A unified theoretical framework for understanding suicidal and self-harming behavior: Synthesis of diverging definitions and perspectives

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Self-harm and suicide: Empirical and theoretical review

The demarcation between self-harm and suicide attempts is continually discussed. Recently, several studies indicate that NSSI is strongly associated with risk for future suicide attempts, at times more so than actual suicide attempts. This is particularly true for adolescents with “treatment-resistant” depression (Asarnow, 2011), and more generally depressed youth who self-harm (Wilkinson, Roberts, Dubicka, & Goodyer, 2011). A recent study by Töring, Gruszczynski, and Söder (2011) demonstrated 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 do 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” (Brasch & Grajziter, 2010) and the “Third variable theory” (Jacobson, Muenkenkamp, 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 and 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 behavior over time.

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 range from lower to higher. Each of the five self-harm behavior groupings fall between the two end-points on a broad self-harming behavior 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’ (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 self-care.
3. Indirect: Sexual self-harm or self-exploitation; behaviours engaged in without sexual interest or the motivation of pleasure or experience.
4a. Direct: 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.
4b. Direct: Putting oneself in harms way, such as laying down on train tracks.
5. Direct: Suicide attempt; Self initiated behaviours undertaken to kill oneself.

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, Wängby-Lundh, Daukantaitė, 2015) are derived from the literature on suicide, self-harm, NSSI, and Borderline Personality Disorder (BPD).
A UNIFIED THEORETICAL FRAMEWORK OF SELF-HARMING BEHAVIOUR:
SYNTHESIS OF DIVERGING DEFINITIONS AND PERSPECTIVES

References


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