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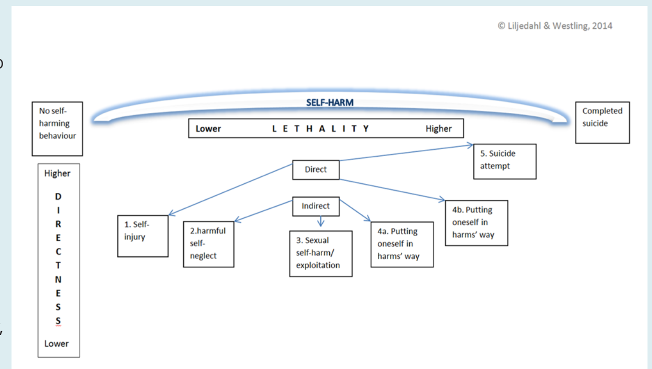
A UNIFIED THEORETICAL FRAMEWORK OF SELF-HARMING BEHAVIOUR: SYNTHESIS OF DIVERGING DEFINITIONS AND PERSPECTIVES

Background

In the field of self-harm research, two major positions and corresponding definitions have evolved. Plener, Libal, Keller, Fegert and Muehlenkamp (2009) note that "Deliberate self-harm" (or simply "self-harm") is a broad definition that does not specify suicidal intent, mainly used by researchers in Britain, Europe and Australia (Hawton, Rodham, Evans & Weatherall, 2002; National Institute for Clinical Health Excellence: NICE, 2004; 2011; 2013). "Non-suicidal self-injury" (NSSI) encompasses only behaviours resulting in direct tissue damage in the absence of suicidal intent, a formulation historically used in North America. Researchers have formulated NSSI as arising from experiential avoidance (Gratz, 2003; 2010) and difficulty regulating emotion (Chapman, Gratz, & Brown, 2006; Gratz, & Gunderson, 2006). Neither position systematically evaluates forms and functions of indirect self-harm. The discrepancy between definitions and deficiency of either alone produces an inability to compare results in clinical research studies, and limits the applicability of evidence-based treatments.

Other research (Brausch & Guitierrez, 2010) and theoretical models (Hamza, Stewart & Willoughby, 2012) have proposed that NSSI and suicide are end-points on a self-harming spectrum. The Unified theoretical framework of self-harming behaviour is developed with an aim to fully encompass all possible forms of self-harming behavior and their possible interrelatedness, to aid individuals with lived experience and their clinicians to detect, understand, and effectively respond when the form of a self-harm behavior changes. This theory, its model, and the clinician-administered assessment measure, the Five self-harm behaviour groupings (5S-HM: Liljedahl, Westling, Wångby-Lundh, Daukantaite, 2015) are derived from the literature on suicide, self-harm, NSSI, and Borderline Personality Disorder (BPD).



Self-harm and suicide: Empirical and theoretical review

The demarcation between self-harm and suicide attempts is continually discussed. Relatively recent studies indicate that NSSI is strongly associated with risk for future suicide attempts, at times more so than an actual suicide attempt. This is particularly true for adolescents with "treatment resistant" depression (Asarnow, 2011), and more generally depressed youth who self-harm (Wilkinson, Kelvin Roberts, Dubicka & Goodyer, 2011). A recent study by Tsirigotis, Gruszczynski and Lewik-Tsirigotis (2013) concluded that indirect and direct self-harm behaviours were not only strongly associated, but shared a relationship with suicidality.

Other self-harm researchers (Klonsky, May & Glenn, 2013) have interpreted the significant predictor of NSSI on future suicide attempts within Joiner's (2005) interpersonal-psychological theory of suicide. This theory posits that to take one's life requires both the desire to die and the capability to take one's life. NSSI may become the vehicle that merges these two aspects of suicide by lowering the threshold of alarm and responsiveness to self-inflicted pain and consequence (Joiner, 2005). An integrated theory of NSSI and suicidal behavior (Hamza, Stewart & Willoughby, 2012) has linked Joiner's (2005) work alongside two other theoretical models, the "Gateway theory" (Brausch & Gutierrez, 2010) and the "Third variable theory" (Jacobson, Muehlenkamp, Miller & Turner, 2008) as described in review by Hamza, Stewart and Willoughby (2012). These theoretical models contribute to the literature by explaining possible predictors and routes from NSSI to suicide attempts.

The difference in earlier theoretical work and our model is our aim to exhaustively query all forms of self-harming behavior, and provide a theoretical framework and assessment measure for clinicians to do so. We propose that accurate mental health functioning in self-harming individuals can only be arrived at by effectively capturing self-harm in all of its various forms, importantly also considering changes in the forms of self-harming behaviour over time.

