no identity?	35.3%
Do you feel chronically empty?	30.8%
Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g. repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)?	28.7%
Do you feel very angry a lot of the time?	23.5%

Perceived Burdensomeness

The presence of PB was assessed within the entire participant group using a set of 21 items. Seven of these items were from the Interpersonal Needs Questionnaire (INQ) and 14 were from the Self-Perceived Burden Scale (SPBS).

An overall *Perceived Burdensomeness Score* was calculated for each individual who completed the survey. This score was calculated by reverse scoring one item on the SPBS ("*receiving help from others makes me feel that they care for me*") before adding responses

for all other items together (from INQ and SPBS) to provide a final score. It is this score that is referred too throughout this section when PB scores are referred too. The PB scores ranged from 22 to 115 out of a maximum possible score of 119 (with a possible maximum of 49 from the INQ and a possible maximum of 70 from the SPBS). Scores on the INQ and SPBS are detailed in Table 7.4 and Table 7.5

Table 7.4

INQ results, contributing to the Perceived Burdensomeness score

Question (INQ)	Percentage of responses 4 or above (on a seven point Likert Scale)
These days the people in my life would be better off if I were gone.	19.5 %
These days the people in my life would be happier without me.	17.4 %
These days I feel like I am a burden on those around me.	36.9 %
These days I think I am a burden on society.	22.4 %
These days I think my death would be a relief to the people in my life.	15.4 %
These days I think the people in my life wish they could be rid of me.	18.2 %
These days I think I make things worse for the people in my life.	27.2 %

Figure 7.3 shows the relationship between the mean PB score (calculated from the groups raw scores which were calculated as described above) for each of the survey groups. Overall PB scores showed a positive linear relationship, where PB scores increased from no self-injurious behaviours to NSSI behaviours and continued to increase from NSSI only to NSSI and Suicide, with the highest PB scores being seen in the suicide only group.

Table 7.5

SPBS results, contributing to the Perceived Burdensomeness score

Question (SPBS)	Percentage indicating a response of 3 or above (on a five point Likert Scale)
I am concerned that my friends, family or partner will "wear out" because of the demands I place on them	41.9 %
I worry that the health of my friends, family or partner could suffer as a result of me	37.3 %
I worry that my friends, family or partner has to take time away from other things in order to help me	40.9 %
I feel guilty about the demands that I make on my friends, family or partner	46.6 %
I'm concerned that my needs are so great that my friends, family or partner can't handle them	36.2 %
I am concerned that if I ask for help it will put too much pressure on my friends, family or partner	48.3 %
I find it easier to ask my friends, family or partner for help when I feel that I can give something in return	69.6 %
I am concerned that my demands have strained my relationship with my friends, family or partner	44.2 %
I am concerned that I am "too much trouble" to my friends, family or partner	39.0 %
Receiving help from others makes me feel that they care for me	76.9 %
I am concerned about the negative effects I have on those around me	53.8 %
I think that I make things hard on my family, friends or partner	47.1 %
Sometimes I feel that my friends, family or partner might be better off without me	34.1 %
I feel that I am a burden to my family, friends or partner	40.5 %

Additional analysis was conducted to understand this relationship further and to ensure consideration was given to the differences in the data sets (for example groups were different sizes, as detailed in Figure 7.1) and this is discussed below.

The authors of the INQ and the SPBS do not provide a specific threshold score for determining when PB becomes relevant to suicidal ideation, rather the higher the score, the

more burdensomeness indicated. Therefore all scores were included in the analysis and interpreted a part of all group analysis and self-injurious group only analysis.

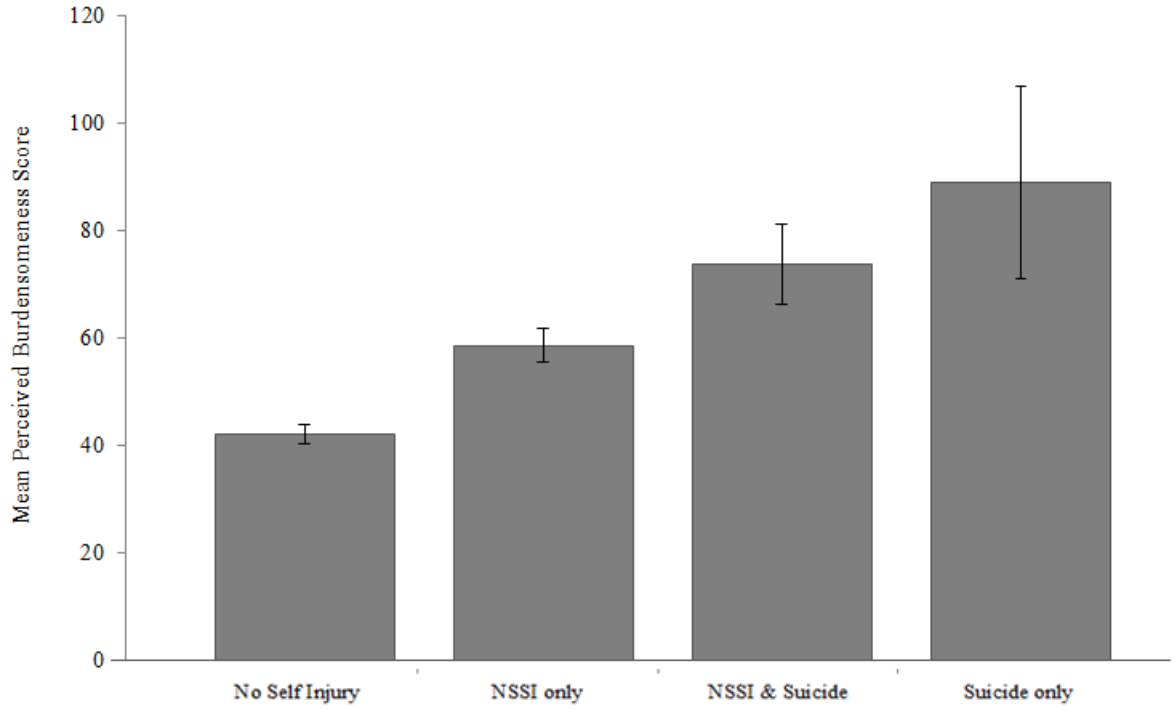

Figure 7.3. Group Mean Perceived Burdensomeness Scores

Univariate analysis of variance was used to investigate whether there was a significant difference in PB scores between ethnicity groups. Results confirmed that there was no difference between PB scores of various ethnic groups, $F(5, 153) = 0.871$, $p \leq 0.503$.

Data from NSSI Groups Only

Table 7.6 shows the percentage of participants who had ever engaged in self-injurious behaviours. Also shown is the percentage of those who report engaging in self-injury who reported self-injury consistent with NSSI, suicide attempts or both of these behaviours.

Table 7.6

Engagement in Self-injurious Behaviours

Status	Percentage of Total
Have not deliberately injured self	45.6%
Have Deliberately injured self	54.4%
Attempting to harm myself but not to end life*	79.3%
Sometimes NSSI/Sometimes suicide attempt*	16.2%
Attempting to end life*	4.5%

**Showing percentage of the 54.4% of participants who reported engaging in deliberate self-injury*

In line with the research questions discussed in Chapter 5, the analysis that follows includes only those individuals who endorsed having engaged in non-suicidal self-injury (either NSSI only or NSSI and at least one suicide attempt) the remaining individuals were not considered as this analysis was aimed at ascertaining the characteristics of the NSSI sample (equating to approximately 52% of all participants).

Age

The mean age of participants from Groups 1 and 2 was 21.0 years and ranged between 18 and 24 years. For these two groups the mean age at which participants first engaged in NSSI was 14.6 years; while the mean age that participants last engaged in NSSI was 21.24 years. (SD = 1.92).

Depression Measure - Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 items are based on the DSM-IV criteria for Major Depressive Disorder (MDD), as such, the instruction manual for this measure states that to consider a diagnosis of

MDD, an individual must endorse either having "*Little interest or pleasure in doing things"* or "*Feeling down, depressed or hopeless"*. In addition to this the individual must indicate that overall at least five of the items are applicable to them at least "*more than half the days"* (the entire PHQ-9 can be found in Appendix A). The instruction manual provides cut point scores of 5, 10, 15, 20 representing the presence of *mild*, *moderate*, *moderately severe*, and *severe* depression respectively (available at www.phqscreeners.com). Results for those who endorsed each of the PHQ-9 items either "more than half the days" or "nearly every day" are included in Table 7.7. As mentioned above, the exact number of participants who may be considered to be depressed cannot be exactly determine without a clinical interview, however based on the details gathered in the screening measure included in the survey, a large proportion (approximately 51%) of those who endorsed NSSI may also meet criteria for a *Moderate* to *Severe* diagnosis of MDD (Table 7.8). For comparison purposes, approximately 15% of survey participants who indicated no experience of self-injurious behaviours provided responses suggesting that they may meet criteria for a diagnosis of *Moderate* to *Moderately Severe* MDD.

Methods of NSSI

Individuals who endorsed having engaged in NSSI were also asked about their methods of self-injury. Descriptive statistics for the methods used to carry out NSSI are provided below in Table 7.9. Almost 20% of individuals who endorsed engaging in self-injurious behaviours indicated that they had *severely scratched or pinched themselves with fingernails or other objects causing bleeding or marks that remain on the skin*. A similar number of responders indicated that they had *cut* themselves (18%).

Table 7.7

PHQ-9, Depression Measure results – NSSI Group

Question	Percentage of responses indicating more than half the days	Nearly every day
Little interest or pleasure in doing things	22.2 %	8.6 %
Feeling down, depressed, or hopeless	23.5 %	13.6 %
Trouble falling or staying asleep, or sleeping too much	22.2 %	27.2 %
Feeling tired or having little energy	25.9 %	35.8 %
Poor appetite or overeating	29.6 %	24.7 %
Feeling bad about yourself /a failure /let yourself or family down	23.5 %	13.6 %
Trouble concentrating	17.3 %	14.8 %
Moving or speaking so slowly that other people could have noticed? Or being so fidgety or restless that you have been moving around a lot more than usual	10.0 %	6.25 %
Thoughts that you would be better off dead	11.1 %	9.9 %

Table 7.8

PHQ-9 Depression Descriptors – NSSI Group

Descriptor	Percentage of Participants
No Depression Indicated	13.6 %
Mild Depression Indicated	35.8 %
Moderate Depression Indicated	21 %
Moderately Severe Depression Indicated	14.8 %
Severe Depression Indicated	14.8 %

Table 7.9

NSSI Methods

Method of Self-Injury	**Frequency**
Severely scratched or pinched with fingernails or other objects to the point that bleeding occurs or marks remain on the skin	19%
Cut wrists, arms, legs, torso or other areas of the body	18.4%
Carved words or symbols into the skin	10.9%
Banged or punched objects to the point of bruising or bleeding	8.3%
Intentionally prevented wounds from healing	7.2%
Ripped or torn skin	6.3%
Punched or banged oneself to the point of bruising or bleeding	5.7%
Bitten yourself to the point that bleeding occurs or marks remain on the skin	5.2%
Burned wrists, hands, arms, legs, torso or other areas of the body	4.9%
Rubbed glass into skin or stuck sharp objects such as needles, pins, and staples into or underneath the skin (not including tattooing, body piercing, or needles used for medication use)	4.9%
Engaged in fighting or other aggressive activities with the intention of getting hurt	2.6%
Tried to break your own bone(s)	2.0%
Ingested a caustic substance(s) or sharp object(s) (Drano, other cleaning substances, pins etc).	1.1%
Medication overdose	1.1%
Hair pulling	0.6%
Suffocate or strangulation	0.6%
Repeatedly pulled rubber band/hair tie around wrist	0.3%
Extremely hot/burning showers	0.3%
Purging	0.3%
Compulsive exercise with the intention of sore muscles	0.3%

Number of NSSI events

The number of times individuals had engaged in NSSI also varied amongst the participant group, Figure 7.5 illustrates the number of times participants reported engaging in NSSI overall.

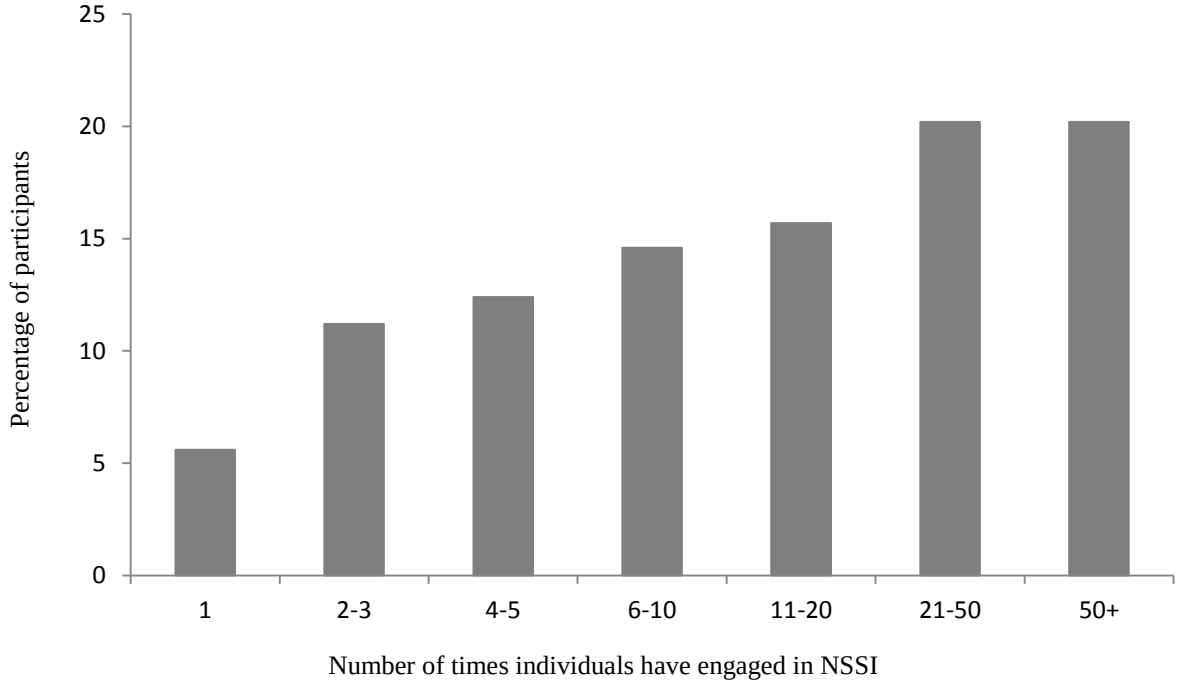

Figure 7.4. Frequency of engagement in NSSI

Functions of NSSI

Individuals who engaged in NSSI were asked for the reasons that they chose to harm themselves, an item that makes up part of The Non-Suicidal Self-Injury Assessment Tool (NSSI-AT). A number of statements were provided and participants were asked to rate each option on a four-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. Results for individuals who agreed with each statement are provided in Table 7.10 below. Almost 80% of participants either "*Somewhat Agreed" or "Strongly Agreed"* that they engaged in NSSI in order "*to cope with uncomfortable feelings*", a similar number either "*Somewhat Agreed" or "Strongly Agreed"* that they engaged in NSSI "*to deal with frustration"*, while 60% either "*Somewhat Agreed" or "Strongly Agreed"* their NSSI was "to deal with anger". Three quarters of participants either "*Somewhat Agreed" or "Strongly Agreed"* that they used NSSI to "*relieve stress or pressure*". When asked if they agreed that

they engaged in NSSI in order "*to change my emotional pain into something physical"*, almost 70% of participants either "*Somewhat Agreed" or "Strongly Agreed".* More than 23% of participants either "*Somewhat Agreed" or "Strongly Agreed"* that they engaged in NSSI as a means to "*avoid committing suicide"*. Only one participant agreed (*"Somewhat Agree")* that they engaged in NSSI "*as a way to practice suicide"*. Table 6.9 provides full results.

Participants were also given the opportunity to identify any further functions to their self-injury that had not been mentioned previously. Four participants took this opportunity stating that they engage in self-injurious behaviours for the following reasons: To avoid participation in something; as a result of alcohol intake; to ascertain if I could kill myself; to calm or soothe; for letting another person hurt me.

Perceived Burdensomeness (NSSI Groups)

In addition to the PB related items that all survey participants were asked, those participants who endorsed having engaged in NSSI were also asked "*Do you feel you are a burden on significant others in your life due to hurting yourself*?" and 35% of those who responded confirmed that this was true for them. Of this group approximately 55% had been overtly told they were a burden by a significant other, the remaining 45% had not been told that they were burdensome. Participants who endorsed feeling like a burden due to their self-injurious behaviours were asked if they considered that feeling like a burden on others made them more likely to engage in self-injury. Approximately 55% answered in the affirmative, 29% answered no to this question and 16% were unsure. These additional PB related questions were not part of the PB measure described earlier.

Table 7.10

Functions of NSSI

Reason I self-injure:	**Somewhat Agree – Strongly Agree**	**Percentage**
to cope with uncomfortable feelings (e.g., depression or anxiety)	71	79.8%
to deal with frustration	70	79.5%
to relieve stress or pressure	67	75.3%
to change my emotional pain into something physical	62	69.7%
to deal with anger	53	60.2%
to feel something	52	58.4%
because of my self-hatred	49	55.1%
to get control over myself or my life	48	53.9%
as a self-punishment or to atone for sins	40	44.9%
because I get the urge and cannot stop it	40	44.9%
to get a rush or surge of energy	39	44.3%
because it feels good	39	44.3%
to relieve the guilt I feel about being such a burden to others	28	31.5%
in the hopes that someone would notice that something is wrong or so others will pay attention to me	26	29.2%
to avoid committing suicide	21	23.6%
because I like the way it looks	15	16.9%
because my friends hurt themselves	10	11.2%
to shock or hurt someone	7	8.0%
as an attempt to commit suicide	6	6.7%
as a way to practice suicide	1	1.1%

Hierarchical Regression Analysis

Data Screening

The completed survey responses were put into a data set for analysis. Screening for normality, linearity and homoscedasticity was conducted prior to conducting further analysis. All statistical working details for data screen is included in Appendix G.

Group Differences between NSSI and no NSSI

Univariate analysis of variance was used to investigate whether there was a significant difference in PB scores between those individuals who engaged in NSSI and those who did not engage in any self-injurious behaviours (Group 1 and Group 2 as one group, compared with Group 4 the control group). Descriptive statistics are displayed in Table 7.11.

Results suggest that there is a significant difference between these groups (those individuals who engaged in NSSI and those who did not engage in any self-injurious behaviours), the Effect size of this difference was determined to be large, $F(1, 153) = 30.765$, $p \leq 0.001$, $\eta p2 = .168$. The Brown-Forsythe test also confirmed that the NSSI group and the control group did not share equal group variances, $F(1, 135) = 31.147$, $p \leq 0.001$.

Table 7.11

Descriptive Statistics for NSSI and Control Groups

				95% Confidence Interval for Mean			
	N	Mean	Std. Deviation	Lower Bound	Upper Bound	Minimum	Maximum
NSSI	81	60.988	25.463	55.357	66.618	22.00	115.00
Control	72	42.139	15.650	38.461	45.816	22.00	103.00

Hierarchical Regression Analysis

A regression analysis was performed to determine the relationship of PB and depression score, borderline personality disorder score, number of NSSI events and function of engagement in NSSI. A hierarchical regression is a series of standard regression analyses. It is an advantageous analysis to conduct with the data obtained from the survey, as by adding variables one at a time, an understanding of the relative contribution of each of the variables to the significance of the final model is obtained (rather than just the final significance of the entire model). The order of adding these variables is irrelevant, as each regression is focused on the variable that is added into the equation (while accounting for the significant conveyed by other variables), the results suggest to what extent the variable in question can explain a statistically significant amount of overall variance seen in the dependent variable. The final model provides the same outcome as entering all variables in one block, as with standard regression.

Selection of Covariates

Age and Sex failed to show significant linear correlations with PB (see Tables 3 and 4 in Appendix G). These were therefore not selected as covariates for further analysis. Preliminary examination of the data suggested that Depression score, BPD score, Number of Methods of NSSI, and Number of NSSI events (frequency) were variables with significant correlations with PB.

Multicollinearity

Multicollinearity of covariates was then examined in order to determine if any variables were measuring the same construct. Table 6.13 displaying the Pearson Correlations and Speaman's Rho shows two correlations above the r=0.6 threshold for multicollinearity,

PB and Depression scores as well as Frequency and Methods used. This suggests that there is a possibility that each of these pairs is measuring the same construct and this will be discussed further in the discussion section. These variables will therefore be controlled for. All other correlations identified were less than r=0.6, and considered too small to be identified as multicollinearity.

Regression Results

In Model 1, only Depression scores were entered. This equation was significantly predictive of PB score, $R^2 = 0.342$, $F(1,77) = 41.473$, $p=0.000$. In Model 2, BPD scores were added to the equation, and significantly improved the prediction of PB scores, $R^2=0.379$, $R^2_{change} = .045$, $F_{change}(1,76) = 5.628$, $p = 0.020$. In Model 3, NSSI Frequency was added to the equation and significantly improved the prediction of PB scores, $R^2=0.386$, $R^2_{change} = .014$, $F_{change}(1,75) = 1.835$, $p = 0.004$. In Model 4, number of NSSI methods was added to the equation and did not contribute significantly to improving the prediction of PB scores, $R^2=0.398$, $R^2_{change} = .019$, $F_{change}(1,74) = 2.489$, $p = 0.119$. The final model predicted 39.8% of the variation in PB scores. Depression scores made the majority contribution to the final model, significantly predicting 34.2% of the variation in PB scores. Full analysis results summary are shown in Table 7.12.

Table 7.12

Regression Analysis Results Summary

				Change Statistics				
Model	R	R Square	Adjusted R Square	R Square Change	F Change	df1	df2	Sig. F Change
1[a]	.592[a]	0.350	0.342	0.350	41.473	1	77	0.000
2[b]	.628[b]	0.395	0.379	0.045	5.628	1	76	0.020
3[c]	.640[c]	0.409	0.386	0.014	1.835	1	75	0.004
4[d]	.655[d]	0.429	0.398	0.019	2.489	1	74	0.119

[a] Predictors: (Constant), Depression Score. [b] Predictors: (Constant), Depression Score, BPD Score. [c] Predictors: (Constant), Depression Score, BPD Score, Frequency of NSSI. [d] Predictors: (Constant), Depression Score, BPD Score, Frequency of NSSI, Number of Methods

The final model was found to be statistically significant $F(1, 78) = 13.874$, $p \leq 0.001$.

Qualitative Results from Survey

Individuals who endorsed engaging in NSSI were also asked two open ended survey questions where they were invited to type their thoughts. The first asked was – "*Do you see any consequences to hurting yourself*?" Of those who responded to this question (n=88), 62.5% answered yes and provided responses as shown in Table 7.13.

The second open ended question was – *"We are interested to know what you think is important for people who want to better understand and help those who intentionally hurt themselves to know."* A total of 56 people provided a response for this question with the most common themes (those themes that were mentioned by at least 5% of responders) as listed in Table 7.14.

Table 7.13

Summary of participant responses to the question "Do you see any consequences to hurting yourself"

	Consequence	Description	Number of Responses discussing this consequence
1	Scars	Scars cause embarrassment, and can cause fear of judgement from others. Physical scars can act as reminder of emotional scars too	65.4%
2	Hurting or upsetting others around me	Individuals who spoke to this consequence were particularly concerned with hurting loved ones as a result of the NSSI	15.4%
3	NSSI makes you feel worse in long run	This consequence was about NSSI becoming habitual and a difficult behaviour to cease despite it only working in the short term. Individuals discussed NSSI as not a long term fix for the difficulties or problems they experiencing.	11.5%
4	I have done irreversible damage to myself	Individuals spoke about permanent/long term damage that they had caused their bodies through NSSI (above and beyond scarring), for example traumatic brain injury from banging head against walls and nerve damage in fingers from cutting. Damage described by these individuals was such that it was currently affecting the individuals life negatively	9.6%

Table 7.14

Summary of participant responses to the question "We are interested to know what you think is important for people who want to better understand and help those who intentionally hurt themselves to know."

Themes	Description	Number of Responses discussing this themes
1	NSSI is not a form of attention seeking, rather it is a coping mechanisms for difficult thoughts and feelings.	19.6%
2	Everyone is different; reasons for engaging in NSSI are different for different people.	12.5%
3	The most helpful response from family and friends is to be empathetic, understanding and supportive, not angry disappointed or judgemental	12.5%
4	NSSI is embarrassing and shameful	10.7%
5	Engaging in NSSI does not necessarily indicate a desire to die	8.9%
6	NSSI can feel addictive, it is hard to control and hard to stop	7.1%
7	NSSI acts as a distraction (can be adaptive) but can be lessened by use of distractions too	7.1%
8	Anger causes engagement in NSSI	5.4%

CHAPTER EIGHT – DISCUSSION OF SURVEY RESULTS

The aim of this quantitative study was to explore engagement in NSSI amongst young New Zealand adults aged 18 – 24 years, particularly the relationship between perceived burdensomeness (PB) and NSSI. Over half of those who participated in the survey endorsed having engaged in self-injurious behaviours, the majority of these individuals endorsed having engaged in NSSI only, with no suicide attempts. A measure of PB was created from the items addressing PB in the survey and scores from this measure were used to investigate how perceptions of burdensomeness might be linked to NSSI.

There are a number of central findings from the survey study and these have been outlined below.

Self-Injurious Behaviours and Perceived Burdensomeness

More than one third of individuals who endorsed engaging in self-injurious behaviours also endorsed feeling like a burden on those around them.

The relationship between NSSI and PB was investigated by analysing the differences in PB score between self-injurious and control groups. Scores on a measure of PB increased as self-injurious behaviour moved from NSSI to suicidal behaviour. Individuals who engaged in NSSI had higher PB scores than those individuals who did not engage in NSSI, but lower PB scores than those individuals who engaged in either NSSI and suicide attempts or suicide attempts alone. These findings are in agreement with Joiner's IPTS model (Joiner, 2005; Van Orden et al., 2010) that proposes PB is a requirement for death by suicide, therefore analysis of the literature would suggest that as self-injurious behaviour increases (or

worsens) we would predict an increase in PB. These results suggest that PB may act to modify the relationship between NSSI and suicide attempts.

NSSI Frequency, Number of Methods of NSSI and Perceived Burdensomeness

A large proportion of participants (40.4%) endorsed engaging in NSSI more than 20 times, with half of these participants reporting engaging in NSSI more than 50 times. Previous New Zealand based research reported a lower proportion of participants endorsing engagement in NSSI 20 times or more (28.1%) but a similar number engaging in NSSI 50 times or more (18.2%; Fitzgerald & Curtis, 2017). It is unclear why rates are higher than previously reported, however it is suggested that recruitment procedures may have some role to play here. This survey recruited through university classes, but also via social media and word-of-mouth. Use of social media and word-of-mouth may potentially target similar individuals (for example friends or family members) of those that shared the information; it is thus possible that the survey was shared with a greater proportion of individuals who engage in NSSI compared to the general population. The higher rates of NSSI may also be due to the much higher proportion of female participants compared to male participants in this study, as it is well-documented that NSSI is more prevalent amongst females (e.g., Bresin & Schoenleber 2015; Xavier et al., 2017).

