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Understanding the extent in which NSSI and ODI-type behaviour are ways of dealing with the same issues for young people in New Zealand

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Abstract

NSSI and some forms of aggression are behaviours that appear to have similar functions and risk factors. There is a gap in the research in understanding the extent of how these behaviours crossover and are ways of dealing with the same issues. 10 semi-structure in-depth interviews were conducted to understand ways of dealing with negative emotions and if this differed with engagement in NSSI or ODI-type behaviours. Overall this research found that while they were ways of dealing with the same issues, the individuals experience of emotion, interpersonal relationships and situational factors determined the extent of what behaviour they engaged in.

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Chapter One: Introduction

Today's adolescents are experiencing a rapid increase in mental health concerns (Sutcliffe et al., 2022). Adolescents are found to experience more stress than any other age groups, as they navigate a challenging social world without adult skills, experience or resources (Celik, 2022). A 2023 New Zealand survey describes the state of adolescent mental health as a crisis with 82% of youth identifying mental health as the biggest issue they were facing (State of the Generation Report, 2023). Struggles with mental health are a risk factor for harmful behaviours against the self, risk of causing harm to others and a strong indicator of suicide (Harford et al., 2017; Kimbrel, Calhoun, et al., 2017; Slesinger et al., 2019; Voss et al., 2020). New Zealand, in particular, is consistently ranked with one of the highest youth suicide rates in the OECD and a higher engagement in non-suicidal self-injury (Fitzgerald & Curtis, 2017; Sutcliffe et al., 2022).

Non-suicidal self-injury (NSSI) is a harmful behaviour against the self and is a stronger prospective predictor of suicide attempts than a prior history of suicide attempts (Glenn & Klonsky, 2013; Harford et al., 2017; Kimbrel, Calhoun, et al., 2017 & Selby et al., 2015). NSSI is described as representing a major public health concern with a dramatic increase in prevalence over the past few decades (Bresin & Schoenleber, 2015). There is insufficient research to precisely determine the prevalence but Garisch and Wilson's (2015) New Zealand study indicated a lifetime prevalence rate of 50% for young people while international prevalence rates vary due to the influence of a range of methodological, demographic, health, and social factors (Slesinger et al., 2019). Individuals who engage in NSSI are likely to also engage in indirect forms of harmful behaviours such as disordered eating or reckless behaviour (Bentley et al., 2014; Christoffersen et al., 2014; Garisch & Wilson, 2015).

NSSI is defined as deliberate self-directed injury or tissue damage without suicidal intent (Dierickx et al., 2023; Kimbrel et al, 2018; Klonsky, 2011; Lengel et al., 2025 & Simone, Yu, & Hamza, 2022). Slesinger et al. (2019) found that the most common methods of NSSI are cutting and severe scratching of skin. Other methods include hitting the self, banging the head, preventing or picking injuries and burning skin. Common beliefs align NSSI as more prevalent among young females, however, literature suggests that males and females engage at similar rates but they may take different forms (Christoffersen et al., 2014; Fitzgerald & Curtis, 2017; Kimbrel, Calhoun, & Beckham, 2017; Kimbrel, et al., 2018; Voss et al., 2020). Research finds that young females engage in behaviour that is explicitly harmful to themselves, such as cutting, whereas young males engage in more externalising behaviours such as instigating fights or striking objects or striking objects with the intention of causing self-injury (e.g. Bresin & Schoenleber, 2015; Christoffersen et al., 2014; Fitzgerald & Curtis, 2017; Voss et al. 2020). When young females injure themselves the intent is more obvious as self-injurious, but with young males it is more likely to be misinterpreted as aggression. Fitzgerald and Curtis (2017) found that both genders' primary reason for their behaviour was to relieve stress and to deal with uncomfortable emotions.

A study by Kimbrel et al. (2017) looked at the prevalence of wall and object punching as a less recognized form of NSSI. As males were significantly more likely to engage in wall and object-punching than females, Kimbrel et al. (2017) found that by not systematically assessing wall and object punching as NSSI there was a bias in the prevalence of male engagement. This study shows that while there is evidence of different types of NSSI, there is little research into the reasons for engaging in different forms. In particular, there is little research into behaviours such as hitting or punching objects and where this could differ from NSSI to aggressive behaviour.

NSSI and aggressive behaviours have similar risk factors and are both linked to psychological disorders and high co-morbidity rates with substance abuse (Christoffersen et al., 2014; Harford et al., 2017; Richard et al., 2022; Voss et al., 2020). Research supports a theory of co-occurrence of aggression against self and aggression against others (e.g. Christoffersen et al., 2014; Harford et al., 2017; Richmond-Rakerd et al., 2019; O'Donnell et al., 2014; Shafti et al., 2021). Aggression against the self and against others are found to be positively associated, with individuals identified through one behaviour found to exhibit more of the other behaviour compared to those who engaged in neither (O'Donnell et al., 2014).