Intent

Given the tendency for co-occurrence of suicide attempts in individuals who self-harm, suicidal intent must also be queried alongside the forms and functions of self-harm evaluated in clinical practice. This is particularly so amongst clinical populations who may experience frequent emotion dysregulation and chronic suicidality as in the case of Borderline Personality Disorder (BPD) (Linehan, 1993). Lieb, Zanarini, Schmahl, Linehan and Bohus (2004) describe BPD as a disorder characterized not only by affective disturbance, but also by cognitive disturbance. Cognitive disturbance in a moment of high distress due to emotion dysregulation may prevent an individual from planning or formulating whether or not their behavior is intended to change their pain or end their life.

It is also possible that cognitive disturbance in situations of heightened emotion dysregulation may not be unique to BPD. There is some suggestion that intent is not always well formulated amongst self-harming individuals without BPD as well. A relatively recent major study followed individuals who sought treatment after harming themselves. No significant difference was found in the risk of suicide with respect to whether or not participants had suicidal intent at the time of the assessment (Cooper et al., 2005). Clearly, the role of suicidal intent and its relatedness to suicidal behaviour in self-harming individuals must be further evaluated.

Model Description: Unified theoretical framework

The model in the accompanying figure depicts *directness* of self-harm vertically and *lethality* of self-harm horizontally. Both dimensions[1] range from lower to higher. Each of the five self-harm behavior groupings fall between the two end-points on a broad self-harming behaviour spectrum (the arc across the top of the figure).

The end points of non-suicidal self-injury (NSSI) and suicide attempts (or suicide behavior disorder if attempts recur within 24 months) are relatively consistent with *Conditions for further study* proposed by the fifth edition of the *Diagnostic and statistical manual of mental disorders*[2] (DSM-5; American Psychiatric Association: APA, 2013). Although NSSI and suicide behaviour disorder (SBD) are proposed as separate clinical entities in DSM-5, with features that distinguish one from the other, they are not formulated to be mutually exclusive at the level of the individual (D. Clarke, personal communication, Feb 8, 2014). That is, the same individual can demonstrate behaviours encompassed by NSSI and SBD over time; only not while coding the same exact behavioural event.

The five self-harm behaviour groupings within the model are (from lower to higher lethality):

1. Direct: Self-injury (consistent with NSSI).
2. Indirect: Harmful self-neglect; behaviours consistent with very poor selfcare.
3. Indirect: Sexual self-harm or self exploitation; behaviours engaged in without sexual interest or the motivation of pleasure or experience.
4.a. Indirect: Putting oneself in harms' way; exposing oneself to high likelihood of injury or violence such as walking alone at night in neighbourhoods known for violence.
4.b. Direct: Putting oneself in harms' way, such as laying down on train tracks.
5. Direct: Suicide attempt; Self initiated behaviours undertaken to kill oneself.

1 We refer directness and lethality as dimensions rather than Y and X axes to avoid the proposal of perfect or orthogonal associations between self-harming and suicidal behaviours.
2 In contrast to Suicide Behaviour Disorder in DSM-5, we do not exclude intoxication, political or religious motivation in our formulation of suicide attempts.

Like NSSI and suicide attempts, we propose that there are common features between direct and indirect forms of self-harm. The behaviours may change form, directness, and lethality. Suicidal intent is understood within the theory and the model as either chronic or episodic, but not perfectly aligned to behaviours due in part to the previously-discussed role of cognitive disturbance. We expect ambivalence, interruptions, and learning to also play a role in the alignment between suicidal intent and suicide attempts (DSM-5, 2013).

Testing the Model: Next Steps

The *Unified theoretical framework of self-harming behaviour* provides a descriptive model uniting self-harming and suicidal behaviours that have sometimes been formulated separately. We conclude that the role of indirect self-harm has not been thoroughly investigated in the existing literature. From clinical experience with individuals who were suicidal and self-harming for years, we believe that the role of suicidal intent must also be more thoroughly investigated alongside indirect and changing forms of self-harm. In order to test the model we have developed, we will begin collecting pilot data to generate clinical cut-offs using the clinician-administered assessment derived from the *Unified theoretical framework of self-harming behaviour* titled the *Five self-harm behaviour groupings* (5S-HM: Liljedahl, Westling & Wångby-Lundh, Daukantaite) in 2015. This measure has been developed in two languages (Swedish and English), for testing in a comparison study once pilot testing is complete.

For more information about measure, the pilot, or comparison study, please contact the corresponding author.

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