The number of times an individual had engaged in NSSI was strongly positively correlated with the number of methods of NSSI. Analysis of the qualitative answers provided in the survey, suggested that at least some individuals engaging in NSSI are aware that NSSI does not help in the longer term, and can in some cases make them feel worse. Thus if one method of NSSI is not creating the desired result, a different method may be tried in the hope of a different long term outcome.

The number of methods used for NSSI showed a moderate positive correlation with PB score, while the number of times an individual had engaged in NSSI showed a weak to moderate positive correlation with PB. These results provide further evidence that as NSSI continues so too does PB, moving along a continuum between wanting to harm one's self and wanting to end one's life and providing evidence that PB plays a role in NSSI in addition to suicide attempts.

Depression, NSSI and Perceived Burdensomeness

Scores on a measure of depression showed a strong positive correlation with PB scores. This is in line with a significant quantity of literature illustrating a link between depression and suicide (e.g., Van Orden, Lynam, Hollar, & Joiner, 2006; Teismann et al., 2016). The number of methods of NSSI used also showed a moderate to strong positive correlation with scores on the depression scale but only a weak to moderate positive correlation with the number of NSSI episodes. These results suggest that feelings of depression may cause an individual to decide one method of NSSI is not meeting their needs (and therefore attempt a different method) more quickly than an individual who is not experiencing depression.

Borderline Personality Disorder and Perceived Burdensomeness

Scores on a scale focused on Borderline Personality disorder (BPD) showed a moderate negative correlation with PB scores. Close analysis of results suggest that 17% of participants would have met the MSI-BPD diagnostic cut off score indicating that they may meet criteria for BPD, this result may provide some further insight into the higher levels of NSSI found in this study compared to previous New Zealand based research. BPD scores were also negatively correlated with number of NSSI methods engaged in and number of NSSI events. This finding may be at least partially explained through an understanding of

BPD traits which often reflect a focus on one's own feelings of distress, rather than the feelings of others (Gaher, Hofman Simons & Hunsaker, 2013). It is thus possible that those affected by BPD do not consider the burden they may be on others around them.

It is noted that inclusion of a scale for BPD does not necessarily allow for an accurate identification of the number of individuals amongst the sample group who do or may meet criteria for BPD. Many of the items included in the MSI-BPD may be considered true for those individuals experiencing feelings of depression, stress (perhaps from university studies) and engaging in NSSI as a coping mechanism. It is possible that very few individuals actually met criteria for a diagnosis of this disorder and thus the sample is not best designed to draw conclusions about any links between BPD and PB. Therefore caution is required when interpreting these results.

Overall Results

Overall, results suggest that scores on a measure of depression, scores on a measure of Borderline personality disorder, the number of times an individual has engaged in NSSI and the number of methods they have used are all able to contribute to the variation in PB scores (together predicting 39.8% of the variation in PB scores). Depression and number of times an individual has engaged in NSSI make the biggest contribution.

Comparison with Existing Theories of NSSI

Results of the current study are consistent with the Emotional Regulation theory of NSSI. Partial support was obtained for the Self-Punishment Hypothesis and Social Signalling hypothesis, with possible support for the Implicit Identification hypothesis. The Social Learning hypothesis was not supported.

NSSI for Emotional Regulation

Difficulties with emotional regulation or reducing internal distress has been widely reported as a reason for both beginning engagement in NSSI and a perpetuating factor (e.g., Adler & Adler, 2007; Claes, Klonsky, Muehlenkamp, Kuppens & Vandereycke, 2010) and suggested as the most common function for engagement in NSSI (Bresin & Schoenleber, 2015; De Riggi, Moumne, Heath, and Lewis, 2017; Gratz & Chapman, 2007; Klonsky, 2007; Nock, Prinstein, & Sterba, 2009). Results reported here are consistent with these findings, showing that as depression increases, NSSI increases, i.e. depression is positively correlated with both number of methods of NSSI (moderate – strong correlation) and number of NSSI events (weak – moderate correlation).

The qualitative responses within the survey also supported this link. Almost 80% of participants engaged in NSSI "to cope with uncomfortable feelings (e.g., depression or anxiety)", 70% "to change my emotional pain into something physical", 60% "to deal with anger" and almost 80% of individuals endorsed engaging in NSSI "to deal with frustration". Of those participants who provided a response to the open ended questions, 7% discussed self-injury as a distraction technique from uncomfortable thoughts and feelings. These results suggest that individuals with depression are less well equipped to tolerate emotional pain in comparison to physical pain.

Social Learning Hypothesis

Engaging in NSSI as a result of seeing friends engaging in such behaviours did not appear to be a major precipitant for engaging in self-injurious behaviours, with approximately 11% of participants endorsing engaging in NSSI "because my friends hurt themselves". Further no participant cited viewing online media, movies or songs as a reason for beginning or continuing to engage in self-injurious behaviours. These results therefore do not offer

support for the Social Learning hypothesis for NSSI or the idea that individuals engage in self-injurious behaviour as a way to socially conform. However, it is possible that those individuals who learn about self-injurious behaviours through social means (online, in movies, television shows or books) are influenced to engage in self-injurious behaviours. But as this type of content has continued to become more common, individuals may not realise the influence of such content on them or consider the knowledge gained from such content as being related to their decision to engage in self-injurious behaviours.

Self-Punishment Hypothesis

Engaging in NSSI as a means of self-punishment was partially supported with 55% of participants endorsing engaging in self-injurious behaviours "because of self-hatred" and 45% of participants endorsing engaging in self-injurious behaviours "as a self-punishment or to atone for sins". These results may convey support for the Self-Punishment hypothesis, however without further research into the reasons why individuals' experience thoughts and feelings of self-hatred, what sins they would like to atone for and why they consider that they are deserving of punishment, further conclusions about this hypothesis cannot be drawn.

Social Signalling Hypothesis

Just under a third of participants (29%) endorsed engaging in self-injurious behaviours "in the hopes that someone would notice that something is wrong and so others will pay attention to me", conveying some support for the Social Signally hypothesis. However, this item may have been seen by some participants as suggesting they were 'attention seeking' through engagement in self-injurious behaviours as opposed to seeking the assistance that they sought. Almost 20% of those participants who gave some feedback as to what they thought was important for people to know about engaging in self-injurious behaviours responded that individuals don't engage in these behaviours for attention.

Therefore, it would have perhaps garnered more accurate results if the second part of the item ("…or so others will pay attention to me") was removed. The term "attention seeking" commonly has negative connotations in society, and suggests that seeking out the attention that one requires is similar to misbehaving and should therefore be ignored or perhaps punished in some way. The Social Signalling hypothesis instead views engaging in NSSI as a means of communicating an individual's need for input from others, their need for attention from others when they have been unable to do this verbally. This provides a good example of how important the language used when working with those individuals who engage in self-injurious behaviours is, especially young people.

Implicit Identification Hypothesis

While items did not specifically address the Implicit Identification hypothesis two items did provide some information about participants understanding of why they continued to engage in self-injurious behaviours. Almost 45% of individuals endorsed engaging in self-injurious behaviours "because I get the urge and cannot stop it" suggesting a feeling of helplessness or lack of ability to make a decision on engaging in self-injury or not, this was also reflected by 7% of those individuals who provided responses to the open ended questions. This may be due to learned reliance on self-injury and a perception that this is all they are capable of doing in terms of achieving the desired function. A similar number of participants (44.3%) endorsed engaging in self-injurious behaviours "because it feels good", again this suggest that these participants may consider that the only way they are able to feel good is to engage in these behaviours, perhaps identifying as a "self-harmer" with an understanding of themselves as an individual who can only feel good by engaging in these behaviours. There is thus perhaps an acceptance of the behaviour and an inability to determine what other behaviours may meet their needs, or indeed individuals may even lack

the knowledge that there are other behaviours that may meet their needs in the way that self-injury does.

Qualitative Responses

Reponses to an open ended question about regrets of engaging in self-injury reflected four major regrets discussed by participants including being left with scaring or long-lasting damage, hurting other people and an understanding that self-injury does makes things worse in the long term. These results provide further understanding as to the strong impact self-injury has in meeting an individual's needs (in the short term). Despite having these regrets, 56% of participants engaged in self-injury more than ten times, 20% of participants engaged in self-injury more than 50 times.

Summary of Findings

The major aim of this study was to investigate the relationship between PB and NSSI. Therefore, perhaps the most important finding is that PB score increases as self-injury worsens, highlighting the importance of PB in the etiology of NSSI. These results are relevant to clinical practice as well as to those supporting loved ones who are engaging in self-injury. These results suggest that a knowledge of PB including how to asses for, monitor and work towards improving is important for practitioners working with individuals who self-injure. Educating loved ones on how they might best assist with improving perceptions of burdensomeness is also likely to be of value for reducing self-injury. Both practitioner work and support by loved ones is of greater importance when the individual in question is meeting criteria for Major Depressive disorder (MDD). Practitioners who are working with individuals diagnosed with MDD should assess for the presence of self-injury and perceptions of burdensomeness. Feedback from open ended questions also provided some useful information for those people supporting loved ones who engage in self-injury. A

number of participants (12.5%) discussed what they perceived to be the most helpful response to self-injury – to respond with empathy, understanding and support, rather than anger or judgement.

Overall the results for this part of the study suggest that PB is an important area for further research into NSSI and an area where practitioners should gain some understanding, to ensure they are conducting the best assessment and monitoring with clients who engage in NSSI. Further research into the measure for PB would also be useful to assist in finding a tool that can help practitioner's better gauge and understand an individual's PB.

CHAPTER NINE: IPA RESULTS

Interpretative Phenomenological Analysis

Following the IPA interview process, five superordinate themes were identified relating to participants' experiences of NSSI and perceptions of burdensomeness. These themes have been labelled - *Experience of burdensomeness*, *I feel guilty*, *I am alone*, *Shame* and *This is how I cope*. The themes have been described in detail and are supported by a number of verbatim extracts from participants in order to illustrate each of the themes and to best represent the meaning behind each theme, therefore allowing the participants to maintain a presence or voice within this analysis. It is important to note that taken out of context, some of the verbatim extracts may appear to be the result of leading questions from the interviewer, however, these are often follow-up questions in response to statements previously made by the interviewee. A model of the emergent themes is illustrated in Figure 9.1. Table 9.1 below lists the names (pseudonyms have been assigned for each participant to maintain anonymity) and ages of each interviewee.

Table 9.1

Participant Characteristics

	Mia	***Andrew***	***Laura***	***Grace***	***Sarah***	***Hannah***
Age	21	21	22	22	23	22
Gender	Female	Male	Female	Female	Female	Female
Ethnicity	NZ European	NZ European	NZ European	NZ European	NZ European	NZ European
Survey Group	Group 2	Group 2	Group 2	Group 2	Group 2	Group 2
Interview Setting	In person	In person	In person	Via Video Call	Via Video Call	Via Video Call

The major focus of the analysis was to gain some understanding of the lived experience of individuals who engage in NSSI and to ascertain to what extent (if at all) perceptions of burdensomeness were involved in their experience. To this end, all interviewees were asked questions pertaining to their perceptions of burdensomeness, the answers provided were then followed up with further questions to gather a fuller explanation of the participants understanding of those perceptions of burdensomeness.

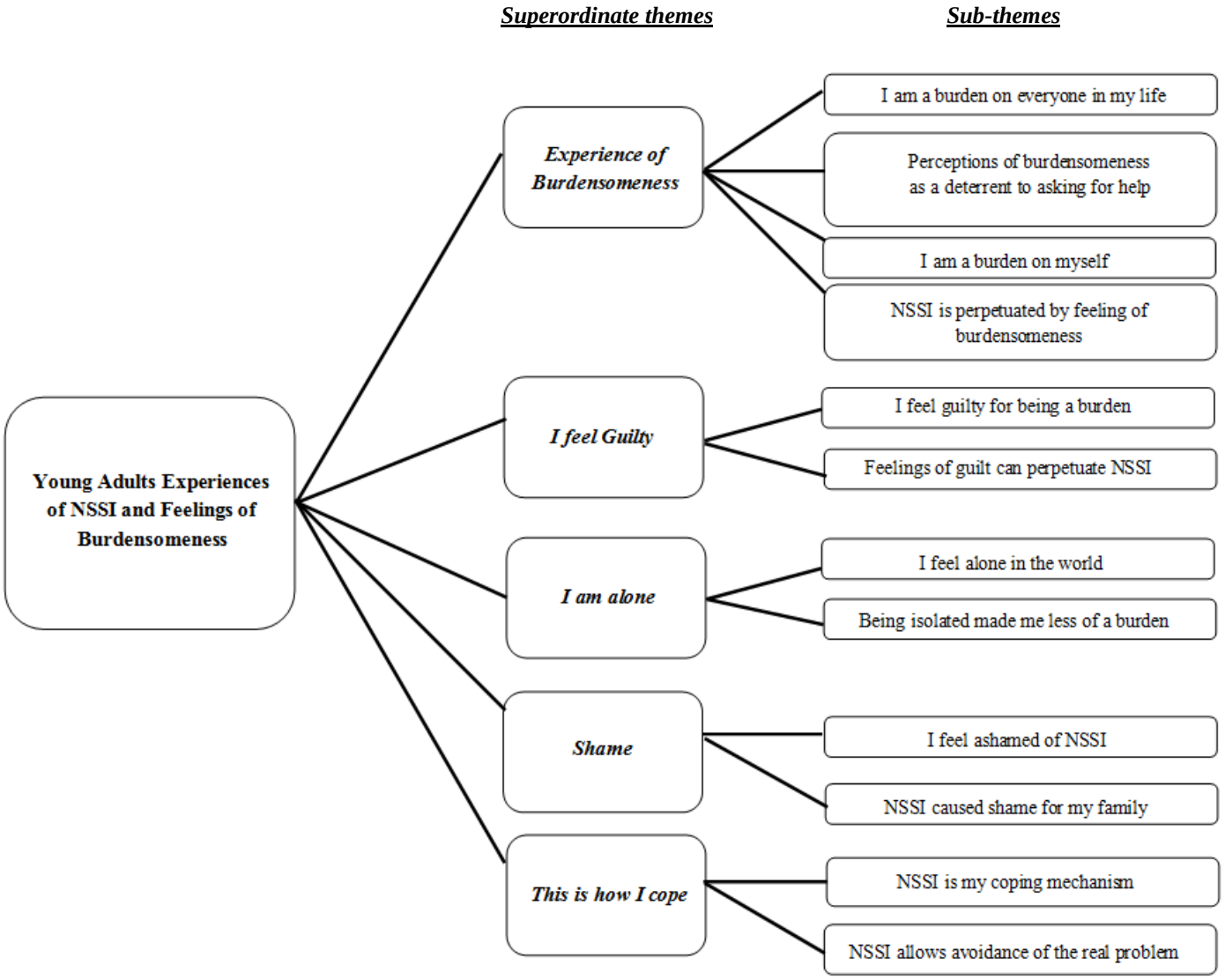

Figure 9.1. Emergent superordinate and sub-themes

Theme 1 - Experience of Burdensomeness

All participants expressed strong feelings of being a burden on others in their lives; therefore further exploration of this area was able to be conducted throughout the interview process as the interviewees made sense of their experiences of burdensomeness. While all interviewees expressed feelings of burdensomeness, not all of them were able to make a connection between feelings of being a burden and engaging in NSSI, despite being able to explain that perceptions of burdensomeness increased difficult thoughts and feelings, and these in turn increased or perpetuated their NSSI. This finding is further explained in the second theme (Theme 2: Guilt).

The superordinate theme of Burdensomeness was broken down into four sub-themes: *I am a burden on everyone in my life; Perceptions of burdensomeness as a deterrent to asking for help; I am a burden on myself; NSSI is perpetuated by feelings of burdensomeness.*

I am a burden on everyone in my life

During the exploration of burdensomeness, participants explained that they believed they were burdensome to different people in different ways or at different times, however most participants also expressed an overall feeling of being burdensome to everyone who knew them, with no one escaping the burden being put upon them by the interviewee. This is illustrated by the following quote from Grace:

Interviewer: *"At this time, was there anyone in your life that you didn't feel like a you were a burden on?"*

Grace: *"No. No definitely not. I think I really felt that I was a burden to everybody. Umm, and because, I mean, you know, I was, really, not a burden but I was, you know because of me people's lives were harder,*

and, you know, everyone from my family to my friends, to the matrons in the boarding house, to my teachers to the principals of the school, like they all had to you know, change stuff because of me, and, that was really hard, it was really, really hard because yeah there was nobody in my life that I didn't feel that I was affecting negatively."

Grace was diagnosed with a medical disorder when she was a young teenager, and as a result experienced frequent episodes of fainting. It appears that Grace's sense of being a burden began when she required additional care from others due to the symptoms of her illness. The teenage years are an important developmental stage, when the identity is forming and individuation from parents is occurring. For Grace the need for others to take care of her acted to hinder her ability to individuate and become more independent, as she would have liked too, and in fact would be expected too. Therefore while Grace may not have felt burdensome to others if she had not been ill, the additional care that she required from family, friends and teachers above and beyond that which her peers required, seemed to act to increase and perpetuate Grace's sense of burdensomeness. Grace also experienced depression and anxiety which appeared to add to the increasing burden that she perceived she was becoming, as she saw other people continue with life with much less assistance. Grace was asked to leave school for a period of time (due to her illness) which likely confirmed her thoughts about being burdensome to others – again highlighting for Grace that she was different to her peers, and that she needed to be looked after.

The perception that one is universally a burden, with no reprieve from this feeling felt overwhelming and almost suffocating for the participants, as the hugely difficult thoughts and feelings associated with the perception that one is a burden, all of the time, were almost inescapable. The definition or understanding of burdensome (illustrated in Grace's quote above), appears to be any instance of the participant inducing a change in another

individual's life, with the assumption that said individual would rather not be required to make changes, despite them often being loved ones. There is also perhaps an understanding of the difference in what constitutes burdensomeness across the age range. For Grace, whose peers were moving towards a more independent life, individuated from parents, her needs were in contrast to this, still requiring almost constant care, like a very young child. Therefore an understanding that she should not require so much assistance, so much care despite not having a choice in this matter, is likely to have contributed to her perception that she is a burden.

The feeling of being burdensome to everyone, was at times overtly stated (as seen in Grace's quote above) but with other participants, the focus was often on being a burden to family, with the perceptions of burdensomeness evolving throughout the interview as the participants continued to make sense of their experiences. This is further illustrated in the following quote from Laura:

Interviewer: *"So you talked about your mother just now, was there other people that you felt you were a burden on?"*

Laura: *"Most of my family, my friends, umm, my poor flatmate, Julia - we're still friends [laughs], umm...both my parents, my siblings a little bit, umm, but I'm not entirely sure they knew much about what was going on, so, I don't know, I was just the crazy sibling, the crazy little sister."*

While some interviewees didn't express a feeling of being burdensome to everyone in their lives, they spoke of being a burden to the only support people in their lives, which was very much experienced in a similar way - that the person I care about most in the world would be better off without me, causing a strong internal conflict. Andrew spoke at length about the burden that he was to his best friend and girlfriend, with absent parents, difficulty making friends and failing high school, Andrew's only support person and the only person he

believed cared about him was his girlfriend. To feel like a burden on his girlfriend, felt to Andrew like he was a burden to everyone who cared for him, and was interpreted as a similar overwhelming experience to those participants who spoke of a more universal burdensomeness. Andrew's experience is illustrated in the following quote by:

> ***Andrew:*** *"I weighted her back and, I kind of, I wouldn't say ruined, but, she could have done a lot better through those years if I wasn't there, umm, but whereas I would have done a lot worse if she wasn't there, so she yeah, I don't know I felt like yeah, I was just the anchor that weighed her down, while she trudged through, pulled me along…"*

All participants had a focus on particular people in their lives who they felt they were most burdensome towards, however perhaps due to these individuals being key people it each interviewee's life, the feeling was of an all-encompassing perception of burdensomeness. Andrew's reference to being like an anchor to his only support person is a powerful illustration of his internal conflict between being burdensome (and in fact detrimental) on other people and finding a way to survive, it also emphasises his belief that he was universally burdensome, or burdensome at all times. When asked if they could name people in their lives on whom they did not feel like a burden, the interviewees were unable to name friends, family or support people in their lives. However, two participants explained that helping other people who were struggling could at times cause their own perceptions of burdensomeness to diminish for a time – as illustrated in the following quote by Laura.

> ***Interviewer****: "During the times when you were self-harming, was there anyone that you didn't feel like you were a burden too"?*

Laura: *"My jobs. That was more just because I was, I like to keep myself busy, and away from my house, I was always more than happy to be at work more do other stuff, help other, help other people…when I was in Year 12, I got like, lots of Year 9's and 10's that I was kind of friends with through some groups at school that had their own issues and so, they could kind of see that I was along the same path as them, but because I'd never talked, I would, like I'd never talked to them about it, I could help them without...so like I could try and help them through stuff, without having to tell them anything, so that I wasn't a burden to them because I could help them without having to tell them anything."*

Interviewer: ***"****So when you were helping, you didn't feel like you were a burden?"*

Laura: ***"****No. I love to help people."*

This idea of finding comfort in helping others (rather than being burdensome) is further explained by the following quote by Mia:

Mia: *"The only reason I don't feel like a burden to them, is because I know that they've gone through some hard times and umm, feel more like I'm a rock to them than a, than a burden, and that umm helps me quite a bit. Just knowing that I can be there for someone, be there for them when they need it."*

There are at least two likely understandings for this behaviour being helpful in relieving feelings of burdensomeness. The first is that by giving something back to the

people around them, or engaging in altruistic acts, the interviewees may have felt less in deficit for the burden they were laying on others in their lives, they were assisting to carry someone else's burden so perhaps were more deserving of the assistance that they may need from others (and of course the associated burden). That is to say, the act of helping someone else who is struggling may in a sense go at least some way to nullifying the burden they perceived they were being on others. Secondly, this helping or altruistic behaviour, the taking on of someone else's burden for a time, may have acted as an avoidance strategy or a distraction for the interviewees (that is to say, if I am only concentrating on your problems for a time, I am unable to concentrate on my own difficult thoughts and feelings), allowing the interviewees to escape their feelings of burdensomeness for a period. It is likely that a combination of both of these possibilities was at play, but it is noteworthy that participants who were able to do this had in fact found a more adaptive coping strategy than engaging in non-suicidal self-injury.

Perceptions of burdensomeness as a deterrent to asking for help

It became apparent throughout the interviews that a major detrimental consequence for individuals experiencing perceptions of burdensomeness on those around them was that they became much less likely to ask for help or support for fear of becoming more of a burden than they already considered themselves to be. While individuals might want to ask for help, or may recognise that seeking support may be the most helpful thing in terms of reducing maladaptive coping mechanisms (including NSSI), they were reluctant to do so despite this decision partially perpetuating the vicious cycle (of NSSI used as a coping mechanism) that these individuals were caught in.

Interviewees described attempting to hide any knowledge of their NSSI from support people (usually family members) in order to reduce the perceptions of burdensomeness they experienced as a result of NSSI, as illustrated in the following quote by Sarah:

Interviewer: *"Did those feelings of...burdensomeness affect your self-harming behaviours?"*

Sarah: *"Um, probably just made me more sneaky, as sneaky as I could be which in hindsight, I probably wasn't that sneaky if I was wearing long sleeves all through summer, but that was my way of trying to hide it...."*

Interviewer: *"So were you trying to hide it so you weren't causing problems for them [your family]?"*

Sarah: *"Yeah, just cos it was an unpleasant thing and so, no one would have to talk about it or deal with it."*

Sarah spoke about wanting to hide the evidence of NSSI because it was "an unpleasant thing". Sarah seems to be speaking about her NSSI being unpleasant for both herself but also for those around her, thus she appears to be hiding her self-injury out a sense of protecting others. By hiding her NSSI, she is not only protecting others from the unpleasantness, but also protecting them from the burden that she perceives she would pass onto her loved ones by being open and honest with them. In protecting others from her own burden she is simultaneously protecting herself from the negative feeling she experiences through the knowledge that she is burdening others. Sarah perceives that she is a burden through the reaction of others to her self-injurious behaviours, and thus by hiding her self-injury she is protecting herself from the difficult consequences that follow, such as feeling like a burden, and the need to explain and speak about why she is engaging in this behaviour.

Some interviewees attempted to hide the evidence of their NSSI to a lesser extent as the physical results of NSSI were able to illustrate the distress the individual was feeling, without them having to actually burden their loved ones by orally expressing their difficulties - acting to somewhat lessen their perceptions of burdensomeness. This seemed to suggest that physically representing their distress (through NSSI) was easier and perhaps considered to be less burdensome. While individuals may feel able to speak to a support person once about the problems they are experiencing, with continuation of the struggles (including engaging in NSSI multiple times), the perception of being a burden for the interviewees appeared to increase. The following quote by Hannah illustrates these points further:

Hannah: *"I wouldn't tell anyone because I wouldn't want to worry them , you know, like I just, I don't know it's complicated, because it's like I want, like a physical representation of what I'm going through because I want people to know that like this is real, something I'm experiencing and I'm not like making it up but also I don't want to show people. Yeah, umm, but no, definitely, I definitely feel like a burden a lot of the time, or like if I talk to someone about something, I am very hesitant to talk to them about the same thing again later on, 'cos I feel like I've already taken up too much of their time, I've already like, kind of like, handed this negatively to them, in the past, and I just don't want to do that again."*

Interviewer: *"So is taking up their time and I guess handing negativity; do you think that's burdensome for them?"*

Hannah: *"Yup. Ah, it's like, it's like ah the thing where you have like, like, your emotional thinking and then like your logical thinking, cos like*

logically, if they didn't want to be my friend, they just wouldn't be my friend. But also there's that like that irrational thought of, like I'm, I'm taking up their time, they'd rather be doing other things, they're only here because they feel like they have to be. That kind of sucks."

Hannah's quotation above appears to speak to a link between burdensomeness and obligation, if a person acts out of obligation alone, then this, by Hannah's definition is burdensome. This understanding neglects to acknowledge the idea that loved ones or people who care or are concerned for others, may actually have a desire to provide whatever assistance may be helpful only because they love or care for another person, rather than acting out of a sense of obligation and also likely without a perception that the person requiring the assistance is burdensome, or a burden on others. Perhaps Hannah feels unloved and unlovable, hence she must only receive help when another person feels obligated to provide it, as an unlovable person cannot receive assistance out of a sense of love or care from another – creating a perception of being a burden on others.

Hannah says that she wanted people to know that her feelings were real, but feels somewhat torn between showing people (via a physical representation of her feelings) that she is struggling, and not telling them, so as not to be a burden on them. It was not clear why Hannah thought that people may consider that her struggles were not real, but it seemed that this may have been due to either her perception or what she believed to be the perception of others – that mental distress is not as 'real' as physical distress. There are still many people who consider mental health distress as a choice and that individuals can choose to avoid such distress. Suggestions that a person can 'just think positively', 'snap out of it' or 'harden up' are common enough notions in society today. However, physical illness is often taken much more seriously. It is therefore perhaps unsurprising that in order to ensure people around

Hannah realised she was suffering, she concluded that physical damage to her body would be more easily heard than a discussion of the experience of difficult thoughts or feelings.

Hannah's explanation of help seeking around her NSSI is a helpful illustration of why it was rare for participants to seek assistance, despite wanting too.

I am a burden on myself

While the focus of the interviews was perceptions of burdensomeness on others, participants also recognised that their coping behaviours, and the drivers for behaviours (difficult thoughts and feelings) as well as their inability to break out of the vicious cycle of NSSI also perpetuated a feeling of being a burden on oneself. To be a burden on oneself is not an easily understood concept, however it is interesting to note that participants expressed a desire to cease their engagement in NSSI, disputing the commonly held (but erroneous) view that individuals engage in NSSI in order to gain attention from others. Some participants interpreted their feelings as being overtly self-burdensome, as illustrated by the following quote from Andrew:

Andrew: *"[I was]letting myself down, and I felt that, that I wasn't going to go anywhere, and I wasn't doing anything, and, yeah I was anchoring myself, burdening myself with myself..."*

However a number of other participants while expressing similar ideas around the detrimental effects of NSSI on themselves and recognising that their coping mechanisms were not assisting them toward feeling less distressed, used somewhat different language as they made sense of their experiences and their NSSI, such as discussion of being deserving of punishment. This is illustrated by the following quote from Mia:

Mia: *"I should be a better person but I'm not, umm, kind of a weird sort of punishment for myself I guess."*

Mia's comment above suggests that she makes sense of her NSSI by seeing it as a form of self-punishment for not being a "better person". It makes sense that a person who believes that they are so devoid of goodness that they deserve to physically punish themselves, and feel better (at least for a short time) after inflicting this punishment, would also likely believe that they were a burden on others around them. It is also possible that Mia's perception of being a burden on others contributes to her feelings that she should be a better person (a better person could perhaps be recognised as someone who is not a burden on others around them). Thus this perception of burdensomeness and her desire to be a better person perpetuate the need for self-punishment in the form of NSSI. NSSI is a negatively reinforcing behaviour for Mia, becoming a type of safety behaviour for her.

Later in the interview Mia described her dismissive feelings towards herself

> ***Mia:*** *"I kinda try not to think about how I feel about myself sometimes, it's only if someone, you know directly asks me 'how do you feel about yourself'- I'm just kind of very dismissive and whatnot, I'd rather focus on other people, I guess people that are probably worth more time thinking about them than myself, which is a kinda reflection of how I feel about myself."*

Mia discusses being dismissive of herself, as she considers that other people are worth more time than she is, this again speaks to Mia's understanding that she should be a better person, because better people are worth thinking about, and she considers that she is not. Mia finds it so difficult to think about herself, due to her feelings of unworthiness, that she avoids doing so when possible, perhaps because she experiences these thoughts and feelings as a burden to herself. She is dismissive of herself, and of her feelings towards herself, which likely affects every part of her life, giving the impression that Mia lives a numbed life,

avoiding almost all thoughts and feelings as much as she can. NSSI acts to perpetuate this avoidance by providing a distraction and a short lived reprieve from the knowledge that she is burdensome to those around her and herself. However, even in engaging in NSSI she is perpetuating the burdensomeness that she perceives she creates. A person who is not worth thinking about, and who is a burden on those around them is very unlikely to be someone who deserves to be loved by themselves or anyone else. Therefore, the motivation to cease NSSI behaviours is likely very low.

There were a number of times throughout the interviews when the researcher interpreted the participants understanding of their experience as being a burden on themselves; despite participants making sense of their experiences by seeing external causes for their NSSI. This is illustrated in the quote below from Grace, who stated that she did not consider herself a burden, yet had a strong desire to be a different person.

> ***Grace:*** *"I didn't ever think that I was a burden to myself; it was much more focused on being a burden to others. Um, but I do wish a lot you know umm, that I wasn't anxious, or that I hadn't had, you know been depressed, and that I hadn't you know, that I didn't have the self-harming urges. "*

Grace described wanting to punish others (as opposed to Mia's motivation, to punish herself). So while Grace appeared to avoid the interpretation that she was a burden on herself, despite discussing ways in which she wished she had been different, this can be understood in light of the fact that Grace instead blamed others for her difficult thoughts and feelings. This is illustrated in the quote from Grace below:

> ***Interviewer:*** *"So you've said a couple of times now, that ... it was, sort of like a punishment for others… was it a punishment for yourself as well?*

Grace: *"Yeah, absolutely. It was, yeah, it was kind of a combination of the two because, you know, there are, um, like, I'm mad at these you know, these people for making me feel bad, but I'm also mad at myself that I feel so bad because of what they did, I'm like, well I'm just being pathetic. You know, I shouldn't be this upset…"*

Grace seems to contradict herself in some ways, as while she does not say that she considers she was a burden to herself, she does consider that she should punish herself for her difficult feelings. She states that she is pathetic for having the feelings that she has, but attributes her thoughts and feelings to other people's actions, explaining that she wishes to punish others through punishing herself. It was interesting to note the contrast in her partial externalisation of her difficult thoughts and feelings in the first quote, with her complete internalisation in the second. This internal confusion is likely to have made it more difficult for Grace to make sense of her NSSI behaviours, and it is possible that this confusion fed into the vicious cycle of NSSI increasing her overall feelings of burdensomeness.

While it was evident that the sense making between participants was varied, the underlying theme behind the individuals' interpretations appeared to fit into the sub-theme of being a burden to one's self as well as others in their lives. All participants were able to recognise, whether through anger or a desire to punish one's self, that their thoughts, feelings and actions were having a negative effect not simply on those around them but also on themselves.

NSSI is perpetuated by feelings of burdensomeness

Throughout the interviews, it became apparent that feelings of burdensomeness were acting to perpetuate the cycle of NSSI behaviours that participants were engaging in, maintaining feelings of burdensomeness (as engaging in NSSI behaviours was often cited as a source of feelings of burdensomeness). At times the link between feelings of

burdensomeness and the likelihood to engage in NSSI behaviours was easily recognised as illustrated in the quote from Mia below:

Interviewer: "*Do you think that feeling like a burden on your parents made you more likely to harm yourself?"*

Mia: "*Yeah, I do think so. Umm, it's, hard not having your parents' full support, I guess, cos you know they're the ones who are supposed to you know, be there through everything and they've been there for me for somethings, but, I guess, it's the little things like you know, just wanting to spend a little bit of time, it's the little things that really speak the loudest, to me anyway"*

Mia believed that she was a burden on her parents; she saw confirmation of her burdensomeness in their unwillingness to provide what she needed, and these feelings of burdensomeness were directly related to her NSSI behaviours. NSSI itself was also described as perpetuating feelings of being a burden, or perhaps more accurately, hindering the individual from working through feelings of burdensomeness in a more adaptive way. With both feelings of burdensomeness acting to perpetuate NSSI and NSSI acting to perpetuate feelings of burdensomeness, the two became part of a vicious cycle, keeping the individual somewhat trapped. The perpetuating nature of feelings of burdensomeness is further illustrated in the quote from Andrew below:

Interviewer: *"Can you relate that feeling of being a burden directly to your self-harming?"*

Andrew: *"Yeah, I mean like, I would self-harm because I felt like a burden, because my mum's just like, you know like 'You f-ing kids, all you do is fucken this, that and the other, you make my life hell' like, and that*

made me just like umm, without you know having any love or anything from mum, it was like, why am I even here, why, like, why do I live in this house, why am I with her, why do I even exist, like you don't care, you don't love me , like I'm just here, I'm another mouth to feed, that you say like, why bother, and like with her I had a lot of suicidal thoughts, and stuff like that and contemplated suicide and stuff like that, umm. Yeah and I just linked those sort of emotions and stuff to self-harming and thoughts of suicide."

Andrew's quotation above speaks of being unloved and unlovable. He suggests that the fact that he believes that he is unloved and uncared for by his mother makes his very existence a burden to her, a situation that he appears to see no way out of. His engagement in NSSI and suicidal ideation is likely driven by a need for self-punishment for not being the sort of person who his mother is able to love and perhaps in an attempt to escape himself, and the all-encompassing burdensomeness he seems to experience. Andrew's thoughts appear to be quite black and white – I am a burden, as surely as I am a human – he perhaps sees this as a flaw in the person he is or a defect present from birth, an attribute that he feels powerless to change or overcome. The only way that Andrew sees to cease being burdensome on his mother is to end his life. It is perhaps likely then that as he continued to engage in chronic NSSI (without ending his life), while perhaps helping in the immediate short-term, he was never really able to feel a reduction in burdensomeness, because his perception was that he remained unlovable and a burden in his mother's life. Andrew did make a suicide attempt at one point in his life, placing that event within this context, perhaps provides an illustration of how NSSI may sit on a self-injurious continuum leading to suicide attempts or death by suicide.

One participant reflected on the perpetuating nature of feelings of burdensomeness on her NSSI by explaining that when she was overtly called a burden, she increased the incidence and severity of her NSSI. Her NSSI was being perpetuated, not only by her feelings of being a burden, but her anger at others for making her feel that she was a burden. In the quote below from Grace, she discusses NSSI as a punishment for others around her, as she blamed them for making her feel burdensome.

Interviewer: "*So, you're feeling like you're a burden on people, how did those feelings relate to your self-harm? So how were they, I guess playing into that self-harming cycle?"*

Grace: *"They made it worse, because I think, I do think that at the beginning that to a certain extent, my self-harm was a punishment tool, um, so a punishment for people around me, like - look how bad you've made me feel. Umm, and then it became such an effective coping strategy, that I was like, oh actually this really helps me feel better, I'm going to carry on doing it, and when I, you know, when I found out people were saying X-Y-Z about me, it definitely was kind of like, okay, well I'll cut more, I'll cut deeper, I'll do it worse."*

Throughout the interviews there were times when participants would discuss the use of NSSI as an alternative to making a suicide attempt. When discussing how feelings of burdensomeness may be related to NSSI, Hannah discussed the use of NSSI in place of attempting suicide, because she recognised that the burden she would be on her loved ones through engaging in NSSI would be less than if she attempted (or died) by suicide. So ultimately, while perceptions of burdensomeness may perpetuate NSSI, in some ways NSSI acts to prevent the perceived increase in burdensomeness that would occur as a result of a

suicide attempt. In this way, while NSSI may begin as a behaviour used to manage perceptions of burdensomeness; it quickly becomes part of a vicious cycle, where in fact the behaviour used to avoid perceptions of burdensomeness is now adding to, or increasing the perceptions of burdensomeness. As such, like the other participants, for Hannah, NSSI behaviours were being perpetuated by feelings of burdensomeness. This is further illustrated in the quote from Hannah below:

> ***Interviewer***: *"Is that [*feelings of burdensomeness*] something you think about before you self-harm or at any stage during that process?"*
>
> ***Hannah***: *"Umm, I don't know , I don't remember like in the past, but I know like most recently, it hasn't been, um, I, I guess like I remind myself a lot about like if I like, for example if I did try to kill myself, um, that it would have a huge impact on the people around me, like ah, I guess my main reason a lot, most of the time, for not doing that was and is how it would impact the people around me."*

Theme 2: I feel Guilty

Throughout the interviews and analysis of interview transcripts, it became apparent that feelings of guilt were closely associated with both engagement in NSSI and PB. All participants discussed feelings of guilt, despite this not having originally been included in the interview schedule. Due to the nature of the semi-structured interview, it was possible to explore the feelings of guilt and how these feeling pertained to both the participants' experiences of NSSI and feelings of burdensomeness. As will be discussed later, participants appeared to strongly connect to feelings of guilt and were able to make sense of how, when

and why these feelings were so profound for them. At times, participants seemed to more easily relate to feelings of guilt in terms of engagement in NSSI (when compared to that of PB), but also related feelings of guilt back to burdensomeness (reasons for this will be discussed below). The superordinate theme of *I feel Guilty* consists of two sub-themes: *I feel guilty for being a burden;* and *Feelings of guilt can perpetuate NSSI.*

I feel guilty for being a burden

Throughout the interview process, participants tended to discuss their perceptions of burdensomeness on others (or on themselves) as a collection of thoughts, rather than a feeling of being a burden. The feeling identified as attached to thoughts of burdensomeness was almost always a feeling of guilt. Guilt was identified as a feeling that was experienced even after the individual had ceased to be such a burden on others, it was described as still remaining despite thoughts of burdensomeness no longer occurring. This idea is further illustrated by the following quote from Sarah:

> ***Sarah****:* *"Um, I had a, a, kind of, not a, yeah, kinda of a phase a while ago, about a year ago, and I still sometimes do feel a lot of guilt for kind of putting my mum through that, and my parents through that, but, and even sometimes now I feel like that and then kind of just tell myself to stop being silly, cos it's all years and years ago* [four years ago], *now. But um so yeah that, sometimes still comes up."*

The perception that while burdensomeness may dissipate with reduction of NSSI but the feelings of guilt may remain is also illustrated by the following quote from Laura:

> ***Interviewer:*** *"So do you feel like a burden on your parents now* [that you are no longer engaging in NSSI*]?"*

Laura: ***"****I don't know, sometimes, but I also feel more, guilty that I just have, I try to have minimal contact with them."*

It is evident that the feelings of guilt discussed by interviewees are long lasting, still being felt long after they were first initiated. In this way, feelings of guilt can be viewed as leaving a lasting scar on the individual, in much the same way that acts of NSSI may leave a lasting physical scar. Physical scars are difficult to avoid, and may be easier to observe or examine because they require an explanation, and likely prompt an individual to remember the circumstances surrounding episodes of NSSI. In contrast to physical scars, guilt can be hidden. This easy recollection of thoughts and feelings at the time they engaged in NSSI may act as a continual reminder for the individual, triggering feelings of the guilt that they felt around the time NSSI occurred. Just as physical scars left on the body are unable to be undone, it is not possible to undo thoughts and feelings experienced at some point in the past, and it is difficult to look back and conclude that particular thoughts and feelings may have been inaccurate - if they were experienced as accurate then, they are likely experienced as accurate now, and even though they may only be scars (memories), this does not necessarily make them any less psychologically painful to be exposed too.

While interviewee Andrew expressed his feelings in terms of feeling "regret" for the burden he had been on others in his life, the sense making appeared to be very similar to other interviewees and the feeling that even when he no longer perceived himself to be acting in a burdensome way, the feelings of regret and unease continued on.

This is further illustrated by the following quote from Andrew:

Andrew: *"I have my regrets for that, and I tried my best later on in the relationship to remedy those mistakes, but it's like the damage had already kinda been done."*

Andrew talks about making mistakes, while it is unclear exactly what Andrew is referring too, it seems likely that he is referring to his perception that he has acted as a burden on others close to him when he speaks of making mistakes ("I made her really unhappy" and "I was the anchor that weighed her down"), but not his engagement in NSSI. Andrew experienced strong feelings of burdensomeness, especially on his partner, he engaged in NSSI as a means of coping with these feelings. The way that Andrew speaks about his mistakes suggests that he is referring to times where he perceives that he has failed other people. Andrew's sense of failing other people appears to be when he is not able to be the strong person in his relationships, the person who is able to lift others, up, but rather drags them down. Andrew's focus in this part of the interview (and throughout most of the interview) is very much centred on the burden he has been to other people, his NSSI is simply a by-product of the mistakes that he believes he has made, a way to cope with the thoughts that he was and maybe still is a burden and the associated feelings of guilt and regret.

Other participants also described feeling guilty as a direct consequence of their PB on their loved ones. This idea of feeling guilty for being a burden is further illustrated by the following quotation from Sarah:

Interviewer: *So when you think about feelings of guilt and feelings of being a burden, like we talked about before, are those two things related…how do they fit?*

Sarah: *Yeah. Yeah, a lot.*

***Interviewer**: And are they similar? Do they feel similar to you?*

***Sarah**: Yeah. I think so, cos I think that's what, most of my guilt is over, just feeling kind of like a burden or just yeah, putting people through stuff.* [4]

***Interviewer**: So you, not only were feeling like a burden at the time, but then feeling guilty for being burdensome?*

***Sarah**: Yeah.*

Sarah describes her guilt and burdensomeness being linked, in that she is predominantly feeling guilty for being a burden on others (as suggested by Andrew in the previous quotation). In this way, Sarah's struggles with mental health problems, including depression and NSSI are also inextricably linked to both perceptions of burdensomeness and feelings of guilt. Sarah was brought up as a member of the Brethren church (an Anabaptist Christian denomination) who teaches the act of forgiveness, despite Sarah's father being a respected elder within this church, she does not appear to believe it possible for her family to forgive her for the burden she perceived that she was upon them. This perhaps provides some further insight into the extent of the burdensomeness Sarah believes that she inflicted on her family. Sarah shares a close relationship with her parents, and her continued strong feelings of guilt suggest that rather than seeking forgiveness from her family, she is in fact searching for a way to forgive herself for the burden she believes she was. When speaking about the guilt that they experienced, Sarah and other participants presented as

[4] Sarah was not asked explicitly what she meant by "stuff", however during the interview Sarah spoke about being a burden to her family in a number of ways - mental health struggles (including depression, NSSI and a suicide attempt), as well as rebellious teenage behaviours such as leaving the house without her parents knowledge to drink alcohol, and "being an angsty teenager and being quite angry."

somewhat ashamed, as less comfortable, as if they were speaking about engaging in an illicit act that should be kept secret. With Sarah it seemed that she saw her burdensomeness, and the consequent guilty feelings that were associated, as a part of her that she would rather hide, a part of her that she considered fundamentally flawed representing behaviours that she could not atone for. Perceptions of burdensomeness and feelings of guilt and NSSI appear to become a vicious cycle that is difficult for individuals to escape. The links making up this vicious cycle have been suggested in Figure 9.2 below.

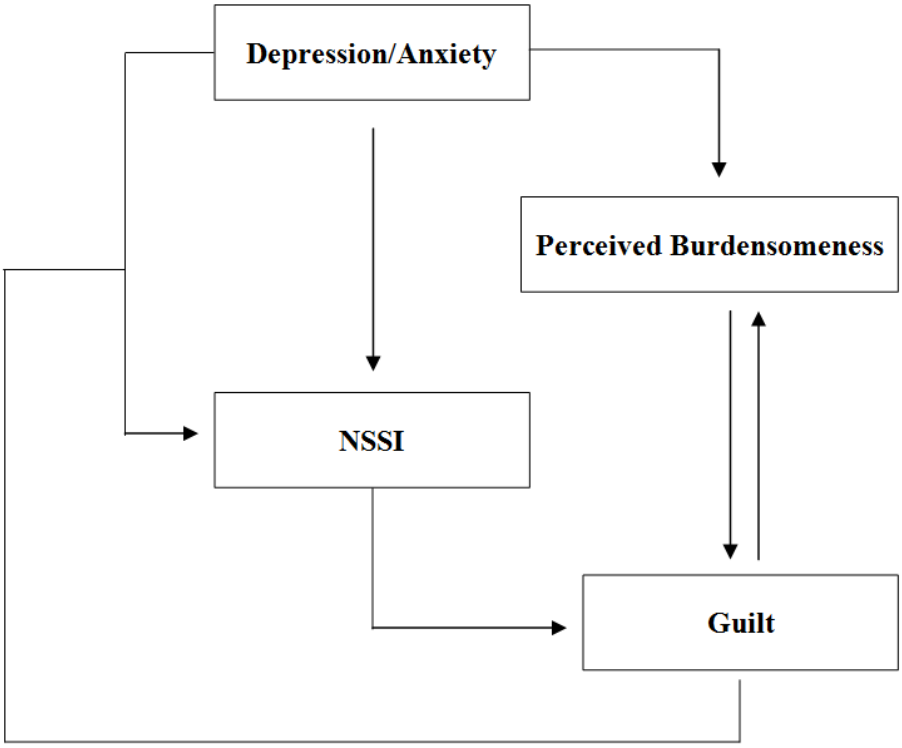

Figure 9.2. Proposed model of the interaction of perceived burdensomeness and guilt

Feelings of guilt can perpetuate NSSI

The feelings of guilt that were experienced by most of the interviewees served as a reminder to individuals that their behaviour perpetuated their perceptions of being a burden on their loved ones, this could therefore indirectly influence NSSI by acting as a discouraging force for help seeking. The more an individual seeks to keep their NSSI hidden from others, the more difficult it becomes for that individual to gain assistance from others and hence NSSI is likely to continue. Some participants discussed perceptions of being a burden as a factor that prevented them asking for assistance, as asking for assistance would confirm their burdensome nature. Therefore, perceptions of being a burden acted to discourage help-seeking, which in turn prevented individuals from finding ways to cease their NSSI behaviours. This is illustrated by the following quote from Laura:

> ***Laura:*** *"I don't know, it makes me feel pretty guilty, but, it also makes me more, not more, less likely to tell them if something's wrong, 'cos then they'll, they'll worry more, and then I'm more a burden, and so like it's more likely that I'm just like 'Nope, it's all fine'."*

The above quote from Laura represents somewhat short-term thinking, in that if she is a burden on her loved ones presently, protecting them by continuing to harm herself is likely to either maintain her burdensomeness or perhaps worsen it, rather than solve the problem of being a burden on others. This is reflective of the use of NSSI itself, as it is always only a short-term solution, with the problem that precipitated NSSI usually becoming apparent again a short time later; this is of course the reason that NSSI can become a chronic behaviour. This short-term thinking is likely to be reflective of the age of participants in this study; they are all young adults and thus may find it more difficult to take a broader thinking approach to problems. Decisions and actions are also likely to be somewhat more impulsive in young

adults and thus the solution that appears to be a quicker and easier 'fix' may be favoured over asking for assistance, which does not necessarily provide any immediate relief from the distress the individual is experiencing. It is likely that while struggling with NSSI, these participants were in an Identity Formation phase of development (Erikson, 1968); perhaps believing that they should be capable of dealing with their difficulties and that asking for assistance was childlike and therefore more burdensome than an individual of their age should be.

Other participants discussed a feeling of being overwhelmed by guilty feelings which they could directly relate to their NSSI behaviours. In the following quote from Sarah she explains how she no longer feels overwhelmed by guilt, and therefore does not feel the urge to engage in NSSI.

> ***Sarah:*** *"It's probably not so strong feelings of guilt* [around what Sarah put her parents through], *they're just kind of feelings I get every so often and just try to ignore them, because it's not that overwhelming [now]"*

The relationship between guilt, PB and NSSI is complex, and is discussed further in the Discussion section of this analysis. Guilt as discussed by Sarah is closely associated to the burden she perceived she was, particularly on her parents. Sarah mentioned at one point in the interview that her father refers to Sarah's difficulties with NSSI and suicide as one of the hardest times of his life, which acts to re-trigger Sarah's guilt for this period in her life. More generally guilt as discussed by participants appears to reflect a feeling of empathy towards others in their lives, and was discussed by participants as being a perpetuating factor for NSSI, both as a way to deal with difficult thoughts and feelings around being a burden and also because individuals were less likely to ask for assistance. Perceptions of burdensomeness and guilt, are likely to be accompanied by feelings of isolation, feelings that

one does not belong and perceptions of being unlovable or unworthy due to regret over behaviours or events (Selby et al., 2010), all of these often distressing thoughts and feelings are reflected in these interviews across a number of themes discussed.

Theme 3: I am Alone

Sitting alongside PB in the IPTS model is thwarted belongingness (as discussed earlier); this construct can be roughly described as loneliness. Despite not being directly asked about feelings of loneliness, interviewees were keen to discuss this area and how feelings of being alone affected them in different ways. Some participants discussed a sense of abandonment leading to their isolation, while others described it as being self-induced; these ideas make up the sub-themes that are discussed below. There was also a sense from all participants that they had a desire to be understood and accepted, especially by those close to them. The superordinate theme of "I am Alone" consists of two sub-themes: *I feel alone in the world and Being isolated made me less of a burden.*

I feel alone in the world

Participants spoke about being alone or being isolated in various ways, one of the strongest ideas across all interviews was the perception that the participant was different from other people in their world, that they were not understood and essentially did not belong. This is further illustrated by the following quote from Mia (at this point in the interview Mia was discussing her conclusion that she was engaging in NSSI for different reasons than other individuals' she knew who were also engaging in NSSI. Mia came to this conclusion because she preferred to keep her NSSI very secret, while her acquaintances told others what they had done, which was difficult for Mia to understand):

Interviewer: *"So what did it mean to you, when you realised that you weren't doing it [*NSSI*] for the same reasons?"*

Mia: *"Umm, it made me feel like umm, I didn't really fit in with them. I thought they were absolutely stupid for doing it for the reasons they were doing it. In hindsight I'm probably no better than them. So I felt quite left out, because yeah, I didn't think about it the same way as they did."*

Later in the interview Mia describes an example of feeling unwanted or unloved that contributed to her belief that she did not belong (and that she was alone in the world):

Mia: *" I tried to overdose and I actually, I ended up in hospital, and I remember the first time seeing her [*Mia's mother*], I, all I really wanted at the time was a hug and someone to tell me that it's okay, it's going to get better, but instead, she kind of just turned around and was like – 'you're ungrateful, I've worked so hard to give you a great life and you've kinda turned around and slapped me in the face with this'"*

Mia described her overdose as "taking it that step further"; however she confirmed that this self-harming behaviour was intended to end her life, unlike her previous self-injurious behaviours, which were not intended to end her life. Mia's quotation clearly illustrates how she may have formed perceptions of burdensomeness and guilt. Her mother's reaction is also likely to have reinforced beliefs that Mia held about being unloved and alone, she speaks of wanting a hug, a physical manifestation of one person's love for another, however her mother did not provide this expression of love, thus illustrating to Mia that she is not loved, she is undeserving and that she is a burden. Despite Mia's mother being present at the hospital, Mia feels very much alone, her mother is physically present, but emotionally

elsewhere (perhaps focused on her own reactions rather than Mia), having abandoned Mia's struggles to focus on her own. It is not surprising that Mia feels that her mother has abandoned her, as Mia's mother speaks as though Mia has set out to harm her (the mother), rather than engaging in harm against herself. This is likely to have been confusing for Mia, who tried to decrease the harm she perceived she was doing to others by attempting to end her own life. This quote also highlights the fear and confusion associated with self-injurious behaviours that Mia and also her mother are likely to have been experiencing at this time.

Mia's description of her transition from NSSI to a suicide attempt illustrates no real conscious planning or decision to end her life, until she actually took the overdose, she expresses surprise at having being able to make a suicide attempt (perhaps providing some insight into the relatively gentle transition to a suicide attempt that is available to those individuals engaging in NSSI). The quote from Mia below illustrates this:

> ***Interviewer:*** *"So what was the difference between when you thought, 'I'll self-harm' and when you thought 'I'll actually try and take my life'"?*
>
> ***Mia:*** "*I kind of surprised myself with that; I didn't think I could do that. But there was just nothing, there was no thoughts running through my head at all I just kinda kept going and going and going and that was it really."*

The above quotation is illuminating as it provides a clear illustration of acquiring the capacity to engage in self-injurious behaviours. Mia's explanation above also provides an illustration of the insidious, almost dream-like or intoxicating nature of transition from self-injurious behaviours without the intention to die to attempting suicide. While NSSI as a risk factor for suicide has been well documented in the literature, current risk assessment tools

and procedures would likely not have been able to predict that Mia was likely to make a suicide attempt in the near future.

Other participants discussed circumstances that led to them not being provided with the support needed to navigate the difficulties in life, leading to them feeling isolated and alone; despite having others around them. The following quote from Andrew further illustrates this:

> ***Andrew:*** *"My brother and I weren't getting the support we needed after our massive move and parents' divorce and then mum's not getting the support she needed looking after two kids acting up, and I feel like that just fed off each other and I became very independent very quickly and so did my brother, and we ended up looking out for each other quite a lot as well. Umm, but through that, because we were so independent, we didn't have anyone to look after us, or care for us, or love us, and it didn't feel like our mother did, our dad didn't really see us and all we had was all of these new people and a new town that we didn't know, so I felt very lonely."*

Andrew is describing a time that was perhaps very confusing for him. His parents, who up until now had been there to support him as he moved through life, were not able or not willing to provide the support Andrew needed as he traversed his adolescent years. Andrew doesn't question his mother's lack of support or care; instead he recognises that she was in a similar position to himself and his brother – without support and struggling. Despite being able to intellectually recognise that he, his mother and his brother were not getting what they needed, resulting in undesirable consequences, his reaction was to withdraw from those who should be his supports in life, and to attempt to become the adult he so needed. While

this was his solution, it did not serve to empower him or to make positive change; rather Andrew was left feeling unloved, unsupported and very lonely. This also speaks to the next sub-theme. While withdrawing may appear to not have served Andrew or his family well, it allowed Andrew to perceive that he was less of a burden on his mother, indirectly doing what he could to perhaps reduce the support his mother needed. Andrew speaks of "acting up". It is likely despite withdrawing and worries over being burdensome to his mother, Andrew's behaviours were in an attempt (either consciously or unconsciously) to gain the attention he was missing from the adults in his life, perhaps leading to further feelings of burdensomeness and/or guilt. It is not difficult to gain some insight into to the overwhelming emotions Andrew must have been facing throughout this period.

Interviewees also described being bullied by peers, which acted to increase their feelings of loneliness and further reinforce the thought that they did not belong. The following quote by Sarah provides an example of the impact of bullying:

> ***Sarah:*** *"I got bullied quite badly in high school around this time. Well from 14 until the end of high school (I think I was 18 when I left), I got bullied quite badly, and I was told things there like after I, um, tried to overdose, one of the guys who was friends with one of my friends, took her phone at morning tea pretending to be her saying stuff like, something, it was silly, but it was like 'Go take some more pills', do you think you've got a headache, I think you should go take some Panadol, no one here at school wants you anyway, there's no point in you coming back...'"*

Sarah discusses the rejection she experienced from peers after her self-injury was disclosed. It is likely that she felt alone and perhaps frustrated at this time. While the

comments and actions of her peers were hurtful, reinforcing negative thoughts she had about herself, she does not appear to care as much about the comments of individuals whom she does not share a close relationship with. Sarah discussed throughout her interview feelings of guilt and worry about being a burden on her parents. It is likely that she was not as negatively affected by school peers' comments because she is not as closely connected to these people, and therefore is unlikely to be a burden on them. Baumeister, Stillwell and Heatherton (1994) suggested that guilt is felt most strongly within communal relationships, where mutual concern would be expected, thus it is likely that while Sarah felt guilt for the burden she was on her parents, she would not experience the same level of guilt (if any) for people she does not share a close relationship with (or perhaps doesn't even like). While the quotation is discussing bullying at school, it also perhaps indicates that NSSI may be used as a coping mechanism following other experiences of trauma.

Being isolated made me less of a burden

While most interviewees discussed wanting a way to fit in, or somewhere to belong, Laura spoke a number of times about wanting to be left alone, and the almost suffocating presence of people who wanted to know how she was. While the feelings of not belonging were similar to other participants, her solution to these difficult thoughts and feelings was to further isolate herself. Laura used the phrase "Leave me alone" and expanded on her meaning five times throughout the interview. Below is a quote from Laura illustrating this:

> ***Laura:*** *"Yeah, but I, when I, everyone was like 'Ohh, it's so difficult' - I was kinda like 'Well just leave me alone' so, like you don't have to deal with me, I can deal with myself and you just worry about yourself, and, leave me alone..."*

Laura's preference to be left alone was in contrast to what was seen with other participants who had concluded that connection and belonging would assist them with their difficult thoughts, and perhaps assist them in reducing their perception of being a burden. Laura explained during the interview that if she could be left alone then she would not be a burden on others in her life, however she was also able to recognise that through pushing others away she was not gaining assistance for her difficulties.

While participants discussed wanting connection in their lives, especially from their loved ones, many discussed their assumption that they would be less burdensome to loved ones if they remained alone, despite this loneliness perpetuating difficult thoughts and feelings and thus most probably perpetuating maladaptive coping mechanisms such as NSSI. This is further illustrated in the following quotes from Mia who was told by her parents that she was a burden and that they didn't want to be around her:

Interviewer: "*Okay. So was there ever a time when you felt like you were being a burden?"*

Mia: *"I know this for a fact that their lives would be a lot better if I wasn't around them so much as I am now. And I can say that with complete confidence because I've been told that before."*

Interviewer: "*Has anyone overtly told you that you're a burden?"*

Mia: *"Yup, yeah. That they just want to be kind of left alone by me. I've, I've told some of my close friends about that, not many people. Umm and their reaction was more or less what I thought it would be – like 'why would they say that, they're your parents – they do love you' and all that kind of stuff. And I know they do but umm, I guess, an outside*

perspective is always going to be, you know, I mean I know that they love me but they, that's, that's how they feel,"

Interviewer: "*So before they actually told you, how did you know, were there other ways that you felt, like the reasons that you felt like a burden on them?"*

Mia: *"Yeah, they never really wanted to spend time with me. Umm, I'd always really ah, cos family means a lot to me, I'd always kinda make an effort to try and you know, just 'hey, do you guys just want to grab a coffee?' or something, 'we could catch up and umm…tell me how everything's going'. Umm…but they'd always kind of dismiss it and ah, sometimes, sometimes it did hurt a little bit, but…I guess when something happens so often, umm, you kinda just learn to accept that that's the way it is."*

Mia's discussion appears to contradict itself in places. Despite being told that she was a burden on her parents and feeling unloved, she states that she knows her parents love her, after consulting a third party. Later in the quotation Mia discusses her parents not choosing to spend time with her, despite Mia asking them too. It does not seem that Mia actually feels that she is loved by her parents. She attempts to make sense of this, and despite earlier clearly stating that she knows her parents love her, she later appears to conclude that in fact her parents do not love her, or at least do not love her in a way that is recognisable to her. She attempts to intellectualise the subject, perhaps saying something that she wanted to be true or she thinks should be true, but while she may tell herself and others that she is loved, it does not seem that she feels this. Mia's idea of what being loved should look and feel like is different to what she has experienced, however it is likely that she believes that this is her

fault as her parents consider her to be a burden on them. Mia would like to be loved, but she appears to be confused as to whether this is even a possibility for someone such as her, who burdens others as she does. Each time Mia was dismissed by her parents or her desire to be loved was not recognised, this would have reinforced her belief that she was too much of a burden to be loved. She seems to blame only herself for her lack of love.

While Mia stated that she knew that her parents did not want to be around her, and that they were better off if she was not around them, Grace had her burdensomeness communicated to her through the actions of a friend's mother, as well as her school friends, as is explained in the quote from Grace below:

Grace : "*I was very isolated from my peers and they, and when I was at school, I felt a real burden to them as well, because, they didn't know what to do with me you know, being 15 and 16 years old and having a friend, you know collapse in front of you all the time, is really frightening, it was really frightening for them and they didn't know how to deal with it, and nobody really knew how to deal with it.*"

Grace further explained her PB (due to having an illness) with the quote below:

Grace : "O*ne of my school friends (who had been really supportive up to that point), her mum said to her that she wasn't to associate with me anymore um, partially because of the cutting, but mostly because of the fainting, she was like 'She's being a burden on you, you shouldn't be having to look after her' … And then my friends got really over it, like really over it. Um, they were just like "get over it" and "just move on", stop being, you know stupid, essentially…*"

This experience was a difficult one for Grace, she experienced the loss of someone she found to be supportive, and likely felt rejected by her. She was then rejected by a number of other friends, experiencing her support system falling away. Rejection by peers is difficult (in Grace's case she was rejected by people she cared for and whom she thought cared for her, unlike Sarah's example of peer rejection above). Grace likely felt confused, upset and angry both at her peers, but perhaps also at herself for being so much of a burden on others that her friends no longer wanted to be around her anymore. Grace was also rejected by an adult who communicated Grace's burdensomeness, considering her to be so burdensome that she should no longer be associated with. This is likely to have reinforced Grace's belief that she was a burden to others, and perhaps widened the range of people that she was negatively affecting. The actions/statements of her friend's mother may perhaps have caused Grace to develop a fuller understanding of the burden she had become, because she was an adult and thus perhaps more likely to be believed. Grace made sense of her friends' actions by assuming they thought she was choosing to be burdensome and needed to 'snap out of it'. This complete lack of validation for Grace's struggles seemed to change her mind-set somewhat – Grace became angry, both at her friends but also at herself. Grace's anger appears to be a combination of a realisation that she was being burdensome to others and to herself, but also at others for pointing this out through their comments and actions.

Overall it appears that perceptions of burdensomeness act to perpetuate both feelings of loneliness, but also the desire to be alone. Despite feeling alone, desiring connection and love from others, the desire to avoid perceptions of burdensomeness, or at least not increase or exacerbate the burden individuals perceive they are on others has a stronger behavioural drive. In this way, perceptions of burdensomeness are self-perpetuating, as isolation acts to lessen burdensomeness, but in turn acts to increase perceptions of being alone and unloved which can lead to behaviours such as NSSI but also to continued feelings of burdensomeness.

Isolation acts as an avoidance strategy providing some relief in the short-term from difficult thoughts and feelings, but contributes to a vicious cycle of unhelpful behaviours in the long-term.

Theme 4: Shame

As well as a sense of burdensomeness around engaging in NSSI, there was also a common sense of shame when employing this coping mechanism. There is a common societal perception that young people engage in NSSI in order to gain attention from others. The interviewees spoke of going to lengths to ensure others didn't learn that they were engaging in NSSI as despite finding NSSI a useful coping mechanism, they often felt a sense of deep shame associated with the behaviour. The superordinate theme of "Shame" consists of two sub-themes: *I feel ashamed of NSSI* and *NSSI caused shame for my family*.

I feel ashamed of NSSI

Shame was brought up and felt in different ways by the participants. At times interviewees felt ashamed because of what they had failed to do during the times they were struggling with NSSI as is illustrated in the following quote from Andrew, who felt ashamed of his inability to be a support to his partner:

Interviewer: *"Can you relate that feeling of being the anchor that weighed her down to your self-harming?"*

Andrew: *"No. I feel like I couldn't relate it to my self-harm, I feel like it would be separate, 'cos all I really feel is shame, because, like, as someone's partner, you're meant to be there, you're meant to help support them, you're meant too, you know help them reach their goals, and not bring*

them down, and I just felt ashamed. In myself, because, or not good enough, 'cos I couldn't help her how I wanted too."

In the quote above Andrew comments that he sees his burdensomeness (weighing his partner down) as separate to his NSSI. He was very focused on his perception that he had failed his girlfriend and that he had not lived up to his own expectations of what a partner is meant to be. Shame has been described as promoting negative self-beliefs, fostering feelings of humiliation and worthlessness (Tangney & Dearing, 2002). Andrew definitely appears to consider that at this time, he was a failure, both in the sense that he has not lived up to his own expectations of himself as a partner, but perhaps also that he has not lived up to his perceptions of what society dictates makes a good partner. This causes Andrew to feel ashamed of his failure. It is likely that Andrew would like to succeed where he perceives that his own father did not. Andrew discussed the lack of care and support his father gave to himself, his brother and his mother, perhaps illustrating where Andrew has learnt the attributes of a good partner, through first-hand experience of a father who in his eyes has failed to be a good partner. Andrew has seen the burden placed on his mother by his father leaving, both directly by his father, but also through lack of support for caring for Andrew and his brother, highlighting the burden that they too posed on their mother.

Andrew discusses shame, perpetuating negative self-beliefs such as "I'm not good enough", however his meaning appears to also have a connection to guilt, feelings of guilt for being unable to provide what his partner needed. Andrew speaks of being upset with himself, focused more on the failing in himself than the effect it had on his girlfriend, this is likely why despite experiencing both feelings of shame and guilt, Andrew chooses to use the term shame at this point in the interview.

Grace described a very difficult situation at school where all of her peers found out she was engaging in NSSI, growing up in a small rural town in New Zealand, this inevitably meant that the majority of Grace's community then became aware of Grace's NSSI, resulting in her realising she had intense feelings of shame related to her NSSI. This is illustrated in the quote from Grace below:

Interviewer: *"So how did it make you feel that everyone saw this at once, something that you wouldn't have told them?"*

Grace: *"I think that's probably one of the worst things that's ever happened to me I think like that one, that, I mean it's not even the memory but the memory of waking up in hospital to a million you know texts from people, being like "what have you done to yourself", cos at that point, everyone thought that I was, that I'd tried to commit suicide, because I was unconscious and I hadn't, um, but, and then to find out everybody knew, like that moment, like I will always remember as being one of the probably worst realisations of my life. Um, and...I think I got held in hospital, under whatever that, not sectioning but the mental health thing, so they held me there under like a psychiatric hold or whatever, um, until, like the psychiatrist could come. Um, but it was awful, it was really, really awful. Really shameful, like I was, I just was, I was so embarrassed, and ashamed, um, that people knew what I'd been doing. Because it had all been very secretive, obviously and yeah."*

Grace experienced shame only after people became aware of her NSSI (perhaps highlighting one of the major reasons that individuals hide NSSI behaviours and seek isolation). While she was able to engage in NSSI alone, she was not ashamed of herself or

this behaviour, but rather it was only after anticipating negative judgement from others that she began to focus on the shame she was experiencing. Grace describes people finding out about her NSSI as "one of the worse realisations of her life", this change in circumstances illustrated just how introspective Grace had become, focusing only on her own thoughts and feelings with what appears to be an inability to consider a broader point of view. She does not appear to have any problem with NSSI itself, but rather on others' judgements of this behaviour. The need to keep the behaviour secret is perhaps associated with the effect it has for her, it is likely that exposure of her NSSI illustrates and/or represents to her a loss of the control that she considered she had as well as a realisation of the burden she may be perceived as in other people's eyes.

It is not clear exactly why Grace considers this 'outing' of her coping mechanism to be so catastrophic, it may be the feelings of shame alone, but perhaps NSSI becoming almost public knowledge in the small town in which she resides signifies a loss of NSSI as a coping mechanism. It is almost as though discovery of NSSI is like being caught in an illicit act, and being caught in the act shines a light on this behaviour, illuminating it for the undesirable behaviour that Grace perceives society considers it to be.

Figure 9.3 shows a revised version of Figure 9.2 above with the inclusion of shame. While it is clear that not all individuals' who are affected by depression and/or anxiety engage in NSSI, when NSSI is used as a means of emotional regulation, it is possible that feelings relating to depression and/or anxiety may drive NSSI behaviour.

NSSI caused shame for my family

As well as discussing how NSSI caused participants to feel ashamed of themselves and their behaviours, there was also discussion around the shame and stigma caused for

participants' family members, which led to an increase in feelings of burdensomeness for the individuals involved.

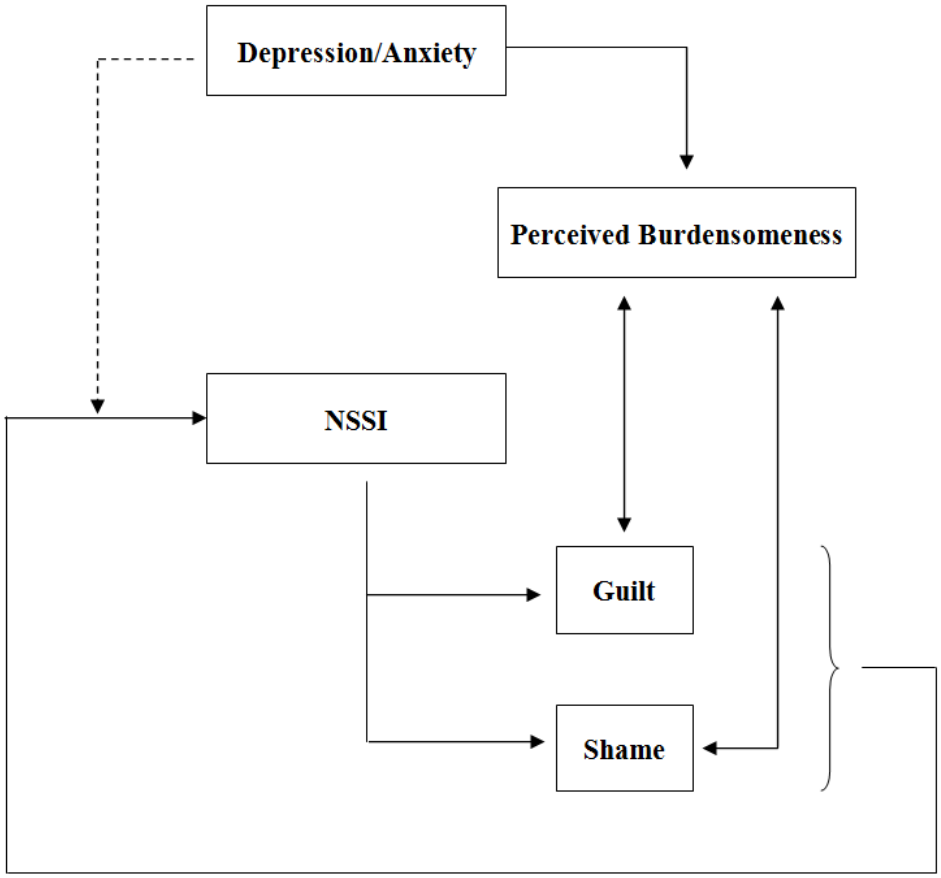

Figure 9.3. Proposed model of the interaction of PB, guilt and shame. The dotted line denotes a possible relationship between depression/anxiety and NSSI.

Mia's description of her mother's reaction after finding out that Mia had been engaging in NSSI further illustrates this sub-theme:

Interviewer: *"What did you think she* [your mother] *was thinking?"*

Mia: *All I can really think umm, all I can really think that she was thinking was 'how could you do this to me'. She's always made it very kind of*

clear that anything that I do impacts her, which is true to an extent, well it is true. But, umm, any kind of consequences…of my actions, you know, umm, it's more of the consequences to kinda her are more important than the consequences are to me, I guess in a way, if I'm kinda explaining it correctly. I think a good example would be when I actually came out to my parents, the first thing my mum said was, umm…'You do know that the family's going to talk about you? You do know that they're gonna talk about us? Umm, and that whenever we go see them they're gonna say bad things about us?' and I think when she said "us", she was meaning more her and my step-dad rather than me. Umm, I told her straight up that I didn't really care what they said about me, and she said 'well I know you don't care about what they say about you but what are they going to say about us?' So that was kind of a clear indication of, it was exactly the kind of things that she said to me when I was in hospital. She's like – 'you know you've ruined the rest of your life but now people are going to say that I'm a bad parent' and all that kind of stuff."

The consequences of Mia's behaviours on her mother are more important than the consequences for Mia herself. It is likely that the prioritisation of her mother's feelings above her own was something that had been going on for a long time, leaving Mia with little ability to understand and adaptively cope with her own difficult thoughts and feelings. It is very easy to see how Mia developed a belief that she is a burden on others - Mia believes that she comes second to her mother - and also that she deserves punishment. While Mia is able to recognise that her mother is not going to give her what she needs, she continues to seek the validation and love that she desires. It is likely that Mia thinks that if only she can be better,

then her mother will love her and give her what she needs. Mia was told numerous times that she was a burden – it was an ongoing theme when Mia was struggling. Added to this, her mother told her that she had ruined the rest of her life, this statement views the consequences of Mia's NSSI through a permanent lens, suggesting that the damage she had done to herself and the struggles that she is currently having are forever. While it is likely that her mother was referring to Mia's physical health/body, Mia may well have taken this statement to include her perceived personality flaws also. It follows then that Mia may have taken this to mean that she will be a burden forever, that her burdensomeness is also of a permanent nature. She is unable to undo the things that have caused her mother distress or worries about judgement from others (for example NSSI and coming out as gay). This is likely to have been very distressing for Mia, who wanted nothing more than to be loved by her parents in a way in which she recognised she was loved, she appears to have strived to do what she could to reduce her burdensomeness on her family but was caught in a very difficult position, as she was using her NSSI to cope with her feelings of burdensomeness, but by engaging in NSSI she perceived that she was being more burdensome to her family (she was told this by her mother), and without ceasing her burdensome status she would be unable to be loved by her parents. Thus she was caught in a vicious cycle which she could see no way out of, perpetuating her NSSI and her feelings of burdensomeness.

Sarah discussed some of the rebellious acts she engaged in as a teenager (for example sneaking out of the house to drink alcohol with friends); however she described NSSI as shameful for her family. She was unable to explain why NSSI was worse, simply saying that "…*anything to do with depression and self-harm and overdosing felt just shameful*…", providing some insight into the fact that perhaps NSSI felt very shameful due to its connection with mental illness.

Theme 5: This is how I Cope

All interviewees discussed the use of NSSI as a way to regulate difficult emotions, or to avoid emotions altogether – ideas that find support in much of the literature focused on emotional regulation as a function of NSSI. At least partially illustrated by the discussions with the interviewees is the self-perpetuating nature of NSSI. NSSI acts to maintain the lack of ability of individuals to more adaptively deal with difficult thoughts and emotions and can facilitate avoidance of the real difficulties. While NSSI is not intended to end an individual's life, use of NSSI as a coping mechanism may lead to self-injurious behaviour that result in accidental death (despite no specific plan to end one's life) or to impulsive suicide attempts. The superordinate theme of "This is how I Cope" consists of two sub-themes: *NSSI is my coping mechanism* and *NSSI allows avoidance of the real problem*.

NSSI is my coping mechanism

All interviewees discussed NSSI as being a way of coping with difficult thoughts and emotions. NSSI was described as being an effective coping mechanism that felt at times, addictive and habitual. In the quote from Grace below, she describes how something that began as a punishment for how others had made her feel, became something she regularly relied on:

> ***Grace***: *"I started fainting a lot, so I was fainting about six times a day, having a lot of panic attacks and anxiety around that, and so the self-harming kind of evolved as a coping mechanism for that, cos I couldn't, I was, my life was so kind of out of control.*

At a further two points during the interview Grace provided additional explanations about her use of NSSI as a coping mechanism:

***Grace**:* *"Umm, and then it became such an effective coping strategy, that I was like, oh actually this really helps me feel better, I'm going to carry on doing it, and when I, you know when I found out people were saying XYZ about me, it definitely was kind of like, okay, well I'll cut more, I'll cut deeper, I'll do it worse so people will actually take me seriously."*

"It was such a sort of effective coping mechanism at the time for me that it's difficult to like not just immediately go back to that."

Grace was coping with the fact that she felt she was a burden on her family and friends. Her sense of burdensomeness was for the most part due to an illness she was struggling with at the time. In these quotations Grace is explaining how she used her NSSI both because it made her feel better, by allowing her to avoid her difficult thoughts and feelings, especially around perceptions of being a burden, but also because it allowed her to flag to others that she was struggling. NSSI appeared to make sense to Grace for a number of reasons; she was able to take out her frustration on herself, for being burdensome to others around her, but also likely because her distress was not being adequately attended too. Grace has a complicated relationship with NSSI, she uses NSSI because it is effective for her, but would like assistance to cope in a different way, unfortunately when those around her do not respond in the way that she would like, she returns to her trusted coping mechanism both to punish herself, to avoid the actual problem and in an attempt to show those around her that they are getting things wrong for her. In Grace's case, she does not appear to see NSSI as being burdensome in isolation, but rather a physical representation of the burden she feels she is to others and the frustration she feels towards herself for being ill, and thus a burden on

others, for being in her view abnormal and therefore facing the judgement of others, and because others are not providing the assistance she thinks she requires.

Andrew described the habitual nature of NSSI and spoke of the safe feeling that NSSI provided which was powerful enough to allow for him to disregard the downsides of engaging in NSSI. This is further explained in Andrew's quote below:

> ***Andrew:*** *"It feels safe, it feels familiar, it feels common, I feel like, that's just what happened it became familiar, and common, it wasn't scary, it never became nerve wracking, it was, it just became the norm, something, as a coping mechanism. If I wasn't getting drunk, or abusing a substance, or both, then I'd be self-harming."*

Andrew spoke of NSSI as he might a good friend, someone who took care of him, someone who was always there for him and who made him feel safe. Andrew spoke of having little containment in his life after his parents divorced, he spoke of growing up very fast and watching his mother struggle in the absence of the support she needed. Many young people would look to their parents to provide a safe place for them, familiar surroundings where they were able to relax, however Andrew did not have this option, rather he had to take care of himself from a young age. NSSI was a constant for Andrew, something he had control of, and something that allowed him to continue to function the best way he could. There are a number of obvious costs to NSSI that should be reflected upon when looking at the benefits of such a coping mechanism; however the potency of having a mechanism that allowed Andrew to escape his difficult thoughts and feelings was greater in his mind than any costs that accompanied the behaviour. Now, reflecting back on some of those costs, Andrew has some regrets, but it is likely that he did not have any better way of coping with things at that time. Andrew speaks of using alcohol and other drugs as other coping mechanisms that

are useful in the short-term, but not so much in the longer-term, he describes having very little ability to spend time without using at least one of these coping mechanisms, this speaks to the level of distress that Andrew was obviously in, but also to his lack of adaptive coping mechanisms. It is likely that Andrew felt less burdensome on others and more in control when he was able to use particular coping mechanisms, as he would have felt unable to cope without them. However it is likely that Andrew's perceptions of being a burden on himself would have increased, as he was unaware how to exit the vicious cycle of avoidance by use of NSSI, and abuse of alcohol and other drugs. During this time period Andrew chose to engage in abusive coping mechanisms, in order to try to live as successfully as he could, with the hope of lessening his burden on others.

Laura described feeling worse about her NSSI and more of a burden to her parents, due to their inability to accept NSSI as her coping mechanism. Laura felt that she had her NSSI behaviours under control, and would have preferred her parents to ignore them, as their worry made her feel worse, feeding into the vicious cycle of engagement in NSSI. This is further explained in the following quote from Laura:

> ***Interviewer:*** "*What do you think she* [your mother] *could have done, or how do you think she could have acted?"*
>
> ***Laura:*** *"I don't think she should have pushed on me that she felt bad about it, that she felt like she'd made a mistake, because, at the time, I was just kinda like, this is just me trying to cope, umm, it's nothing about you, and now I'm feeling bad, that you feel bad, even though I don't want you too."*

Laura's quotation above describes a reciprocal burdensomeness, between herself and her mother. She is very clearly feeling burdened by her mother's expression that her

behaviours have such an effect on her. Laura would rather not know her mother's difficult thoughts and feelings as this knowledge acts to burden Laura, and to cause her to consider how much her mother is currently struggling due to the mistakes she feels she has made. At the same time, Laura is reminded of the burden she is placing on her mother currently, because her behaviours are causing her mother distress. Laura uses NSSI as a coping mechanism, it works as she is able to avoid facing difficult thoughts and feelings (such as the burden she is on others around her) and she feels frustrated at her mother because she is not allowing her to make full use of the coping mechanism that NSSI is for her – where NSSI used to make her feel better (at least in the short-term), her mother's disclosure of her own struggles and her own worries that she burdened Laura cause Laura to feel badly again. Laura states that she doesn't feel that her mother should have told her about her struggles, she discusses this as if her mother made a conscious choice to act in a burdensome way to Laura. Laura appears unable to acknowledge that her mother's struggles likely come from a place of caring for her, despite the fact that ironically, Laura has a similar internal reaction to her mother's struggles. Both women see the other struggling and feel badly about it, however neither one knows how best to communicate this to the other, leaving them both unable to move through their current difficulties and both feeling they are a burden to the other and they are burdened by the other.

Laura states this is her trying to cope, that this is her coping mechanism, but it is also possible that another function of her NSSI is to gain the attention and assistance she needs from her mother. In this way it is perhaps a coping mechanism but also an attempt to work to alleviate the difficulties Laura is experiencing, in order to move forward and to feel better (without the need for NSSI).

NSSI allows avoidance of the real problem

Some participants were able to describe their awareness that NSSI was actually an unhelpful coping mechanism in the long-run, despite it being viewed as their only method of coping that they had considered, or were willing to use at the time. This is further illustrated by the following quote from Mia:

Interviewer: *"So how did you make sense of that?"*

Mia: "*Umm I just put it down to it was how I coped with things, it was my way of coping with things, that's, umm, everyone would, obviously everyone coped with things differently and I just thought that was the way I, I did it myself, and I thought that was a good enough reason, and I think that's why it went on for so long because I wouldn't get help."*

Mia went on to further explain this:

Mia: "*I kind of thought to myself – 'well this is how I cope with things, what am I going to do if I don't have a coping mechanism'? I'm just gonna, you know, fall over, and not be able to get back up."*

Mia acknowledges here that her choices caused her to be a burden to others around her, not only due to continuing to engage in NSSI, but by either a reluctance or perhaps an inability to seek out alternatives for coping with her difficulties. Mia describes not being able to see an alternative that would provide her with the same relief from her difficulties as NSSI was, and this was a greater motivator for Mia than the burden she was to her family.

Hannah was able to succinctly discuss how her NSSI was acting as an avoidance technique for the real reasons causing her to want to harm herself, despite this NSSI is still a regular coping mechanism that Hannah employs.

Interviewer: *"So that's something that obviously works well for you?"*

Hannah: *"Yeah. Um, like short term it works well for me, but it also means that I ah, I guess end up avoiding the actual reason that I want to self-harm. Um, but yeah, short term is okay."*

It is easy to assume that individuals who engage in NSSI do so because they don't realise the unhelpful cycle they are getting into and perhaps even that they don't understand the triggers or drivers behind such behaviours, only that they are not feeling good and NSSI helps them to feel better. However Hannah is able to explain that NSSI is only a temporary distraction to what is really acting to make her feel unhappy. This quotation therefore, is not unlike the one above from Mia, in that Hannah is aware that her choices to engage in NSSI are burdensome on others, but she is unwilling to attempt to find a longer-term solution that may assist her in ceasing NSSI altogether. It is unclear why Hannah considers the temporary fix a better option than looking for longer-term coping mechanisms, but it is likely that distress tolerance is difficult for Hannah and indeed for most of the participants. Facing and working through the "actual reason" that Hannah is engaging in NSSI is most probably a daunting prospect for Hannah, so she chooses to avoid the problem. Objectively she is able to see that taken with a big picture view, NSSI is not assisting her to lessen the things she is struggling with. However when she is experiencing distress, use of NSSI is so effective that she makes the choice to engage in this behaviour. This provides some illustration about how potent a coping mechanism NSSI can be.

CHAPTER TEN – DISCUSSION OF IPA

Discussion of Interpretative Phenomenological Analysis

The aim of this qualitative study was to explore themes, narratives and meaning making of burdensomeness amongst a New Zealand population of young adults who have engaged in self-injurious behaviours. Five superordinate themes emerged from the interviews that encapsulated the participants' experiences. *Experience of Burdensomeness* illustrates the strong feelings of burdensomeness that exists within this population, and the way in which burdensomeness may perpetuate difficult thoughts or feelings which in turn may perpetuate NSSI behaviour. The second theme, *I feel Guilty*, was closely related to the first theme, in that participants often expressed experiencing feelings of guilt for being burdensome on others. Theme three, *I am Alone,* captures how extremely isolated participants felt at times during their engagement in NSSI behaviours and their desire to feel understood. The fourth theme, *Shame,* was illustrated by participants' strong desire to avoid having others find out about their NSSI behaviours due to fear of the judgement that would inevitably follow. The final theme, *This is how I cope,* captured how hugely effective NSSI can seem for coping with difficult thoughts and emotions, and the inability or lack of desire for interviewees to find a more adaptive method of coping.

Theme 1 – Experience of Burdensomeness: The first theme explored the participants' perceptions of feeling like a burden. All participants had engaged in NSSI for an extended period of time, and all participants had made at least one suicide attempt. Initially the idea of feeling like a burden on others was kept as a broad consideration, but as participants' were able to relate this idea to their own lived experience, more in-depth discussion was had. All participants were able to strongly relate to feeling like a burden on others, which at times acted to perpetuate engagement in NSSI as a form of self-punishment, as predicted by the

self-punishment hypothesis (Maniglio, 2011; Vaughn, Salas-Wright, Underwood, & Gochez-Kerr, 2015; Zoroglu et al., 2003), but also aligns with much of the current literature that suggests that NSSI is used as a form of emotional regulation (as discussed for Theme five). The idea that one may feel they are a burden on themselves provides an idea of just how intensely all encompassing feelings of burdensomenss can be. There are perhaps ways to work towards lessening your burden on others (for example, as discussed above, isolation may lessen perceieved burdensomeness), however there is no effective or adaptive way to isolate one from oneself and thus lessen the perception of being a burden.

Perceptions of being a burden on others appeared to be enhanced by factors pertaining to the developemental phase that participants were transitioning while they were engaging in NSSI. All participants began self-injurious behaviours during adolescence, the phase in life when Identity Formation (Erikson, 1968) occurs. Identity is subjective, it refers to feelings of sameness and a sense of stability across both time and context (Claes, Luyckx, & Bijttebier, 2014). This important developemental stage of adolescence and early adulthood is viewed by Erikson (1968) as a tension between identity synthesis (the extent to which the components of identity seem to fit together and identity confusion (a lack of intention and direction in life, where life defining choices cannot be made), it is the developmental stage where a sense of self is formed. Identity formation coincides with individuals taking more responsibilty and beginning to live more independently from the people who have cared for them as they have grown up, it seems likely that a sense of burdensomeness may be experienced when an individual believes they should be moving to a more independent phase of life, but instead feel somewhat lost and unable to move forward as they will have seen peers and siblings do. Thoughts such as "I should be able to look after myself" may lead to feelings of failure, confusion and perceptions of being a burden on others around them. These feelings are likely perpetuated by engaging in NSSI. Research has suggested that engagement in NSSI is

indicative of identity confusion, and it has been reported that NSSI is negatively related to identity synthesis and positively related to identity confusion (Claes et al., 2014). Lower levels of self-esteem have been reported by adolescents who engage in NSSI (Hodgson, 2004) perhaps making it more difficult for individiuals to achieve identity synthesis and more likely to experience perceptions of burdensomeness on others. This developmental period is associated with individuation from parents, when this individuation is hindered, or not what may have been expected or desired, perceptions of burdensomeness may be increased and perpetuated, as was seen in Grace's experience.

A powerful illustration of the burden that Andrew felt was his description of feeling like an anchor weighing his partner down, giving a sense that he was a perpetual burden, but having an understanding that this was the only way he knew to survive. The participants often portrayed the experience of being overwhelmed by their feelings of burden, both on others and on themselves. Discussions around the universality of burdensomeness gave a sense that these very difficult thoughts and feelings were inescapable, yet the individual was the burden, so the escape that would have provided the reprieve for these individuals was escape from themselves – NSSI provided that escape, at least temporarily. Further, if one's experience is that they need to escape themselves, then it must be difficult to believe that others would not want to escape them also. If the experience of an individual is that they are a burden on both themselves and everyone around them, then it may be expected that a belief that everyone would be better off without them may develop. This is important because it perhaps provides some explanation around how and why repeated NSSI can be a precursor to suicide attempts, and death by suicide.

The notion of feeling less burdensome when helping others is likely to be helpful for those struggling with perceptions of burdensomeness and NSSI, as it has been suggested to provide some reprieve from difficult thoughts and feelings. This finding is in line with

studies focused on the effects of altruism on wellbeing. One such study reported that engaging in altruistic behaviours was associated with increased well-being in adolescents. The authors of this study proposed that engaging in altruistic behaviours require the individual to focus on others, rather than remain internally focused. This outward focus allows for an interruption and respite from one's problems and challenges, and this disengagement from one's own problems allows for enhancement in perceived quality of life. (Schwartz, Keyl, Marcum, & Bode, 2009). It is therefore likely that helping others as described by participants in this study resulted in a reprieve from the overwhelming perceptions of burdensomeness they were experiencing.

The perception that young people who are engaging in NSSI are doing so to gain attention from others is not supported by the analysis found here, instead participants desired to hide their NSSI behaviours from others for a number of reasons both to protect others around them, but also to protect themselves from stigma and bullying. Some participants were equivocal about exposing their NSSI to others, as they desired a physical representation of the psychological pain that they were experiencing. It seems that physically showing the struggle that the individual is experiencing is much easier than speaking about it directly. Unlike behaviours/actions/events that cause physical pain, the causes of psychological pain cannot be seen directly and cannot be easily quantified by another person; therefore translation into a physical wound may allow an individual to feel that their struggles are being heard or that they are real. Ascertaining the function behind an individual's desire to either hide their NSSI or not would be helpful clinically.

It is important to realise that an individual's definition of what they deem to be burdensome may differ from that of others, and as such a strong sense that one is a burden on others could easily be missed in either a clinical or family setting. There was a strong sense of feeling unloved and unloveable amongst the participant responses. This is linked to

perceptions of brudensomeness, as participants appeared to consider that it was more difficult to be a burden on a person if you are loved by them, rather than simply being assisted out of an obligation (for example, one may consider that a parent is obligated to take care of their child, or a teacher is obligated to ensure the safety of a student while they are at school). This raises the question, that perhaps if an individual felt loveable and loved, would their perceptions of burdensomeness be less? This would emphasise that percieved burdensomeness is a social and reciprocal experience, rather than a personal or private one.

A strong link was seen between the themes. Thoughts and feelings around burdensomeness were described as leading to feelings of guilt, and the idea that one may be less of a burden by remaining isolated, and not asking for help. Feelings of guilt or perceptions of burdensomeness then perpetuated engagement in NSSI as a way to cope with the difficult thoughts and feelings the individual was experiencing. While participants often recognised that the lack of help-seeking was acting to prolong their engagement in this maladaptive coping mechanism, there was also a strong urge not to ask for help, due to fears that they would become more of a burden to those around them. This appears to be a significant factor in the chronicity of NSSI behaviours, and highlights the importance of targeting perceptions of burdensomeness when working with young people engaging in these behaviours. Participants felt strongly ashamed of the behaviours they were engaging in, and again this acted as a barrier to seeking assistance, or searching for another way to cope with their difficult thoughts and feelings

Theme 2 – I feel guilty: As mentioned above, throughout the interviews, the idea of perceptions of burdensomeness as thoughts, which induced feelings of guilt became clear – that is to say, the relationship between the two appears to be – 'I think I am a burden and I feel guilty about this'. At times participants could discuss the two constructs separately, but when a deeper understanding was sought, individuals almost always made a similar link. The

feeling of being guilty, while often brought about by thoughts of PB, did not dissipate just because perceptions of burdensomeness were no longer as strong, or even when the individual was able to acknowledge that they were no longer a burden on others in their lives. Feelings of guilt appeared to lessen, but at a rate much slower than that of perceptions of burdensomeness. This is perhaps a rather helpful experience, because the IPTS would suggest that an absence of those perceptions of burdensomeness greatly lessens the risk of an individual engaging in a suicide attempt. As mentioned above feelings of guilt also acted to perpetuate engagement in NSSI. In this way feelings of guilt are burdensome themselves and while this was not a concept mentioned by interviewees, the feeling that one may not ever be able to escape the unpleasant feelings of guilt they have, may act to perpetuate other feelings, such as depression, anxiety or low self-worth.

The relationship between guilt, PB and NSSI is complex, however the individuals interviewed have reflected on explanations and understandings that highlight some of the ways that these constructs and behaviours are connected. Rogers, Kelliher-Rabon, Hagan, Hirsch and Joiner (2017) conducted a study and reported a relationship between guilt and suicide risk, accounted for by PB, the findings from the current analysis appear to suggest a similar relationship between guilt and NSSI.

Theme 3 – I am alone: This theme was made up of a number of different experiences and understandings of NSSI and PB. While all participants spoke about the idea of being alone, some spoke of deliberately isolating themselves (which lessened their perceptions of burdensomeness), some spoke of using NSSI to feel less alone (as they met other people who were often struggling in similar ways), and some spoke of feeling abandoned by those they wanted to be close too. All of these similar yet different experiences may align with the IPTS construct of thwarted belongingness as the fundamental human need to belong is not being met. Even those individuals, who suggested purposeful

isolation, seemed to make this choice due to the need to reduce their burdensomeness, or prevent others from learning of their ill-fitting behaviours (i.e., NSSI behaviours). Rather than attempt to fit in when they felt they did not belong (due at least to feelings of PB) these individuals chose isolation. It is likely that a choice to be isolated may also have aided these individuals in managing some of the strong negative emotions that resulted from the knowledge that they did not belong (avoidance).

If we were to look at this IPA analysis in terms of the IPTS, we would predict that each of these individuals was at high risk of making a suicide attempt (for the period that was discussed during interviews). Each of the individuals in this study experienced thoughts and feelings around PB, each of them experienced some form of thwarted belongingness (or isolation) and each engaged in chronic NSSI (likely providing the acquired capability for suicide). The fact that all of these individuals discussed making at least one suicide attempt during the time period they were engaging in chronic NSSI, is very much in support of the IPTS.

As discussed above, this analysis highlights the insidious nature of transition from NSSI to attempting suicide. Analysis suggests that perhaps the likelihood of this insidious transition may be increased if an individual makes the decision to willingly embrace isolation, as a way of minimising perceptions of burdensomeness indirectly leading to (or perpetuating) NSSI behaviours. Some individuals did make the choice to be alone, as they described feeling less burdensome in isolation. Isolating one's self was therefore used as a form of avoidance of difficult thoughts or feelings, and is important in the context of risk, as while choosing isolation may lessen perceived burdensomeness, it may inadvertently be increasing overall suicide risk. This finding appears to be similar to that reported in the current literature, with a recent review concluding that social isolation is strongly associated with suicide (Calatia et al., 2019). It is therefore suggested that thorough risk assessment

should include an in-depth investigation of perceptions of belongingness as well as perceptions of burdensomeness.

Bullying, as well as feelings of rejection and abandonment were also discussed by participants. The experience of being bullied by peers and difficult feelings such as rejection and abandonment are likely to reinforce beliefs that one is not good enough, is unloved and unlovable. These beliefs may directly contribute to feelings of burdensomeness and the desire to engage in NSSI. Rejection and feelings of not belonging are particularly difficult during the adolescent period when fitting in and being part of a group are usually considered to be highly important (as discussed above) and the lack of such things contributed to feelings of burdensomeness.

Theme 4 – Shame: This theme was informative as anecdotally there appears to be a societal perception that young people engage in NSSI in order to seek attention. All the participants in this study sought to conceal their NSSI behaviours and felt that the NSSI behaviour was something that they should be ashamed of as it brought shame and stigma not only on themselves, but on their families. Again this could be related to perceptions of burdensomeness. Firstly, because participants described hiding their NSSI behaviours from loved ones so as they would be less of a burden on their families, therefore reducing help seeking and perpetuating engagement in NSSI. Secondly, because participants were aware of the stigma that exists around not only NSSI type behaviours but mental illness generally, and described not wanting to bring shame upon their families as a result of their behaviour.

The terms guilt and shame are often used interchangeably, however the two are distinct emotions (Dearing, Stuewig, & Tangney, 2005), shame is considered to be one's feelings about the self and thus feelings of shame pose danger to the self, guilt tends to be a more localised emotion, as it can be attributed to one behaviour or event (Tangney & Dearing, 2002). This perhaps indicates why people speak of guilt more readily than shame,

because feelings of shame speak to who a person is, or believes they inherently are, and thus refers to a much more permanent or long-lasting attribute of a person. Feeling guilty is uncomfortable, and can be difficult to experience, however guilt is able to be more easily separated from who a person is, associated more with what the person did. Studies examining alcohol use problems and their link to shame and guilt have suggested that shame (but not guilt) predicts reduced ability to psychologically adjust or ability to reduce tension leading to alcohol use problems (Treeby & Bruno, 2012), as problem use of alcohol often serves similar functions to NSSI (especially in terms of avoidance and emotional regulation), it is possible that shame conveys more serious or long term engagement in NSSI than guilt does. Or perhaps that perceptions of guilt lead to perceptions of shame. Research has found that perceptions of guilt are more likely to drive compensatory behaviours than shame. As when one feels guilt over their behaviour they are thinking of the people whom they have done wrong too, conversely when one experiences perceptions of shame, they are focused on themselves, tending to want to be unseen by those that they may have affected or those who have judged them (Lindsay-Hartz, 1984), this is perhaps one of the reasons that individuals who engage in NSSI find it difficult to ask for assistance, and thus continue in the vicious cycle of guilt, shame and NSSI.

It seems likely from the experiences of these participants that guilt and shame are closely connected for them, becoming part of a vicious cycle, where perceptions of burdensomeness cause perceptions of guilt and shame, and perceptions of guilt and shame represent the burden the individual is.

Theme 5 – This is how I cope: Theme five speaks to NSSI being a useful coping mechanism for individuals and relates to all four of the previous themes, as thoughts and feelings around burdensomeness, guilt, loneliness and shame are all difficult to cope with and therefore likely all acted to perpetuate engagement in NSSI. All interviewees discussed the

use of NSSI as a way to regulate difficult emotions, or to avoid these emotions altogether – ideas that find support in much of the literature focused on emotional regulation as a function of NSSI. There were different reasons given for why this coping mechanism was useful, but potency of NSSI was well described by all participants.

NSSI works; it meets the need to avoid dealing with difficult thoughts and feelings, that are emotionally painful and overwhelming (including perceptions of being a burden on those around them and the associated feelings of guilt and shame), but also overwhelming feelings of being unloved and unlovable. NSSI was described as providing a calming effect, a numbing effect, a distraction, and a physical manifestation of emotional pain. It was at times spoken about in the way one may speak about a good friend who provides comfort when one is distressed, showing strong parallels to that seen amongst individuals with eating disorders who engage in restriction, and purging behaviours (Muehlenkamp, Takakuni, Brausch & Peyerl, 2019). Engagement in NSSI became habitual, almost part of the individual's personality, their identity – when I'm distressed this is what I do. NSSI as a means of emotional regulation has been reported as the most common function for engagement in NSSI (Bresin & Schoenleber, 2015; Gratz & Chapman, 2007; Klonsky, 2007; Nock, Prinstein, & Sterba, 2009; De Riggi, Moumne, Heath, & Lewis, 2017), despite it's very temporary effect and thus it is not surprising that this function of NSSI was reported by participants.

The results seen in this analysis were in agreement with Adler and Adler (2007) who discussed the way that NSSI can be at times impulsive, but can also be planned and completely intentional (both were seen amongst the interviewees in this study). The use of NSSI as a means of punishment to either themselves (for being burdensome) or to others (for making them feel burdensome) was also strongly reflected in this analysis. It was informative to note that most participants realised that more adaptive ways of dealing with

their difficulties would be helpful, but the effect of NSSI as both a means of avoidance, and punishment was so strong in most cases, that it was difficult to make a decision to either seek help or to cease the behaviour all together.

Final Proposed Model

Figure 10.1 shows the final model, proposed following analysis and including all factors discussed, illustrating the overall findings of the IPA. It is quite clear from this analysis that PB along with perceptions of guilt and shame should be thoroughly investigated when assessing and monitoring risk, particularly in those individuals who engage in NSSI behaviours. The proposed model suggests that PB indirectly leads to engagement in NSSI behaviours, via guilt (which appears to lead directly to NSSI behaviours) and shame, which leads to avoidance or isolation and in turn leads to NSSI behaviours. As discussed above, the dotted line denotes a possible relationship between depression/anxiety and NSSI.

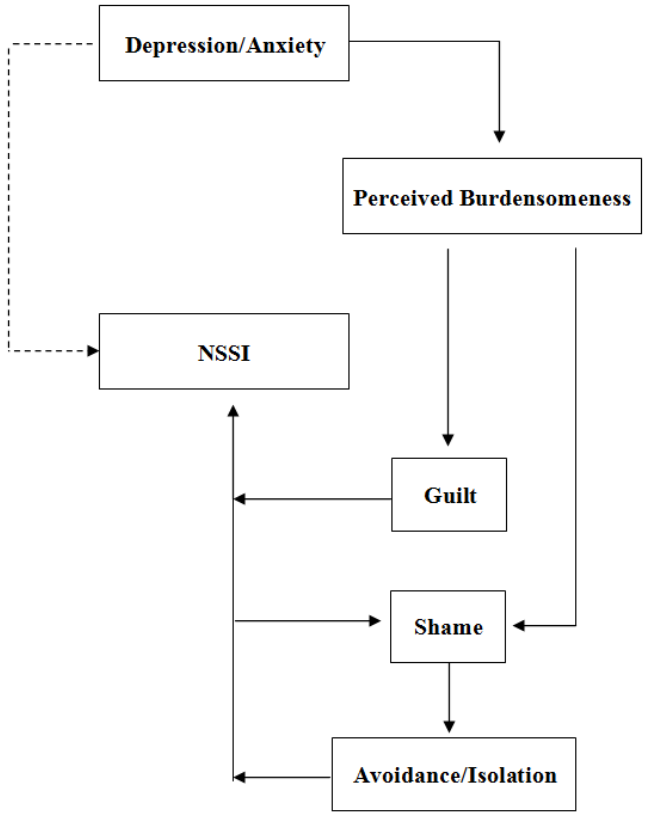

Figure 10.1. Final proposed model of the interaction of PB, guilt and shame.

CHAPTER ELEVEN: CONCLUDING DISCUSSION

Summary of Key Findings

Engagement in non-suicidal self-injury (NSSI) is known to be a key risk factor for making a suicide attempt (e.g., Victor & Klonsky, 2014), a greater predictor than even past suicide attempts (Wilkinson et al., 2011). A thorough understanding of NSSI and how it might be related to suicidal behaviour is therefore considered important for studies into self-injurious behaviours. Joiner's Interpersonal-Psychological Theory of Suicide (IPTS) discusses three main constructs for death by suicide to occur, acquired capability, thwarted belongingness and perceived burdensomeness (PB). Of these three constructs, PB is the least well understood. This study aimed to gain further insight into the role of PB and its relationship with NSSI and to explore meaning making around PB for individuals who have engaged in NSSI, asking the questions – does PB exist on a continuum aligned with intent behind self-injurious behaviours. This study is the first to explore a relationship between PB and NSSI in a New Zealand population and one of few that has included a mixed methods approach to investigating this relationship. This study focused on New Zealand youth (aged 18 – 24 years) and consisted of a survey of 159 people and an interpretative phenomenological analysis (IPA) consisting of six semi-structured in-depth interviews exploring the themes, narratives and meaning making of PB for individuals who had engaged in NSSI.

A total of 51.6% of the study sample endorsed having engaged in NSSI at least once; this finding was slightly higher than that reported by Garisch and Wilson (2015), who reported lifetime history of NSSI as 48.7% in a sample of New Zealand adolescents. A slightly higher rate might be expected for the current sample, due to the older age of participants. Of those who had engaged in NSSI more than one third experienced PB on

others in their lives, despite the majority (86.8%) of these individuals never having made a suicide attempt. This finding together with previous research that has reported NSSI to be a significant risk factor for suicidal behaviour (e.g., Asarnow et al., 2011; Victor & Klonsky, 2014; Wilkinson et al., 2011) and the research on the IPTS (e.g., Van Orden et al., 2010; Joiner, Ribeiro & Silva, 2012) is supportive of both a link between PB and NSSI, but also of the possibility of a continuum existing between NSSI behaviour and suicidal behaviours. Further evidence of the existence of such a continuum was seen when looking at rates of PB across different self-injurious groups, with levels of PB increasing as engagement in self-injurious behaviours worsened (from no self-injurious behaviours to engagement in NSSI, to engagement in NSSI and making at least one suicide attempt and finally to suicide attempts only), showing a positive linear relationship.

Qualitative findings suggested that individuals not only experienced perceptions of burdensomeness on others, but at times also felt that they were a burden on themselves, leading to a need to escape themselves, suggesting that NSSI may be used as a form of escape from aversive thoughts and feelings prior to a suicide attempt.

Findings from this study showed that as the number of methods of NSSI increased, so too did a score of PB, this finding also provides evidence for the existence of a continuum between NSSI and suicidal behaviour, as it is known from previous research that as the number of methods of NSSI increase, so too does suicide risk. We would therefore predict an increase in PB as methods of NSSI increased (i.e., as risk for suicide increased).

A strong relationship was found between depression and PB scores, this finding was aligned with previous research showing a link between depression and suicide (e.g., Van Orden et al., 2006; Teismann et al., 2016). In the quantitative part of this study, a regression analysis demonstrated that depression scores, scores on a screening measure for borderline

personality disorder, the number of times an individual has engaged in NSSI and the number of methods they have used all contribute to the variation seen in PB scores, together predicting 39.8% of the variation seen, however depression scores alone contributed 25.4% of this variation. This finding appears to fit well with results obtained by the qualitative part of the study, which suggested that depression contributed to PB.

Qualitative findings suggested that perceptions of burdensomeness (cognitions) indirectly led to NSSI via the difficult to manage emotions of guilt and shame. Analysis clearly reveals that feelings of guilt (due to perceiving that one is a burden on others) acted to perpetuate NSSI, a finding that was in agreement with previous research findings (Rogers et al., 2017). An important finding was that guilt did not necessarily dissipate at the same rate as perceptions of burdensomeness, and thus the influence that PB has on NSSI (and perhaps suicidal behaviour) may continue even after current perceptions of burdensomeness have reduced. Shame was also highlighted in both qualitative and quantitative findings as a difficult emotion experienced along with cognitions related to PB, but also as a result of engaging in NSSI. In this way, shame both perpetuated NSSI (by perpetuating PB), but was also perpetuated by NSSI, contributing to a vicious cycle that proves difficult to break, and may act as a driver for individuals to move further along a continuum from NSSI to suicidal behaviour. A high percentage (65.4%) of individuals endorsed items that would indicate a feeling of shame around scars from NSSI, while 10.7% of individuals endorsed that engaging in NSSI itself was shameful. Shame was seen to be not only something that affected the individual, but also families. Being responsible for bringing shame on family members appeared to further perpetuate PB. Findings from this study clearly indicate that difficulties with emotional regulation play a role in engaging in NSSI (and perhaps moving along a continuum toward suicidal behaviour). A total of 80% of participants endorsed engaging in NSSI as a means of coping with uncomfortable feelings, while 70% endorsed engaging in

NSSI as a means of changing emotional pain in to physical pain. Thus findings from this study are in agreement with previous international research (e.g., Bresin & Schoenleber, 2015; Gratz & Chapman, 2007; Klonsky, 2007; Nock, Prinstein, & Sterba, 2009; De Riggi, Moumne, Heath, & Lewis, 2017). Feelings of depression, guilt, shame, loneliness, being unloved or unlovable and PB are all difficult emotions to regulate, and engagement in NSSI behaviour is a potent coping mechanism. Another such coping mechanism from the findings of this study, is self-induced isolation. Isolation was used as a form of avoidance of difficult thoughts and feelings, but also as a means to reduce the burden individuals felt they were on others around them. However, while isolation was perceived as lessening feelings of burdensomeness and thus also guilt and shame, it appeared to be a form of avoidance that increased risk for suicide (perhaps through increasing thwarted belongingness).

The findings from this study suggested the existence of an insidious, slow moving transition from NSSI to suicidal behaviour and showed support for the IPTS model.

Conclusions

- That higher levels of perceived burdensomeness are present in individuals who have engaged in NSSI compared to those who have not engaged in any self-injurious behaviours.
- As perceived burdensomeness increases so too does the number of methods used to engage in NSSI and frequency of NSSI
- That there is evidence to suggest that a continuum of perceived burdensomeness may exist moving from NSSI behaviours to suicidal behaviours, suggesting that perceived burdensomeness may act as a moderator between self-injurious behaviours without suicidal intent and suicidal behaviour

- That in a sample of individuals who engage in NSSI, levels of depression make the biggest contribution to the variation seen in perceived burdensomeness scores
- That levels of perceived burdensomeness may not be a helpful indicator of NSSI or suicide attempts in those individuals who meet criteria for borderline personality disorder
- The results of this study suggest the Emotional Regulation theory of NSSI is the most well supported theory of why young adults engage in NSSI
- That perceived burdensomeness is an important construct clinically and for research into NSSI and suicide prevention.

Implications for Clinical Practice

The literature provides strong evidence for NSSI being a risk factor for suicidal behaviour, perhaps one of the strongest predictors. Despite this knowledge, suicide continues to be a significant problem both in New Zealand and around the world. This study suggested that if NSSI and suicidal behaviour share a strong relationship, then it is possible that a model that predicts death by suicide (the IPTS model) may also be useful for understanding NSSI, and providing further illumination around NSSI and how practitioners might best work to assist people struggling with NSSI and reduce the risk of NSSI transitioning into suicidal behaviour.

Results from the current study suggest that PB is important and requires consideration. It is exceedingly clear from the findings of this study that PB along with feelings of guilt and shame should be addressed by anyone working with individuals engaging in self-injurious behaviours. Practitioners working with individuals who are

currently engaging in NSSI or have engaged in NSSI previously should ensure they have a sound knowledge of PB, and how to assess for the presence of, and extent of PB (it is acknowledged that few validated measures are currently available). For those individuals deemed to be at risk of suicidal behaviour, those engaging in NSSI or in fact any young person being treated in a mental health service, PB should be assessed and used for robust formulation, and monitoring should occur to ensure rates are not increasing. Working to reduce PB should be addressed along with other areas of importance in therapeutic work.

Experiences of both guilt and shame should also be addressed, in relation to both PB and self-injurious behaviours and used for the wider formulation. Ascertaining the function of self-injurious behaviour (and other related behaviours, such as self-imposed isolation) is likely to provide useful information around how best an individual might have their needs met in a more helpful and longer term way. Findings from this study suggest that young people engaging in NSSI often feel helpless to change their behaviours, as they do not know how else to help themselves. Monitoring of the changes in feelings of guilt and/or shame is also recommended. Awareness that guilt and/or shame may not reduce at the same rate as PB is also considered important for practitioners working with individuals struggling with engagement in self-injurious behaviours.

Alongside those areas already covered, a thorough risk assessment should include assessment of PB, perceptions of belongingness and feelings of guilt and shame. Rather than questions that allow dichotomous (yes/no) answers, the goal of assessment should be to gain an in-depth understanding of how these thoughts and feelings are related to an individual's behaviours (especially self-injurious behaviours).

Most young people who experience PB are focused on the burden they convey on their families. It is for this reason that the suggestion is made - that where possible, involving

close family members in interventions with young people struggling with PB, perceptions of belongingness and feelings of guilt and shame or engaging in self-injurious behaviours, or alternatively providing psychoeducation sessions with care-givers separately. Psychoeducation should include discussion of PB and an explanation around the fact that different events/situations can induce PB in different people. Findings from this study also indicated that individuals who engage in NSSI find being treated with judgement difficult, and this may increase or strengthen PB, therefore, psychoeducation for families around NSSI could be helpful for reducing any behaviours (reactions) that may perpetuate PB in young people. Psychoeducation with families may also include discussion of Identity Formation and how PB and self-injurious behaviours may be seen through the viewpoint of this developmental stage (Erikson, 1968). The involvement of family members with young people who are struggling requires careful planning and may work differently with different individuals.

Findings from this study suggested that engaging in behaviours that helped others, was helpful in reducing feelings of burdensomeness. It may therefore be useful for practitioners or family members working with young people struggling with PB or self-injurious behaviours to assist in facilitating engagement in activities where young people are able to experience opportunities to help others.

It was clear from the findings of this study that what may induce PB in some individuals may not do so in others, that is, perceptions of burdensomeness are different for different people. Individuals may find discussing their PB difficult as it acts to remind them of the burden they are and thus, as much knowledge as possible around PB for those practitioners working with people dealing with PB would be advantageous.

Limitations

One of the biggest limitations of the study was the overall sample size as well as the small sample size of participant groups. While overall the sample size was acceptable, when broken down into groups sample size was relatively small. It would have been beneficial for all group sizes to be bigger, this was especially true for Group 3 (the Suicide Only group), and findings for this group should be viewed with caution, due to the small sample size. More robust findings would be provided by increasing the sample size of all groups.

The study was limited by not including a gender diverse sample. Both studies had a considerable over-representation of women, and under-representation of men, with gender diverse populations (such as transgender and non-binary populations) not represented in the sample. Including data on gender diverse populations in the sample may have provided useful information for these populations, especially transgender populations as previous research has reported that transgender individuals have a higher prevalence of both NSSI and suicidality when compared to cisgender individuals (Marshall, Claes, Bouman, Witcomb & Arcelus, 2016). It is also known that while more females engage in NSSI compared with males (e.g. Bresin & Schoenleber 2015; Xavier, Marina Cunha, & Pinto-Gouveia, 2017), more males die by suicide (e.g., Gutierrez, Rodriguez, & Garcia, 2001), therefore a more balanced sample distribution would have been useful for ascertaining the gender differences between males and females (as well as gender diverse populations).

Participants were not asked about their sexual orientation, and thus no information was able to be gathered on PB or NSSI for different sexualities. Gathering this data may have been useful, as the literature suggests that individuals who do not identify as heterosexual have higher rates of PB (Baams et al., 2015, Hill & Pettit, 2012), and suicidal ideation (Woodward, et al., 2014).

While differences amongst different ethnicities was not a focus of this study, it is noted that Pacific ethnicities were underrepresented within the sample (according the New Zealand Ministry of Health). In order to gain the most accurate data for a New Zealand population as a whole, the ethnicity proportions should be as close to that of the actual population from which it is sampled. A greater proportion of those identifying as being a Pacific ethnicity would have perhaps provided findings that were more reflective of the New Zealand 18 – 24 years old population.

Recruitment was predominantly through universities, and thus the sample had an overrepresentation of university students. This may mean that the sample is not fully representative of those 18 - 24 year olds who are not currently studying at university.

While IPA offers a number of strengths, such as allowing participants to have a voice in how their experiences are understood, and allowing for a more in-depth exploration and understanding of those experiences, beyond the simple descriptive answers provided by quantitative analysis. It also poses some limitations that should be considered.

IPA is not designed to be predictive of future behaviour, thus despite gaining useful understandings of participants' experience of NSSI and PB, the idiographic nature of IPA suggests that results may not be generalisable to a wider population. Conclusions are made by gaining an understanding of the particular participants' understandings of their own unique social reality and situation (Biggerstaff & Thompson, 2008), thus this should be considered when considering generalisability to the wider population. While the number of participants included in the IPA study was sufficient for this type of analysis, it is difficult to have representation from all groups within the population with such a small number of participants. Conducting the IPA with a much larger number of participants was not possible in a research study of this size, and the sample size was difficult to increase due to reluctance

of individuals to engage in this type of research (all individuals who agreed to be interviewed for the IPA were included in the study). It is noted that the IPA study only included individuals who had engaged in NSSI and also made a suicide attempt (that is to say there were no individuals from groups who only engaged in suicide or NSSI alone). This did not occur by design, but rather because those individuals who volunteered to be a part of the IPA study all fell within this group (Group 2). This poses another limitation that should be considered, while it was not the aim of the IPA study to compare the self-injurious groups, only including individuals' from Group 2 does not allow for a comparison between different self-injurious groups to be made. The possibility therefore exists that individuals' who only engage in NSSI or only engage in suicide attempts may have differing responses to that presented in the IPA study. In a study with no limitations of time or researcher numbers more IPA studies could be undertaken to ensure representation of different groups within the target population. These IPA studies could then be compared to ascertain if similar findings were seen across groups.

A further consideration is that the current study did not engage 'member checking' – the process of presenting analysis results back to participants for checking and altering (Creswell & Miller, 2000). Participants were offered transcripts and advised that they were able to request a copy at any time, (no participants wanted copies), however, follow-up interviews to discuss final results were not conducted. The reasoning behind this was that it has been suggested that member checking as part of IPA research is incongruent with 'double hermeneutic' process as it imposes a search or a need for the 'right' interpretation, rather than an acknowledgement of the principle of multiple truths created by the participant making sense of their experience and the researcher making sense of the participant's sense making (McConnell-Henry, Chapman, & Francis, 2011; Smith & Osborne, 2008). Follow-up interviews could therefore apply pressure on participants to make changes, or feel unsure

about the understanding they have expressed. Going back over the content of these emotional interviews may also prove to be an unpleasant experience for participants as they may become concerned with presenting the 'right' interpretation (McConnell-Henry et al., 2011). For these reasons, follow up interviews were considered to be inappropriate and not required for the current study. Participants were given the option of having an electronic copy of the final results sent to them following the conclusion of the study.

It is unknown how many individuals received the survey, as it was distributed by a number of different means, and due to the nature of participant recruitment, knowledge of how many individuals saw the invitation is not known by the researcher. Therefore response rate cannot be calculated. However, it was observed that from those who started the survey, there were high attrition rates, with 209 eligible individuals beginning the survey, but only 159 completing it, equating to a total of 50 people or 24% of those who began the study, dropping out at some point prior to the end to the survey. There are a number of reasons that such a large number of individuals may have dropped out. The survey was relatively long for those individuals who self-selected into groups that included NSSI behaviours. These individuals were asked to respond to a maximum of 144 items after demographic questions (the control group and suicide only group were asked to respond to a maximum of 42 items). It is likely that the number of items for these individuals was too long, causing drop out when they no longer wanted to answer questions (Krosnick, 2018). It might be assumed that individuals in the NSSI groups may drop out, due to the difficulty of the subject matter, however attrition rates for NSSI groups compared to the control and suicide groups were very similar, with 24 individuals (21.6%) and 21 individuals (22.6%) respectively dropping out of the survey before completion. These results show that a higher proportion of control group individuals failed to complete the survey after starting, compared to those individuals who self-selected into self-injurious groups (no attrition was seen for the suicide group, although it

is difficult to draw conclusions from such a small group and caution is suggested). It is possible that despite similar attrition rates for NSSI groups and control groups, that different causes have contributed to individuals dropping out prior to completing the survey. Of those who began the survey there were slightly more who self-selected into a self-injurious group (rather than the control group), this may be because it is not unexpected looking at previous research that over 50% of individuals within this sample would have engaged in self-harming behaviours at least once. However, it could also have been because those individuals who have personal experience of self-injurious behaviours are more driven, or have more motivation to contribute to research in this area, perhaps because they would like to tell their story, provide an opinion informed from lived experience or because they think their contribution might help other people like themselves. This reasoning may also provide some understanding as to why those in the NSSI groups may not have considered the survey too long, where as those in the control group (who were asked significantly less questions) found it too long.

A further limitation of the study is that participants were made up of both current self-injurers as well as those with a history of self-injury (who were not self-injuring presently). No differentiation was made between these groups. Having a larger sample size would allow the researcher to break participants into groups based on the length of time they had been engaging in NSSI behaviours and the length of time since they last engaged in NSSI behaviours, this would allow for more conclusions to be drawn about PB and its relationship with NSSI.

Finally, the measure used to ascertain levels of PB in this study is not a validated measure, rather it is a measure created from other validated measures in an attempt to gain as much insight as possible into the link between NSSI and PB. There are few measures for PB and this study sought to gain a broader understanding of PB, specifically in the context of

engagement in NSSI – thus the focus of the current research was outside that which could be provided by any one existing measure. Responses from the questions chosen for this measure were not used for diagnostic purposes or indeed for any further interaction or intervention with participants, but rather used for comparison within the participant sample. Should there be a desire to utilise this measure in clinical settings working with individuals at risk of or engaging in NSSI or suicidal behaviours, further investigation and validation of this measure would be required.

Future Research

Future research is required to replicate the current findings with a larger sample size, and a more representative participant group. In order to ensure that future study findings will provide useful contributions to the literature, some changes in study design are recommended. An expansion of participant recruitment is recommended, in order to get a more representative sample of individuals aged 18 – 24 years (including a more representative proportion of university students and those who are not university students). A sample inclusive of diverse gender and sexuality should be sought, as well as a sample with higher representation of male participants and individuals of Pacific ethnicity. Individuals who identify as minority gender or sexuality groups make up a smaller proportion of the overall population; however studies into NSSI and suicidal behaviour are important within these populations, due to the knowledge from previous studies that these populations are at higher risk of mental health difficulties. Therefore it is suggested that a separate study focused specifically on minority gender and sexualities would be advantageous, to gain insights around PB and its relationship with NSSI and suicidal behaviour within these minority populations. A further suggestion is that a briefer more targeted survey is used. A

more concise survey may assist in having lower attrition rates, and thus gaining more useful data.

It is recommended that the PB measure used in the current study should be analysed and further data gathered to ensure that this measure is useful for use in future research or as a clinically available tool. It may be possible to use the measure from this study to inform creation of a novel measure that can be used by practitioners working with individuals struggling with PB and self-injurious behaviours, as both an assessment and monitoring tool. Such a tool would provide a means to better understanding an individual's perceptions of burdensomeness and how they related to self-injurious behaviours. Cut off scores for when PB becomes relevant to suicidal behaviour should be investigated to provide further guidance to practitioners working with young people struggling with self-injurious behaviours.

Future research should include both qualitative and quantitative studies, as both have a role in informing the literature and both provide useful and at times complimentary research findings.

Overall the results of the current study make a strong contribution to the current literature and suggest that PB is an important area for further research to inform the NSSI literature, the suicide prevention literature and the relationship between these two areas.

Final Remarks

It appears that within our communities there still exists much misunderstanding and at times fear around mental illness and those living with mental illness (there are many examples of this, but these are beyond the scope of this thesis). Throughout the time I have been working on this thesis, I have been surprised at the fear-based reactions of people who learn that I am researching NSSI. It is perhaps not surprising then, that those individuals who

engage in self-injurious behaviours feel shame about these behaviours, feel guilty and consider themselves a burden on those they are close too. The perception that NSSI is a behaviour that people engage in 'for attention' (or that suicide is a 'selfish' act), appears in my experience to be rather common. NSSI is almost considered to be misbehaviour, somewhat akin to a naughty child. Yet if an infant cries as a means of having their needs met (to gain the attention of the individuals who is able to assist them in meeting these needs), much more understanding appears to exist around this behaviour. Few people would consider the infant to be burdensome, and it is even less likely that the infant would consider themselves to be burdensome. Negative connotations appear to exist around behaviours aimed at gaining attention after a child reaches an age where they are supposedly able to access their needs cognitively and simply ask for the things that will ensure they have every need met. These negative connotations can lead to dismissive and invalidating behaviour, aimed at shutting down emotions that might be uncomfortable for us to face. The developmental phase of Identity Development is fraught with difficulties as young people learn to navigate their own way in the world, it is often a time of high emotion, yet a time when individuals have not yet learnt how to regulate extremes of emotion. The findings of this study suggest that perceptions of burdensomeness (experienced as cognitions) coupled with strong emotions, including guilt and shame contribute to engagement in NSSI, and as perceptions of burdensomeness increase, so too do self-injurious behaviours. Thus this speaks to the importance of gaining a greater understanding of the perceptions of burdensomeness that our clients or our loved ones experience.

NSSI alone does not often result in loss of life; however it is a highly important area to understand, both in order to find ways in which to assist those who struggle with NSSI, but also as a way of working towards decreasing the transition to suicidal behaviour. A greater understanding of NSSI and the constructs that drive this behaviour (such as PB), especially in

the context of an individual's developmental stage, is helpful for those people who work or live with adolescents and young adults. Much media attention in New Zealand recently has focused on high youth suicide rates and when the current study was designed, it was with the aim of contributing to New Zealand based youth suicide prevention. However, as the study evolved and findings were analysed, it has become much more about understanding how PB is related to NSSI behaviours, with the realisation that the issue of youth suicide in New Zealand is likely much broader than perhaps it is currently being treated, and requires more than to ascertain risk factors. Human beings are indeed more complex than a list of risk factors may lead us to believe.

PB provides us with another starting point for understanding what drives individuals to engage in self-injurious behaviours, and thus provides us with another tool to be used in assisting young people who are struggling with these behaviours. PB, made up of self-hatred and the belief that others would be better off without me, fits with much of the knowledge that already exists around NSSI, yet it seems to be a much lesser known construct (compared to other suicidal risk factors). We are unable to conclude from this study the exact relationship PB plays in the transition between NSSI and suicidal behaviour, but we are able to conclude that this relationship exists. For this reason, further research is warranted into this complex construct that until recently has been relatively poorly understood.

I was somewhat hesitant to use a mixed methods approach for this research, having only conducted quantitative research previously; however I am glad that I did so. Qualitative data collection is generally more time consuming and can be more difficult to interpret, however it is superior in its ability to validate the participant, allowing them to feel heard. In this way participating in research can at times be helpful for individuals despite the topic of research being difficult. This study has been part of my training to become a clinical psychologist, and while I am glad for the experience of gathering all of the data presented

here, it is in the qualitative research where I feel that I was able to make use of my skills as a clinical psychologist to gather useful information, while giving something back to the participants, something that I think is important to consider in all psychological research. Qualitative research, particularly IPA allows the participant to be at the heart of the knowledge being gained, allowing individual's agency in their own story.

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Appendix A: Survey

MASSEY UNIVERSITY | School of PSYCHOLOGY

Information Page

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Non-suicidal self-injury (NSSI) and suicide risk among young adults: An examination of the role of perceived burdensomeness

Information Sheet

Introduction

Hello, my name is Louise Edwards and I am a fulltime Doctorate of Clinical Psychology student at Massey University in Wellington. I am currently conducting research on non-suicidal self-injury (NSSI) and the link between this type of behaviour and suicide attempts amongst New Zealand youth. The research aims to learn more about this link by collecting information from both young people who engage in self-harm and young people who don't. It is hoped that focusing on the link between NSSI and suicide attempts among New Zealand youth will assist in reducing the incidence of both NSSI and suicide attempts.

The first step I will be undertaking in order to look at this link is to conduct a survey exploring NSSI and suicidal behaviours.

This research is being conducted under the supervision of Dr John Fitzgerald of Massey University, a registered Clinical Psychologist with extensive experience.

I would like to invite you to participate in this study. The survey is conducted online and no identifying information will be made available (thus your answers will remain completely anonymous). This information sheet provides full details on the study as well as contact details should you have any questions.

Participant Recruitment

It is important for you to know that you are not obliged to take part in this study. If you do decide to participate in the survey you are able to withdraw your data at any time, and you are not obliged to participate any further. You are also welcome to contact the primary investigator with any questions or queries prior to consenting to participate in the study, or at any time after completing the survey.

What will you have to do?

If you agree to participate you will need to read all the information in this information sheet. Then you will need to read the consent page and tick the "Agree" box at the bottom of the page to confirm that you consent to taking part in the study.

Participation in this study requires responding to questions online. The length of your participation in this survey is dependent on how you respond to some questions, however on average, it will take you about 15 - 30 minutes to complete.

Once you have ticked the "Agree" box on the consent page you will be directed to Item One of the survey to begin.

Confidentiality

Your individual data will be collated with all the data collected and analysed collectively. Therefore your individual data will not be reported. If you provide your name or any other identifying information, this will be kept confidential and will also not be reported.

Collective data and analyses will be included in a journal publication, thesis and possibly a conference presentation. However, no one will be allowed to see the raw data except for the principal investigator (Louise Edwards) and the two project supervisors (Dr John Fitzgerald and Professor Janet Leathem). Data collected will be stored electronically on a secure server, with access to the questionnaire data under password-protection

You may request a summary of the research findings by indicating so on the consent form. The summary will be posted or emailed to you at the conclusion of the project.

Risks & Benefits

This survey addresses the topic of self-harm, and therefore, may be difficult to think about. Please keep in mind you may choose to not answer a question or questions and may stop your participation at any time by simply closing your web browser. In addition, at the end of this information sheet and at the completion of your participation in this online survey, a list of contact information for people who can provide you with help and information about any mental health concerns you may have will be provided.

There are no direct personal benefits to participating in this study. However, your involvement will enhance general understanding of the self-harming behaviours in New Zealand.

Prize Draw for All Participants

As a thank-you for completing the survey participants may elect to enter a draw to win one of eight $50 Visa Gift Vouchers. If you wish to enter this draw simply enter your first name and a contact telephone number or email address into the Prize Draw page at the end of the survey. This information will be separated from the survey data when we download the final results to ensure that your survey answers remain anonymous.

Follow up interviews

You do NOT need to complete a follow up interview. However as part of this study, follow-up interviews (in person) with a small number of participants will also be conducted, to talk about some of the issues raised in more detail. If you would like to take part, you should include your contact information on the appropriate screen in the survey. However, you are under no obligation to participate in a follow-up interview.

Personal Information

It is up to you whether you provide any identifying information; if you prefer not to, you are still very welcome to complete the survey. There are two reasons why you might choose to give us your contact information (such as your first name and email or phone number):

1. To be entered into the prize draw. We would use your name and telephone number only to alert you if you have won a prize.
2. To volunteer for a possible follow-up interview. We may contact you to arrange an interview if you volunteer.

Unless you choose to give us this information we will have no idea which of the many completed surveys we receive is yours.

The data will be stored on a secure server, and access to the survey data is password-protected. Only the principal investigator and the project supervisor will have access to your responses.

Massey University has a 10 year policy for storage and disposal of data. After 10 years all the raw data will be destroyed.

You are under no obligation to accept this invitation

If you do decide to participate, you have the right to:

- Decline to answer any particular item;
- Withdraw from the study at any time up until you submit your survey responses;
- Ask any questions about the study at any time (prior to participation or afterwards);
- Provide information on the understanding that your name will not be used;
- Be given access to a summary of the project finding when it is concluded

Contacts and Questions

If you have any questions regarding this research or your rights as a participant please feel free to contact the principal investigator – Louise Edwards using the contact details at the end of this information sheet.

Thank you for considering participation in this survey.

Many thanks,
Louise Edwards

Researcher
Louise Edwards
School of Psychology
Massey University
Wellington
New Zealand
Phone: 0800 568-473
Email: nssi.researchproject@gmail.com

Supervisor
Dr John Fitzgerald
School of Psychology
Massey University
Palmerston North
New Zealand
+64 4 801-5799 ext 63620
J.M.Fitzgerald1@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 15/50.

If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487, Email: humanethicsoutha@massey.ac.nz.

Help

If you need to talk to someone...

We understand that some of these questions deal with topics that may be difficult to think about, so we feel it is sensible to remind you that there are a number of services that you can access for support if you feel you need it.

Crisis Assessment & Treatment Team

Telephone:
0800 745 477 (Wellington);
0800 653 357 (Palmerston North);
0800 800 717 (Auckland)

The CAT team provide 24 hour, 7 days a week assessment and short-term treatment services for people experiencing a serious mental health crisis and for whom there are urgent safety issues.

Lifeline Aotearoa

New Zealand's telephone counselling service provides 24 hours a day, 7 days a week counselling and support.

Lifeline 24/7: 0800 543 354
TAUTOKO Suicide Crisis Line 0508 828 865
www.lifeline.org.nz

Youthline

Youthline works with people from all walks of life, from all cultures and with all sorts of things going on in their lives. This can be anything from just wanting to talk something through (big or small) via TXT, email or phone.

Phone: 0800 376 633
Free Txt: 234
Email: talk@youthline.co.nz
Online Chat: http://www.youthline.co.nz/

Healthline

0800 611 116
Open 24 hours a day, 7 days a week. Phone calls are free from within New Zealand.

In an emergency, call 111 or proceed directly to the emergency department of the hospital.

Consent

Respondent Consent

I have read the Information Sheet and understand the details of the study. I have sought explanation about any details of the study I do not understand.

I have had time to consider my participation and my questions have been answered to my satisfaction. I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet and I understand that I can withdraw myself and any data that has been collected from the study at any time..
(Please click on the 'Yes' choice if you wish to proceed.)

- ○ Yes
- ○ No

Instructions

Instructions

Please answer each question by checking the relevant answers. While we would like for you to answer all of the questions presented to you, if there are any questions that your do not feel comfortable answering, please feel free to move on without providing a response.

At the conclusion of the survey you will have the opportunity to enter the prize draw to win one of eight $50 Visa Gift Vouchers. Should you provide your contact details in order to be part of this prize draw, they will be stored separately to your survey responses, in order to ensure your responses remain anonymous.

Screening

Demographics

What is your age?

- ○ Under 18
- ○ 18
- ○ 19
- ○ 20
- ○ 21
- ○ 22
- ○ 23
- ○ 24
- ○ Over 24

Demographics

What is your gender?

- ○ Male
- ○ Female

Which nationality/culture do you identify with?
(please select all that apply).

- ☐ New Zealand European
- ☐ Māori
- ☐ Samoan
- ☐ Cook Island Māori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ United Kingdom
- ☐ Philippines
- ☐ Other (please specify)

Please choose the answer that currently applies best to you.

- ○ I am currently an undergraduate student and do not work
- ○ I am currently an undergraduate student and do work
- ○ I am currently a post-graduate student and do not work
- ○ I am currently a post-graduate student and do work
- ○ I am currently working and am not a student
- ○ I am currently unemployed and am not a student

Mood etc

Mood, Relationships & Perceived Burdensomeness

Have you ever deliberately physically harmed yourself?

- Yes
- No

When you engaged in this harming behaviour which of the following best applies to you?

- I was attempting to harm myself but NOT to end my life
- I was attempting to end my life
- On some occasions I was attempting to end my life, but on some occasions I wanted to harm myself without the desire to end my life

How true are each of the following statements for you?

	Not at all true for me			Somewhat true for me			Very true for me
	1	2	3	4	5	6	7
These days the people in my life would be better off if I were gone.							
These days the people in my life would be happier without me.							
These days I feel like I am a burden on those around me.							
These days I think I am a burden on society.							
These days I think my death would be a relief to the people in my life.							
These days I think the people in my life wish they could be rid of me.							
These days I think I make things worse for the people in my life.							

How true are each of the following statements for you?

	Not at all true for me		Somewhat true for me		Very true for me
	1	2	3	4	5
I am concerned that my friends, family or partner will "wear out" because of the demands I place on them					
I worry that the health of my friends, family or partner could suffer as a result of me					
I worry that my friends, family or partner has to take time away from other things in order to help me					
I feel guilty about the demands that I make on my friends, family or partner					

I'm concerned that my needs are so great that my friends, family or partner can't handle them	○	○	○	○	○
	1	2	3	4	5
I am concerned that if I ask for help it will put too much pressure on my friends, family or partner	○	○	○	○	○
I find it easier to ask my friends, family or partner for help when I feel that I can give something in return	○	○	○	○	○
I am concerned that my demands have strained my relationship with my friends, family or partner	○	○	○	○	○
I am concerned that I am "too much trouble" to my friends, family or partner	○	○	○	○	○
Receiving help from others makes me feel that they care for me	○	○	○	○	○
	1	2	3	4	5
I am concerned about the negative effects I have on those around me	○	○	○	○	○
I think that I make things hard on my family, friends or partner	○	○	○	○	○
Sometimes I feel that my friends, family or partner might be better off without me	○	○	○	○	○
I feel that I am a burden to my family, friends or partner	○	○	○	○	○

Over the last 2 weeks, how often have you been bothered by any of the following problems.

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
	Not at all	Several days	More than half the days	Nearly every day
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○

Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○

Have any of your closest relationships been troubled by a lot of arguments or repeated breakups?

- ○ Yes
- ○ No

Have you had at least two other problems with impulsivity (e.g. eating binges and spending sprees, drinking too much and verbal outburst)?

- ○ Yes
- ○ No

Do you experience periods of extreme moodiness?

- ○ Yes
- ○ No

Do you feel very angry a lot of the time?

- ○ Yes
- ○ No

Have you often acted in an angry or sarcastic manner?

- ○ Yes
- ○ No

Are you often distrustful of other people?

- ○ Yes
- ○ No

Do you frequently feel unreal or as if things around you are unreal?

- ○ Yes

○ No

Do you feel chronically empty?

○ Yes
○ No

Have you often felt that you had no idea of who you are or that you have no identity?

○ Yes
○ No

Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g. repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)?

○ Yes
○ No

The remainder of the survey was only done by those individuals' who had self-selected into Group 1 of Group 2.

Self-harming behaviours

Self-Harming Behaviours

The following questions ask about your experience with intentionally hurting yourself.
We know that this can be a difficult issue to think and talk about, so please note that there are contact details for a number of helplines below. These can be printed and kept for use later.

This contact sheet will also be provided at the conclusion of the survey and should be used if you feel like you would like to talk with someone.

The information you provide about this topic will be used to help others who intentionally hurt themselves.

If you need to talk to someone...

We understand that some of these questions deal with topics that may be difficult to think about, so we feel it is sensible to remind you that there are a number of services that you can access for support if you feel you need it.

Crisis Assessment & Treatment Team

Telephone:
0800 745 477 (Wellington);
0800 653 357 (Palmerston North);
0800 800 717 (Auckland)

The CAT team provide 24 hour, 7 days a week assessment and short-term treatment services for people experiencing a serious mental health crisis and for whom there are urgent safety issues.

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TAUTOKO Suicide Crisis Line 0508 828 865
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Youthline

Youthline works with people from all walks of life, from all cultures and with all sorts of things going on in their lives. This can be anything from just wanting to talk something through (big or small) via TXT, email or phone.

Phone: 0800 376 633
Free Txt: 234
Email: talk@youthline.co.nz
Online Chat: http://www.youthline.co.nz/

Healthline

0800 611 116
Open 24 hours a day, 7 days a week. Phone calls are free from within New Zealand.

In an emergency, call 111 or proceed directly to the emergency department of the hospital.

Print

Have you ever done any of the following with the purpose of intentionally hurting yourself?
(Please select all that may apply.)

- [ ] Severely scratched or pinched with fingernails or other objects to the point that bleeding occurs or marks remain on the skin
- [ ] Cut wrists, arms, legs, torso or other areas of the body
- [ ] Dripped acid onto skin
- [ ] Carved words or symbols into the skin
- [ ] Ingested a caustic substance(s) or sharp object(s) (Drano, other cleaning substances, pins etc).
- [ ] Ripped or torn skin
- [ ] Bitten yourself to the point that bleeding occurs or marks remain on the skin
- [ ] Burned wrists, hands, arms, legs, torso or other areas of the body
- [ ] Rubbed glass into skin or stuck sharp objects such as needles, pins, and staples into or underneath the skin (not including tattooing, body piercing, or needles used for medication use)
- [ ] Tried to break your own bone(s)
- [ ] Broken your own bone(s)

- [ ] Banged or punched objects to the point of bruising or bleeding
- [ ] Punched or banged oneself to the point of bruising or bleeding
- [ ] Intentionally prevented wounds from healing
- [ ] Engaged in fighting or other aggressive activities with the intention of getting hurt

Are there any other ways that you have physically hurt or mutilated your body with the purpose of intentionally hurting yourself?

- ○ Yes *(Please specify)*
  _____
- ○ No

How true are the following statements about **why** you hurt yourself? Please select the most accurate response.

I hurt myself…

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
to feel something	○	○	○	○
because my friends hurt themselves	○	○	○	○
as a self-punishment or to atone for sins	○	○	○	○
to get a rush or surge of energy	○	○	○	○
to deal with frustration	○	○	○	○
to cope with uncomfortable feelings (e.g., depression or anxiety)	○	○	○	○
	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
in the hopes that someone would notice that something is wrong or so others will pay attention to me	○	○	○	○
to relieve the guilt I feel about being such a burden to others	○	○	○	○
because it feels good	○	○	○	○
to deal with anger	○	○	○	○
to get control over myself or my life	○	○	○	○
to shock or hurt someone	○	○	○	○
	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
to avoid committing suicide	○	○	○	○
because I get the urge and cannot stop it	○	○	○	○
to relieve stress or pressure	○	○	○	○
to change my emotional pain into something physical	○	○	○	○
because of my self-hatred	○	○	○	○
because I like the way it looks	○	○	○	○
	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree

as a way to practice suicide	○	○	○	○
as an attempt to commit suicide	○	○	○	○
Other *(please describe)*	○	○	○	○

When was the last time you intentionally hurt yourself in one of the ways listed in the previous question?

- ○ Less than 1 week ago
- ○ Between 1 week and 1 month ago
- ○ Between 1 and 3 months ago
- ○ Between 3 and 6 months ago
- ○ Between 6 months and 1 year ago
- ○ Between 1 and 2 years ago
- ○ More than 2 years ago

How likely are you to intentionally hurt yourself again?

- ○ Very likely
- ○ Somewhat likely
- ○ Not sure
- ○ Somewhat unlikely
- ○ Very unlikely

How old were you the **first** time you intentionally hurt yourself? (in years)

How old were you the **last** time you self-injured? (in years)

Approximately on how many total occasions have you intentionally hurt yourself?

- ○ Only once
- ○ 2-3 times
- ○ 4-5 times
- ○ 6-10 times

11-20 times

- 21-50 times
- More than 50 times

On what areas of your body have you intentionally hurt yourself?
(Select all that apply)

- Wrists
- Hands
- Arms
- Fingers
- Calves or ankles
- Thighs
- Stomach or chest
- Back
- Buttocks
- Head
- Feet
- Face
- Lips or tongue
- Shoulders or neck
- Breasts
- Genitals or rectum
- Other *(please specify)*

Which of the following descriptions best describes your motivations for first intentionally hurting yourself?
(Select all that apply)

- A friend suggested that I try it
- I read about it on the Internet and decided to try it
- I saw it in a movie / on television or read about it in a book and decided to try it
- It seemed to work for other people I know
- It seemed to work for celebrities I have heard of
- I accidentally discovered it - I had never heard of it or seen it before
- It was part of a dare
- I felt guilty
- I did it because I had friends who did it and I wanted to fit in
- I wanted to be part of a group
- I felt I was a burden to others in my life

- [ ] I wanted to shock or hurt someone
- [ ] I was upset and decided to try it
- [ ] I wanted someone to notice me and / or my injuries
- [ ] It felt good
- [ ] I was angry at someone else
- [ ] I was angry with myself
- [ ] I was drunk or high
- [ ] I cannot remember
- [ ] Other *(please specify)*

Have you ever intentionally hurt yourself more severely than you expected?

- ○ Yes
- ○ No

Have you ever intentionally hurt yourself so badly that you should have been seen by a medical professional (even if you were not)?

- ○ Yes
- ○ No

Have you ever sought medical treatment (not therapy) for any of the physical injuries you intentionally caused?

- ○ Yes
- ○ No

How many times have you intentionally hurt yourself more severely than you expected?

- ○ 1
- ○ 2-3
- ○ 4-5
- ○ More than 5

Were you under the influence of drugs or alcohol in any instance that you hurt yourself more severely than you expected?

- ○ Yes

- No

Do you see any consequences to hurting yourself?

- Yes *(Please explain)*
- No

The fact that I intentionally hurt myself interferes with:
(Please select all that apply)

- Relationships which are important to me
- My ability to complete University or work obligations
- My ability to take care of myself (eat right, exercise, etc.)
- My ability to engage in hobbies or things that I like to do
- My self-worth / self-esteem
- The clothing I wear
- Other; please specify
- It does not interfere with my life in any way

Do you feel you are a burden on significant others in your life due to hurting yourself?

- Yes
- No

Burdensome?

If so, who do you feel you are a burden to?
(Select all that apply)

- Parents
- Girlfriend or Boyfriend
- Brothers or sisters
- Other family members
- Friends
- Tutors/teachers
- Workmates
- Everyone
- Other *(please specify)*

In what ways do you feel you are a burden?
(Select all that apply)

- [ ] Demands on time of others
- [ ] Financial demands on others
- [ ] Emotional demands on others
- [ ] Other *(please specify)*

Do you feel more of a burden than you did 12 months ago?

- ○ Yes *(Please explain)*
- ○ No

Do you believe that you are more likely to self-harm/make a suicide attempt if you feel you are a burden to others?

- ○ Yes
- ○ Maybe
- ○ Unsure *(Please explain)*

Has anyone in your life explicitly told you that you are a burden/burdensome?

- ○ Yes
- ○ No

Roundup

We are interested to know what you think is important for people who want to better understand and help those who intentionally hurt themselves to know?

Appendix B: Participant Information sheet (Part One)

Non-suicidal self-injury (NSSI) and suicide risk among young adults: An examination of the role of perceived burdensomeness

PARTICIPANT INFORMATION SHEET

Introduction

Hello, my name is Louise Edwards and I am a fulltime Doctorate of Clinical Psychology student at Massey University in Wellington. I am currently conducting research on non-suicidal self-injury (NSSI) and the link between this type of behaviour and suicide attempts amongst New Zealand youth. The research aims to learn more about this link by collecting information from both young people who engage in self-harm and young people who don't. It is hoped that focusing on the link between NSSI and suicide attempts among New Zealand youth will assist in reducing the incidence of both NSSI and suicide attempts.

The first step I will be undertaking in order to look at this link is to conduct a survey exploring NSSI and suicidal behaviours, looking particularly at the way young people perceive their relationships with others and to what extent these are supportive and mutual. The survey results will provide useful quantitative data. However, for clinicians working with clients who are engaging in NSSI or suicidal behaviour, a knowledge of how these behaviours are experienced in real life would be especially helpful.

This research is being conducted under the supervision of Dr John Fitzgerald of Massey University, a registered Clinical Psychologist with extensive experience.

I would like to invite you to participate in this study. The survey is conducted online and no identifying information will be made available (thus your answers will remain completely anonymous). This information sheet provides full details on the study as well as contact details should you have any questions.

Participant Recruitment

It is important for you to know that you are not obliged to take part in this study. You are also welcome to contact the primary investigator with any questions or queries prior to consenting to participate in the study, or at any time after completing the survey.

What will you have to do?

If you agree to participate you will need to read all the information in this information sheet. Then you will need to read the consent page and tick the "Agree" box at the bottom of the page to confirm that you consent to taking part in the study.

Participation in this study requires responding to questions online. The length of your participation in this survey is dependent on how you respond to some questions, however on average, it will take you about 15 - 30 minutes to complete.

If you have any questions you would like to discuss please do not hesitate to contact me on the contact details provided at the end of this information sheet.

Once you have ticked the "Agree" box on the consent page you will be directed to the Item One of the survey to begin.

Confidentiality

Your individual data will be collated with all the data collected and analysed collectively. Therefore your individual data will not be reported. If you provide your name or any other identifying information, this will be kept confidential and will also not be reported.

Collective data and analyses will be included in a journal publication, thesis and possibly a conference presentation. However, no one will be allowed to see the raw data except for the principal investigator (Louise Edwards) and the two project supervisors (Dr John Fitzgerald

and Professor Janet Leathem). Data collected will be stored electronically on a secure server, with access to the questionnaire data under password-protection

You may request a summary of the research findings by indicating so on the consent form. The summary will be posted or emailed to you at the conclusion of the project.

Risks & Benefits

This survey addresses the topic of self-harm, and therefore, may be difficult to think about. Please keep in mind you may choose to not answer a question or questions and may stop your participation at any time by simply closing your web browser. In addition, at the end of this information sheet and at the completion of your participation in this online survey, a list of contact information for people who can provide you with help and information about any mental health concerns you may have will be provided.

There are no direct personal benefits to participating in this study. However, your involvement will enhance general understanding of the self-harming behaviours in New Zealand.

Prize Draw for All Participants

As a thank you for completing the survey participants may elect to enter a draw to win one of eight $50 Visa Gift Vouchers. If you wish to enter this draw simply enter your first name and a contact telephone number or email address into the Prize Draw page at the end of the survey. This information will be separated from the survey data when we download the final results to ensure that your survey answers remain anonymous.

Follow up interviews

As part of this study, follow-up interviews (in person) with a small number of participants will also be conducted, to talk about some of the issues raised in more detail. If you would like to take part, you should include your contact information on the appropriate screen in the survey. However, you are under no obligation to participate in a follow-up interview.

Personal Information

It is up to you whether you provide any identifying information; if you prefer not to, you are still very welcome to complete the survey. There are two reasons why you might choose to give us your contact information (such as your first name and email or phone number):

1. To be entered into the prize draw. We would use your name and telephone number only to alert you if you have won a prize.

2. To volunteer for a possible follow-up interview. We may contact you to arrange an interview if you volunteer.

Unless you choose to give us this information we will have no idea which of the many completed surveys we receive is yours.

The data will be stored on a secure server, and access to the survey data is password-protected. Only the principal investigator and the project supervisor will have access to your responses.

Massey University has a 10 year policy for storage and disposal of data. After 10 years all the raw data will be destroyed.

<u>You are under no obligation to accept this invitation</u>

If you do decide to participate, you have the right to:

- Decline to answer any particular item;
- Withdraw from the study at any time prior to submitting your responses;
- Ask any questions about the study at any time (prior to participation or afterwards);
- Provide information on the understanding that your name will not be used;
- Be given access to a summary of the project finding when it is concluded

Contacts and Questions

If you have any questions regarding this research or your rights as a participant please feel free to contact the principal investigator – **Louise Edwards** using the contact details at the end of this information sheet.

Thank you for considering participation in this survey.

Principle investigator

Louise Edwards (DClinPsyc Candidate)
C/- Psychology Clinic
Massey University, PO Box 756, Wellington

Phone: 0800 568 473
Email: nssi.researchproject@gmail.com

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 15/50. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487,
email humanethicsoutha@massey.ac.nz

Appendix C: Help Sheet

If you need to talk to someone...

We understand that some of these questions deal with topics that may be difficult to think about, so we feel it is sensible to remind you that there are a number of services that you can access for support if you feel you need it.

Crisis Assessment & Treatment Team

Telephone: 0800 745 477 (Wellington);

0800 653 357 (Palmerston North);

0800 800 717 (Auckland)

The CAT team provide 24 hour, 7 days a week assessment and short-term treatment services for people experiencing a serious mental health crisis and for whom there are urgent safety issues.

Lifeline Aotearoa

New Zealand's telephone counselling service provides 24 hours a day, 7 days a week counselling and support.

Lifeline 24/7: 0800 543 354

TAUTOKO Suicide Crisis Line 0508 828 865

www.lifeline.org.nz

Youthline

Youthline works with people from all walks of life, from all cultures and with all sorts of things going on in their lives. This can be anything from just wanting to talk something through (big or small) via TXT, email or phone.

Phone: 0800 376 633

Free Txt: 234

Email: **talk@youthline.co.nz** Online Chat: http://www.youthline.co.nz/

Healthline : 0800 611 116

Open 24 hours a day, 7 days a week. Phone calls are free from within New Zealand.

In an emergency, call 111 or proceed directly to the emergency department of the hospital

Massey University Student Health and Counselling Services

The Student Health Service is able to provide full medical and counselling services. They provide a General Practice service for students as well as trained and experienced counsellors on staff. Emergency appointments are available each day and these will be allocated only on that day so please tell the person making the appointment if you feel you need to use this appointment.

WELLINGTON:
Student Health Centre (SHCC) Third Floor, Student Services Building, Massey University

Phone: (04) 801-2542

The service is open Monday- Friday 8:30am – 4:30pm throughout the year apart from public or University holidays. During the semester break the service is open Monday-Friday 9am – 4pm

Appointments can be made at the reception desk or by phoning (04) 801-2542.

PALMERSTON NORTH:
Manawatu Student Health and Counselling Service, Level 1 Registry Building, Turitea Road

Phone: (06) 350 5533

Email Address: For Student Counselling email: s.counselling@massey.ac.nz

For Medical Centre email: medical-centre-pn@massey.ac.nz

The service is open Monday to Friday 8.30am-5.30pm, and 8.30am to 4.30pm during Semester break.

AUCKLAND:
Albany Health and Counselling Centre, Level 2, Student Centre

Phone: (09) 443 9783

Email Address: studenthealth@massey.ac.nz

The service is open Monday to Friday 8.30 a.m. - 5 p.m (open until 6pm on Tuesdays).

Appendix D: Participant Information sheet (Part Two)

Non-suicidal self-injury (NSSI) and suicide risk among young adults: An examination of the role of perceived burdensomeness

PARTICIPANT INFORMATION SHEET

Introduction

Hello, my name is Louise Edwards and I am a fulltime Doctorate of Clinical Psychology student at Massey University in Wellington. I am currently conducting research on non-suicidal self-injury (NSSI) and the link between this type of behaviour and suicide attempts amongst New Zealand youth. The research aims to learn more about this link by collecting information from both young people who engage in self-harm and young people who don't. It is hoped that focusing on the link between NSSI and suicide attempts among New Zealand youth will assist in reducing the incidence of both NSSI and suicide attempts.

The first step I have undertaken in order to look at this link has been to conduct a survey. You will have already completed this part of the research so will have some knowledge as to the types of questions that were included in this questionnaire.

The second part of this study involves one-on-one interviews. These interviews will be used to explore ideas about NSSI and suicide in more depth.

The survey results will provide useful quantitative data. However, for clinicians working with clients who are engaging in NSSI or suicidal behaviour, a knowledge of how these behaviours are experienced in real life would be especially helpful. The interview questions will, look particularly at the way young people perceive their relationships with others and to what extent these are supportive and mutual

This research is being conducted under the supervision of Dr John Fitzgerald and Professor Janet Leatham of Massey University. Both are registered Clinical Psychologists with extensive experience.

Participant Recruitment

t is important for you to know that you are not obliged to take part in this study. You are receiving this information sheet because you indicated that you may be willing to participate in this part of the research, however, this indication of interest does not place any obligation on you. If you do decide to participate in the interview you are able to withdraw your data at any time prior to the in-depth data analysis beginning (this will occur after you have had the opportunity to check the final interview transcript). The face-to-face interviews will be audio recorded. You will be offered the opportunity to review the typed record of your interview to ensure you are comfortable with the information collected. You are also welcome to contact the principal investigator with any questions or queries prior to consenting to participate in the interview, during the interview process or at any time after completing the questionnaire. Full contact details are included at the end of this information sheet.

What will you have to do?

If you agree to participate you will need to sign the consent form and return it in the freepost envelope provided or via email. If you have any questions you would like to discuss please contact me using the contact details provided on page five of this information sheet. Once I have received your signed consent form I will contact you to set up an interview time that is convenient for you. Interviews will take place at the Massey University Psychology Clinic (King Street, off Adelaide Road, Newtown).

A registered clinical psychologist from Massey University will supervise interviews via a video link (they do not need to be present in the interview room). Discussing self-harm and suicide can be distressing for some participants and it is helpful to have a clinical psychologist available to ensure the safety of participants. The clinical psychologist providing supervision will have many years of experience working with individuals with

similar experiences to the participants - they may therefore suggest that an interview is postponed or terminated if they feel it is appropriate.

It is important to note that participants are able to terminate or postpone their interview at any stage should they not wish to continue. The time taken to complete the interview will be between 60 and 90 minutes.

Confidentiality

Data collected will be included in a journal publication, thesis and possibly a conference presentation. However, there will be no way to identify you in anything that is presented or written.

No one will be allowed to see the raw interview data except for the primary investigator (Louise Edwards) and the two project supervisors (Dr John Fitzgerald and Professor Janet Leathem).

Data collected will be stored electronically on a secure server, with access to the questionnaire data under password-protection. Any hard copy documentation (such as signed consent forms and interview transcripts) will be locked in a secure cabinet in a locked room at the Massey University Wellington Campus. Signed consent forms will be kept separately to interview transcripts, no identifying information will be stored with interview transcripts. Massey has a 10 year policy for storage and disposal of data. After 10 years all the raw data will be destroyed.

You may request a summary of the research findings by indicating so on the consent form. The summary will be posted or emailed to you at the conclusion of the project.

Risks & Benefits

This research addresses the topic of self-harm, and therefore, may be difficult to think about. Please keep in mind you may choose to not answer a question or questions and may stop your participation at any time.

In addition, attached to this information sheet and at the completion of your interview you will be provided with a list of contact information for people who can provide you with help and information about any mental health concerns you may have.

There are no direct personal benefits to participating in this study. However, your involvement will enhance general understanding of self-harming behaviour in New Zealand.

Reimbursement

Should you agree to participate in an interview, both travel and parking reimbursement will be provided.

Support Person

Should you agree to participate in this phase of the study you are welcome to bring a support person (or people) along to your interview.

<u>You are under no obligation to accept this invitation</u>

If you do decide to participate, you have the right to:

- Decline to answer any particular item;
- Withdraw from the study up to two weeks following the interview;
- Ask any questions about the study at any time (prior to participation or afterwards);
- Provide information on the understanding that your name will not be used;
- Be given access to a summary of the project finding when it is concluded

Contacts and Questions

If you have any questions regarding this research or your rights as a participant please feel free to contact the principal investigator – **Louise Edwards** using the contact details at the end of this information sheet.

If you have any general questions about this project which you would like to discuss with my supervisor please contact Dr John Fitzgerald (j.m.fitzgerald1@massey.ac.nz, 04-979-3620)

Thank you for considering participation in this questionnaire.

Principle investigator

Louise Edwards (DClinPsyc Candidate)

C/- Psychology Clinic

Massey University, PO Box 756, Wellington

Phone: 0800 568 473

Email: nssi.researchproject@gmail.com

***This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 15/50. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487, email* humanethicsoutha@massey.ac.nz**

Appendix E: Participant Consent Form (Part Two)

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Non-suicidal self-injury (NSSI) and suicide risk among young adults: An examination of the role of perceived burdensomeness

CONSENT FORM

I have read the *Information Sheet* and understand the details of the study. I have sought explanation about any details of the study I do not understand.

I have had time to consider my participation and my questions have been answered to my satisfaction. I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet and I understand that I can withdraw myself and any data that has been collected from the study at any time prior to the in-depth data analysis beginning.

YES NO

I wish to receive a summary of the research when it is completed

YES NO

Postal or Email Address for Summary:

.....

.....

..... Postal Code.....

Contact phone number: .....

Signature: ..... Date: .....

Full Name Printed .....

Appendix F: IPA Interview Schedule

IPA – Interview Schedule:

Made up of four main questions plus prompts:

HOW DO YOU MAKE SENSE OF THAT?

1. **Can you tell me about your experiences of self-harming?**
    a. What was/is it like just before you harm yourself?
    b. How do you feel immediately afterwards?
    c. Can you tell me about the first time you harmed yourself?
    d. How do you make sense of harming yourself?

DOES THAT RELATE TO FEELING LIKE A BURDEN?

2. **Have you ever felt like a burden on family friends, partner or others (during the period you were self-harming)?**
    a. Tell me about feeling like a burden
    b. How did you know you were being a burden?
    c. Did someone ever overtly tell you, that you were a burden?
    d. How does feeling like a burden relate to your self-harming behaviours?
    e. Who specifically did you feel a burden on?
    f. Was there anyone that you didn't feel like a burden too? Tell me about this…
    g. Was there anyone you ever felt might be better off without you? Tell me about this…

HOW DOES THAT RELATE TO YOUR SELF-HARMING?

3. **How did your family, friends, partner or others respond to you self-harming?**
    a. What effect did this reaction have on your self-harming?

DO YOU FIND THAT BURDENSOME TOO?

4. Is there anything further you would like to say that might give a better understanding of your experience of self-harm?

Appendix G: Data Screening for Survey Data

Data Screening for normality, linearity and homoscedasticity of Survey Data sets

Normality of full Dataset

Characteristics of normality for the dependent and independent variables were tested using one-sample Kolmogorov-Smirnov Test (K-S Test). Test statistics for K-S Test were found to be in the significant range for Perceived Burdensomeness score (PB score), depression measure score and BPD measure score (summarised in Table 7.10). This suggests that these variables have a non-normal distribution and both non-parametric and parametric analysis was conducted.

Table 1

Normality of full Dataset

	Normal Parameters		Most Extreme Differences				
Variables	Mean	SD	Absolute	Pos.	Neg.	Kolmogorov-Smirnov Test Statistic*	Asymp. Sig. (2-tailed)
PB Score	52.1	23.5	0.143	0.143	- 0.106	0.143	.000**
Depression Measure	8.7	6.6	0.137	0.137	-0.095	0.137	.000**
BPD Measure	16.1	2.8	0.117	0.098	-0.117	0.117	.000**

Normality characteristics for PB (Perceived Burdensomeness) Score, Depression Measure score and BPD (Borderline Personality Disorder) measure Score. SD=Standard Deviations; Pos. =Positive; Neg.=Negative. *One sample Kolmogorov-Smirnov Test indicating that PB Score, Depression Measure Score and BPD Measure Score deviate from normality. **Lilliefors Significance Correction

Normality of the Dataset for NSSI (Groups 1 & 2)

The data was then split by group (1 & 2) and characteristics of normality for the dependent and independent variables were tested as for the previous dataset using the one-sample Kolmogorov-Smirnov Test (K-S Test). Test statistics for K-S Test were found to be in the non-significant range for Perceived Burdensomeness score (PB score), and therefore there is no evidence to suggest that this variable deviates from normality. K-S Test statistics for depression measure score and BPD measure score were found to be significant; this suggests that these variables have a non-normal distribution (results are summarised in Table7.11).

Given that a number of measures from the Group 1 and 2 data set do not appear to be normally distributed, in line with best practice recommendations (Tabachnick & Fidell, 2013 both non-parametric and parametric analysis was conducted for these measures.

Table 2

Normality of NSSI Group Dataset

	Normal Parameters		Most Extreme Differences				
Variables	Mean	SD	Absolute	Pos.	Neg.	Kolmogorov-Smirnov Test Statistic*	Asymp. Sig. (2-tailed)
PB Score	61.5	25.7	0.090	0.090	-0.065	0.090	0.099**
Depression Measure	11.2	6.7	0.119	0.119	-0.053	0.119	0.006**
BPD Measure	15.0	2.5	0.107	0.107	-0.078	0.107	0.020**
Number of Methods	3.59	2.61	0.193	0.193	-0.100	0.193	0.000**
Number of NSSI Events	4.59	1.90	0.168	0.106	-0.168	0.168	0.000**

Normality characteristics (for Group 1 and 2 only) for PB (Perceived Burdensomeness) Score, Depression Measure score, BPD (Borderline Personality Disorder) measure Score, Number of Methods and Number of

NSSI Events (Frequency). SD=Standard Deviations; Pos. =Positive; Neg.=Negative. *One sample Kolmogorov-Smirnov Test indicating that Depression Measure Score, BPD Measure Score, Number of Methods and Number of NSSI Events deviate from normality. **Lilliefors Significance Correction

Linearity of full Dataset

Bivariate correlation coefficients for all independent and dependent pairs are presented in Table 6.12 (full dataset). Results suggested that some variables did not show a linear relationship. Those variables that do not show a linear relationship with PB score were removed from the regression analysis (Age and Sex).

Linearity of the Dataset for NSSI (Groups 1 & 2)

Bivariate correlation coefficients for all IV and DV pairs are presented in Table 6.13 (NSSI dataset). Results suggested that some variables did not show a linear relationship. Those variables that do not show a linear relationship with PB score were removed from the regression analysis (Age, Sex, and Frequency).

Table 3

Bivariate Correlations between PB Score, Group, Depression score, BPD Score, Age, Sex, Ethnicity Number of Methods of NSSI and Number of NSSI events for ALL data

		PB	Group	Depression	BPD	Age[a]	Sex[a]	Methods
Group[a]	r	- .327						
	Sig.	.000						
Depression	r	- .406	- .387					
	Sig.	.000	.000					
BPD	r	- .338	.388	- .661				
	Sig.	.000	.000	.000				
Age	r	.083	- .057	- .044	-.061			
	Sig.	.301	.476	.582	.442			
Sex	r	.041	.019	- .090	.073	- .092		
	Sig.	.613	.820	.266	.370	.258		
Ethnicity	r	-.265	.622	-.316	.203	0.031	-.052	
	Sig.	.001	.000	.000	.010	.700	.521	
Methods	r	.491	.347	.556	- .583	.151	.184	
	Sig.	.000	.002	.000	.000	.181	.107	
Frequency[a]	r	.444	.272	.356	- .357	.082	.111	.700
	Sig.	.000	.014	.001	.001	.463	.326	.000

Bivariate correlations between the Perceived Burdensomeness score (PB), group, depression score (Depression), BPD score (BPD), age, sex, number of NSSI methods (methods) and number of NSSI events (Frequency). (a) Spearman's Rho is presented for all pairs with one or more categorical variable (Sex, Ethnicity, xxx). In all other cases, Pearson's Correlations are presented.

Table 4

Bivariate Correlations between PB Score, Depression score, BPD Score, Age, Sex, Number of Methods of NSSI and Number of NSSI events for NSSI Group

		PB	Group	Depression	BPD	Age[a]	Sex[a]	Methods
Depression	r	.662	.279					
	Sig.	.000	.012					
BPD	r	- .518	- .284	-.555				
	Sig.	.000	.010	.000				
Age	r	.080	- .012	- .004	- .206			
	Sig.	.475	.911	.972	.064			
Sex	r	- .014	- .046	- .068	-.026	-.126		
	Sig.	.900	.685	.549	.822	.270		
Methods	r	.502	.320	.577	- .507	.090	.104	
	Sig.	.000	.003	.000	.000	.424	.362	
Frequency[a]	r	.427	.349	.376	- .350	.062	.091	.714
	Sig.	.000	.002	.000	.002	.588	.433	.000

Bivariate correlations between the PB score (PB), group, depression score (Depression), BPD score (BPD), age, sex, number of NSSI methods (methods) and number of NSSI events (events). (a) Spearman's Rho is presented for all pairs with one or more categorical variables (Age, Sex, Frequency). In all other cases, Pearson's Correlations are presented.

Homoscedasticity of full Dataset

The homogeneity of variance of the dependent variable was analysed using a non-parametric Levene's Test. PB Score was found to be homoscedastic when grouped with the Group variable (Levene's = 1.659, p=.178).

Homoscedasticity of Groups 1 & 2 Dataset

The homogeneity of variance of the dependent variable was analysed using a non-parametric Levene's Test (as this is the most robust test for data that has some skew). PB Score was found to be homoscedastic when grouped with number of NSSI events (Levene's = 1.335, $p \leq .253$).

Appendix H: Research Case Study

Research Case Study[5]

A Research Case Study: How My Doctoral Thesis Research Has Contributed To My Clinical Practice As a Clinical Psychology Intern

Louise Edwards

DClinPsych Candidate, Massey University

Clinical Psychology Intern

Central Region Eating Disorder Service, Hutt Valley DHB

This case study represents the work of Louise A Edwards during her internship in 2017.

Clinical Supervision was received during all the work described in this case study. Names and other identifying information within the case study have been changed to protect the privacy clients. Please note however, this case study is to be kept confidential.

[5] This case study was completed as a requirement of the Doctor of Clinical Psychology training program.
The purpose of this case study is for doctoral candidates to consider the impact their research process has had on their clinical work during their internship. This case study was included in the author's 2017 examinations.

ABSTRACT

This case study outlines and reviews my doctoral thesis, discussing the development of the thesis topic focused on the role of perceived burdensomeness in young adults who engage in non-suicidal self-injury and suicide in New Zealand. The development of the research topic is discussed, including a brief explanation of Thomas Joiner's Interpersonal Theory of Suicide, currently the most widely accepted theory as to why people die by suicide. Each of the two research studies including aims, methodology and overview of preliminary findings to date are summarised. The second half of the case study provides my own personal reflections on how the process of and the results from my research have assisted me in my transition from psychology researcher to intern clinical psychologist at the Central Region Eating Disorder Service (Hutt Valley District Health Board). My reflections include discussions of assessment and interview skills, similarities between non-suicidal self-injury and eating disorders, the presences of perceived burdensomeness and self-harm amongst eating disorder clients and self-confidence.

Keywords: Eating disorders, Clinical psychology, Intern Clinical Psychologist, Learnings, Non-suicidal self-injury, Research

DOCTORAL THESIS OVERVIEW

My doctoral thesis topic focused on the role of perceived burdensomeness in young adults who engage in non-suicidal self-injury and suicide in New Zealand. The overall study was made up of two separate research studies with a focus on both quantitative and qualitative data collection. The following is an overview of the thesis topic, aims, methodology and initial results for each of the two research studies.

THESIS TOPIC DEVELOPMENT

The thesis topic developed out of a long standing passion to address the high rates youth suicide in New Zealand. While the literature on suicide, causes, risk factors and prevention continue to grow, suicide rates worldwide continue to be a major health concern (e.g., Cox et al., 2013). The World Health Organisation suggests that a life is lost to suicide approximately every 40 seconds (World Health Organization, 2014). In New Zealand suicide has been a regular media topic over recent years, with over 500 people completing suicide in this country every year and many more making attempts. New Zealand's youth suicide rather is reported to be one of the highest in the OECD (Ministry of Social Development, 2016).

A comprehensive review of the literature highlighted a number of things, the first was that research studies into suicide in New Zealand were limited, much of the data that is currently available is either a number of years old, and therefore perhaps inaccurate or data that was collected from other countries and therefore also perhaps inaccurate when applied to a New Zealand population. It is evident from the literature that the characteristics of suicide and suicide attempts vary significantly between countries, communities, and demographic groups, differences are also seen across time (World Health Organization, 2014). The literature around suicide risk factors suggested that a highly correlated risk factor for suicide attempts was engaging in non-suicidal self-injury (NSSI; Glenn & Nock, 2014; May, Klonsky & Klein, 2012). What proved surprising at the time was that research had shown that engaging in NSSI conveys a greater risk for a suicide attempt than does any other known risk factor, including a past suicide attempt (Klonsky, May & Glenn, 2013). This initial literature review therefore suggested that while there are a number of important risk factors to consider when researching suicide, the link between NSSI and suicide may be one of the more important ones. If we could elucidate more about the link between these two behaviours, we could perhaps be better able to predict which individuals will and which individuals will not go on to make a suicide attempt, allowing for early intervention as a

method for reducing suicide rates. Further examination of the literature illustrated that New Zealand based research on NSSI was also limited. Literature investigating the link between NSSI and suicide attempts has not yet been conducted, although some international studies exist (e.g., Asarnow et al., 2011; Bryan, Bryan, Ray-Sannerud, Etienne, & Morrow, 2013; Cox et al., 2013; Klonsky, May & Glenn, 2013; Whitlock et al., 2013).

Overall, literature in this area was limited, and no literature was found for a New Zealand population. During the literature review process it was discovered that currently the most widely accepted theory for why people die by suicide is the Interpersonal Theory of Suicide (IPTS; Joiner, 2005; Van Orden et al., 2010). The IPTS is briefly explained below.

The Interpersonal Theory of Suicide

The Interpersonal Theory of Suicide (IPTS; Joiner, 2005; Van Orden et al., 2010) was first proposed by Thomas Joiner in 2005. The IPTS posits that serious suicide attempts occur when an individual has both the desire to die and the capability to act upon that desire. The desire to die is thought to develop in the presence of two interpersonal constructs occurring concurrently – *thwarted belongingness* and *perceived burdensomeness*. However, in order for an individual to engage in serious suicidal behaviour, they must also acquire the *capability for suicide* (Van Orden et al., 2010). **Figure 2** shows a simplified illustration of the IPTS model, illustrating how the three constructs suggested as being central to suicidal behaviour combine, resulting in a relatively small proportion of individuals who make a serious suicide attempt (Van Orden et al).

Thwarted Belongingness is focused on social isolation or alienation from valued social circles such as friends and family. When the fundamental human need to belong is not met, the multidimensional construct of thwarted belongingness (akin to social connectedness or social integration) results (Baumeister & Leary, 1995).

To feel that one is a burden or a liability on significant others has been shown to be a key variable in the development of suicidal ideation and behaviour, and correlated to both hopelessness and levels of depression (Van Orden, Lynam, Hollar, & Joiner, 2006). Perceived burdensomeness is a mental state comprising two components – self-hate and a

belief that others would 'be better off without me' which is fostered when the need for social capability is unmet (Van Orden et al., 2010).

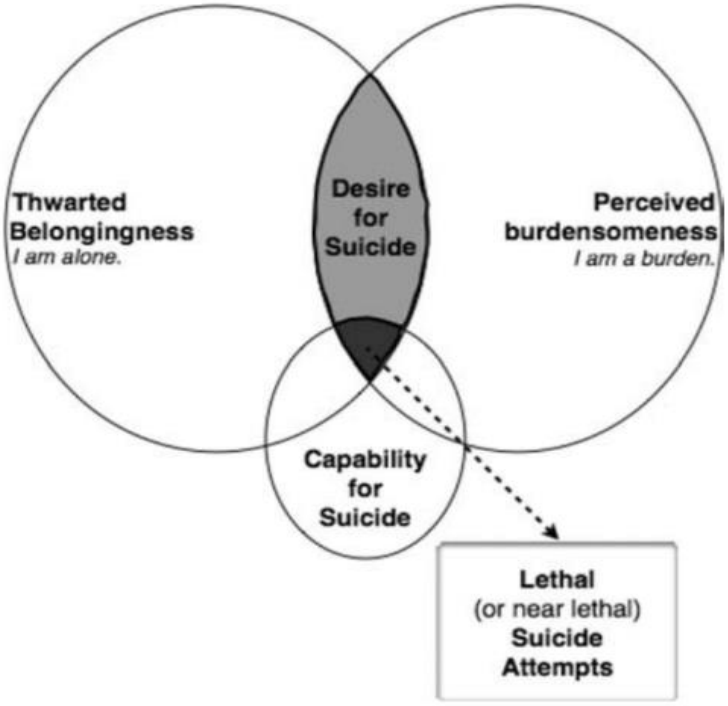

Figure 2: Assumptions of the interpersonal theory of suicide (Van Orden et al., 2010)

The desire to die by suicide is not adequate to result in a serious suicidal attempt. Individuals must also eliminate some of the fear related to making a serious suicide attempt in order to engage in self-injury with lethal intent (Joiner, 2005).

NSSI is a risk factor for suicidal attempts (Klonsky et al., 2013), and thus the relationship between NSSI and suicide attempts suggests that these three factors are also related to NSSI (although perhaps to a somewhat lesser extent), for example acquired capability for suicide may be gained through NSSI. It is therefore appropriate to use the IPTS model to attempt to ascertain the difference between NSSI and suicide attempts for the three constructs the IPTS includes (acquired capability, thwarted belongingness and perceived burdensomeness). Of the three constructs, a significant amount of literature was available on thwarted belongingness and acquired capability; however literature focused on perceived burdensomeness was limited. To date, there has not been any data published

specifically looking at the role of the perceived burdensomeness or its role in either NSSI or suicide within a New Zealand population. Perceived burdensomeness was therefore decided on for the focus of the doctoral study.

RESEARCH STUDY AIMS

The rationale for this research was driven by the distinct lack of research into non-suicidal self-injury and its link to suicidal behaviour within the New Zealand population. By conducting research into both NSSI and suicidal behaviour within the New Zealand context it is possible to gain a better and more in-depth understanding of these behaviours in New Zealand. In turn this would provide further elucidation around each of these behaviours and the link between them. It was hoped that this better understanding would lead to a greater ability to treat people at risk of or already engaging in such behaviours and as such make some difference to the rate of both NSSI and suicide attempts in New Zealand.

The aims and methodology of the two studies are be outlined below.

1. To gain further insight into the role of perceived burdensomeness and its relationship with NSSI and suicidal behaviour

2. To ascertain at what point perceptions of burdensomeness become relevant to suicidal behaviour

3. To explore themes, narratives and meaning making of burdensomeness amongst those who have engaged in self-injurious behaviours

METHODOLOGY – STUDY 1

DESIGN

A quantitative between-subjects survey design was utilised, in order to assess group differences across a number of areas focused on perceptions of burdensomeness, non-suicidal self-injury (NSSI) and suicide attempts (SA).

PARTICIPANTS

Respondents were New Zealand citizens aged between 18 and 24 years of age.

Recruitment – Participants were recruited through a variety of methods, including through Massey University course coordinators, graduate student mailing lists and Facebook groups. The survey information and a link to the online survey were shared or emailed to prospective participants

Exclusion Criteria - If prospective participants were between ages 18 and 24 years they were eligible to be included in the study. The survey included psychometric measures designed to highlight possible depression or borderline personality disorder traits which may increase the likelihood of either NSSI or a suicide attempt, however this did not mean they were excluded from the study.

PROCEDURE

The survey - Between 20 and 60 items long (the number of items varied depending on participant answers as they worked through the survey). The items making up the survey were selected from existing measures possessing good reliability and validity. Questions focused on NSSI and perceived burdensomeness with some emphasis on suicidal thinking and attempts, mood and borderline personality disorder traits.

METHODOLOGY – STUDY 2

DESIGN

Interpretative Phenomenological Analysis (IPA) (e.g. Smith, 2008), a qualitative methodology was utilised for Study 2. IPA allows for the examination of how people make sense of their life experiences (Smith, 2008) and therefore aligns well with the third research aim.

PARTICIPANTS

Respondents were New Zealand citizens aged between 18 and 24 years of age.

Recruitment – Participants were recruited through similar methods to Study 1. In addition, those participants who completed Study 1 were asked to indicate if they would be

willing to participate in a one-on-one interview to further explore the areas covered in Study 1.

Exclusion Criteria – There were no exclusion criteria, however participants who were currently engaged in mental health services were encouraged to speak to their key healthcare worker about the interview.

PROCEDURE

Semi-structured Interview - Data collection for IPA is required to be flexible; as such a semi-structured interview used, allowing the researcher to follow up on areas of importance as they come to light. The interview was designed to focus on the extent of perceived burdensomeness of the individual on others in his/her life and questions were informed from data obtained from Study 1.

All interviews were recorded and fully transcribed verbatim following completion, IPA was then used to analyse the transcripts both individually and together.

ETHICAL CONSIDERATIONS

Due to the focus of the proposed study being self-injurious behaviours, including both non-suicidal and suicidal behaviours, it was important to consider the effects that participating in the study may have on individuals. While it was anticipated (following careful consideration) that the risk for an increase in self-injurious behaviour in participants as a result of answering survey questions or participating in a one-on-one interview would be low, thorough safety procedures were still implemented in order to mitigate any risk. At two points during the online survey and at the end of the interview, participants were provided with an information sheet that detailed a number of helplines and face-to-face counselling services that the participant could contact should they decide they needed to talk to someone about any issues raised during the survey.

Prior to conducting each one-on-one interview, an initial risk assessment was conducted with each participant (including but not limited to use of the *Beck Hopelessness Scale*). This risk assessment was conducted by the researcher, and any concerns were reported to a registered clinical psychologist for consultation or to take further action. Each

interview was also supervised in real time by an highly experienced clinical psychologist as further safety measure.

In addition to these measures, both members of the research supervision team are registered clinical psychologists with extensive experience whom the researcher was able to discuss any problems or concerns with.

Full ethics approval was granted by the Massey University Human Ethics Committee (Approval 15/50)

SUMMARY OF INITIAL RESULTS

Data Analysis is still currently being conducted; however some valuable learnings that are applicable to working as an intern clinical psychologist are outlined below:

STUDY 1

204 individuals participated in the survey.

- The mean age for beginning NSSI was 14 years old and the mean age for ceasing this behaviour was 20 years old.
- Reasons for engaging in NSSI were overwhelming reported to be as a form of **regulating emotion**, for example feeling upset (62% of participants) or feeling angry (45% of participants). Feeling like a burden on others was endorsed by 20% of participants.
- Almost 40% of participants indicated that they had injured themselves more seriously than they intended to do and almost 30% have injured themselves badly enough to require hospital attention. 20% of participants who had engaged in NSSI had harmed themselves in a non-suicidal manner more than 50 times.
- 35% of participants endorsed feeling like a burden on others in their lives (most commonly on parents – 81% and on friends – 67%)

STUDY 2

Six interviews were completed to make up the Interpretative Phenomenological Analysis

- Results suggested that while a sense of **perceived burdensomeness** was almost always present, equally important was a sense of **guilt**. Guilt for engaging in NSSI, guilt for being a burden and guilt around various other things.
- To use the Five Part Model and cognitive behavioural terms to illustrate, it is suggested that when the behaviour is NSSI, it is common for the cognitions to involve thoughts of perceived burdensomeness and blame, and a feeling of guilt.

CLINICAL PSYCHOLOGY INTERNSHIP – SELF REFLECTION

In January 2017, I started at the Capital & Coast District Health Board as a clinical psychology intern. The first six months of my internship was spent at the Infant, Child, Adolescent and Family Service based at the Hutt Hospital. The second six months was spent at the Central Region Eating Disorder Service based in Johnsonville. This research case study is written during the second half of my internship. The following section consists of a discussion and self-reflection on my transition and development from psychology researcher to intern psychologist. These reflections outline and analyse how skills gained through conducting my research study have assisted with my work as an intern psychologist.

Assessment & Interview Skills

The skills required to conduct a thorough and comprehensive assessment with a client are numerous. While my research consisted of interviewing participants on just a few main areas, the skills that I learned and the confidence I gained in interviewing people on a psychological level were evident when I began my internship.

While I was conducting my research, I began to hone the skills required to build rapport and gain pertinent information efficiently while ensuring the individual being interviewed felt heard and validated. Each of my interviewees was very different, while they were linked by mental health struggles (as all my clients have been during my internship), it was necessary to build a relationship (albeit a brief one) in order to ensure the participant felt comfortable sharing very personal information. When I began interviewing people within each of my services I have worked in during my internship I relied on these skills that I had learnt while conducting research, facilitating a strength in my clinical work – that of building rapport and a therapeutic alliance.

One of the strengths of a semi-structured interview is that the interviewer is able to move where the interviewee would like to go with the interview, rather than containing the interview with tight parameters. This is similar to the way in which a clinical interview within the DHB must be conducted, to follow a tight script allows for the possibility of missing the person in the room, and seeing them only as a list of diagnostic criteria, checked off a list. The skills I gained while conducting interviews during my research laid a very strong foundation for me as I moved into each of the services during my internship.

Risk Assessment

Conducting my doctoral research provided me with much knowledge on risk and risk assessment. I gained much confidence in discussing risk with participants and ascertaining both what the level of that risk might be and also what the function of self-harming might be. Knowledge and understanding in the areas of burdensomeness and guilt have also provided me with areas that are important to explore during a thorough risk assessment. The skills and confidence that I gained in this area during my research led to risk assessment being a strength of mine during assessment. In order to thoroughly understand risk, the function of behaviours must be explored. Going into my internship I had a skill set, accompanied by much knowledge around how to assess these areas adequately, giving me confidence when working with clients who posed some risk, either through NSSI, possible suicide attempts, disordered eating and associated behaviours (such as restriction or purging).

Clients sense making and Clinician making sense of their sense making

Through conducting an interpretative phenomenological analysis I learned a lot about the interpretation of lived experience, both by the individual living that experience and by the clinician interpreting the individual's interpretation. It has quickly become apparent when working with individual's with eating disorders that the clinician must be able to remain focused on the person and not on the illness. There are many medical risks associated with eating disorders and I have been exposed to examples where the person has been lost in the myriad of medical symptomology. By dedicating so much time during my research in attempting to interpret an individual's own interpretation of their lived experience, I have developed strengths in keeping the person and their own lived experience central to my work. This is so important when practicing as a clinical psychologist, because our work with clients is a partnership, and if we are unable to find the person in the room, then we are unlikely to have the skills to make a different in that person's life. The very idea that we as

psychologists are only interpreting the client's interpretation of their life is important. We are able to guide, to illuminate, to illustrate and to teach, but we cannot, nor will we ever be able to truly experience life for our client's. Separation of the person from the illness is of utmost importance, especially in the eating disorder field, because by assisting clients (and their family members) to attribute the symptomology to the illness and not the person they are able to once again gain some control and motivation to recover.

Similarities between NSSI and ED

While working at the Central Region Eating Disorder Service (CREDS), it became apparent very quickly how the skills and knowledge gained through conducting my research are highly relevant when working as a clinical psychologists with eating disorder clients. Through conducting my research I learnt about the link between emotional dysregulation and impulse control in the context of distress and engaging in NSSI. Research (including my own research) suggests that NSSI is used as a maladaptive coping strategy for dealing with aversive emotions. Very early in my work with individuals afflicted by eating disorders showed that compensatory behaviours including binge-purge cycles seen in individuals with eating disorders, are also often a way in which these individuals attempt to regulate difficult emotions. When talking to individual's with eating disorders I have found that they are often talking to me about the same struggles as the individuals' who participated in my doctoral study. Over and over when talking to clients who engage in severe restriction and/or binge-purge cycles I am told things such as the client felt angry, they felt sad, they were upset, or they felt anxious and eating disorder behaviours helped these client's to cope with these overwhelming emotions. The similarities are marked, and my knowledge of NSSI through conducting my research has given me a much more in-depth and greater understanding for the clients I am seeing at CREDS. Both NSSI and eating disorders involve maladaptive behaviours used as a short term coping mechanism for overwhelming emotion. Various physical dangers are associated with both and both can become almost habitual, at times resembling a physiological addiction (although neither is). This understanding of maladaptive attempts to regulate difficult emotions was a huge help for me in understanding my clients at CREDS.

Guilt

"…I feel guilty if I purge. But if I don't purge, I feel just as guilty for missing an opportunity…"

While working with clients at CREDS I commonly see broad feelings of guilt and a desire (and often action) to engage in self-punishment. A common theme apparent during my research was feelings of guilt around NSSI and suicide attempts. Guilt for engaging in NSSI (or suicide attempts), guilt for being a burden on those close to them and even guilt when they do not engage in this maladaptive coping strategy. This knowledge and understanding has again given me a particular understanding for the clients I am working with who suffer from eating disorders. Feelings of guilt are strong amongst all eating disorder presentations. One client explained to me that she felt guilty when she didn't eat anything, however if she did eat she felt just as much guilt. As a result she made the choice that would cause her not to put on weight (her greatest fear), and therefore chose not to eat - since she would feel guilty either way. Another client explained that if she missed an opportunity to purge she would feel a lot of guilt around wasting opportunity, causing her to feel anxious and desperate for another opportunity, increasing her purging behaviour, which also led to strong feelings of guilt. This internal conflict is something that is seen almost universally with eating disorder clients.

Perceived Burdensomeness

Perceived burdensomeness has thus far been more difficult to see, perhaps because the incredibly strong perfectionistic tendencies and the significant enmeshment with the disorder, limits the clients' ability to see what effect they may or may not be having on those around them. I am interested to see if this changes as weight is gained, full cognitive ability is restored and recovery is reached. Due to the learnings from my research, perceptions of being a burden on others is always something that I am alert too due to its relationship to self-harm and suicide. Suicide in eating disorder clients is not uncommon and my doctoral research has allowed me to feel comfortable and confident around dynamic risk factors.

Summary

To summarise, my doctoral research has equipped me with a significant amount of both practical skill and knowledge to greatly assist me with my transition from psychology researcher to intern clinical psychologist and my development in this role. I consider myself incredibly lucky to have gained so much knowledge that is directly applicable to the client's I am working with, allowing me to feel comfortable and confident as I work towards becoming a fully qualified clinical psychologist.

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