Adolescents struggling with mental health challenges such as mood, personality and substance use disorders are also found to be at an increased risk for violent behaviour or aggression (Garofalo & Velotti, 2017; Harford et al., 2017; Velotti et al., 2016). Aggressive behaviour is more often associated with young males and viewed as anti-social behaviour (Miller, 1994; Robinson & Wilson, 2020). These behaviours can appear in forms such as verbal and physical aggression against others or property (Harford et al., 2017). Data from the New Zealand Police (2025) show that acts intended to cause injury are the second most common crime type. Adolescents are consistently found to dominate this category, in particular young males making up for more than 70% of all acts. The New Zealand Ministry of Education also report an increase in violent behaviours amongst adolescents in schools (2025). However, this highlights more extreme behaviour and there is little research or data into less violent acts, particularly into the function of the behaviour.

The main models of the function of NSSI highlight the importance of the role of both intrapersonal and interpersonal factors such as interpersonal influence, self-punishment, emotion regulation, counteracting dissociation and feeling-generation (Bresin & Schoenleber, 2015; Kimbrel et al., 2017). Engagement with NSSI can be linked to exhibiting traits of

alexithymia as well as difficulty with recognition of internal psychological processes (Garisch & Wilson, 2015). Evidence suggests that the most common reason for NSSI engagement is relief from negative emotions and a way to deal with distress (Fitzgerald & Curtis, 2017; Klonsky, 2011). Similar to NSSI, research into the function of aggression and outward-directed violence show difficulties with alexithymia, emotion regulation and impulsivity as well as conflicting interpersonal and intrapersonal factors increase the risk of engagement in these behaviours (Garofalo & Velotti, 2017; Harford et al., 2017). Exposure to violence and childhood abuse are also congruent with increased risk of engaging in aggressive and violent behaviour (Watts & McNulty, 2013). Similarly, experiencing exposure to sexual abuse, physical acts of violence or threats to life in childhood are also associated with an increased risk of engaging with NSSI (Christoffersen et al., 2014; Garisch & Wilson, 2015; St Germain & Hooley, 2012).

NSSI and aggressive behaviour have commonalities in comorbidity, function and risk factors. There is a crossover of this behaviour with lower level aggressive behaviour such as wall and object punching, hitting the self and banging the head also being understood as a type of NSSI behaviour (Christoffersen et al., 2014; Fitzgerald & Curtis, 2017; Kimbrel, Calhoun, & Beckham, 2017; Kimbrel, et al., 2018; Slesinger et al., 2019; Voss et al., 2020). However, there is a gap in research in understanding to what extent these and other outward-directed injurious (ODI) type behaviours are ways of dealing with the same issues or if there are differences in their functions. A better understanding of these types of behaviours could ensure that populations are not misrepresented or misunderstood. By being able to understand the processes behind choosing to engage in these behaviours it could be determined if they are ways of dealing with the same issues and therefore if the same interventions can be used to treat them. Having effective interventions will provide better outcomes for adolescents.

Overview

This thesis will be comprised of four subsequent chapters. Chapter two will be a literature review. The review will commence with understanding and defining NSSI and ODI-type behaviours. The chapter will then focus on prevalence, followed by the context of New Zealand and the sociocultural factors which impact these rates. This will then follow with a review and comparison of theories, co-morbidities, risk factors, dual harm, role of gender and sexuality. The final section will review intervention strategies before concluding with a summary of key points and the research aims of this study.

The third chapter will consist of the methodology informing the study, followed by the method. This section will give an overview of the epistemology and provide an understanding of the research design. This will be followed by a description of the participants and how they were recruited. The chapter will also describe the research method with reference to research instruments, and an explanation of the chosen data analysis. This chapter will conclude with the considerations taken to ensure the wellbeing of the participants.

Chapter four will present the findings of the study. This will outline the key themes identified through data analysis. This will be followed by discussion of the results and compare these to the literature which informed the research. This section will also acknowledge the limitations as well as theoretical and clinical implications and suggestions for further research. Finally, chapter five will finish with a summary of the key findings.

Chapter Two: Literature Review

The chapter will start by reviewing the commonalities and differences in function, theory and risk factors of NSSI and ODI-type behaviour. NSSI has had a significant amount of research in the past few decades and there is a range of literature which has helped to define and understand the behaviour. The research for ODI-type behaviour comes from more general research on aggression but will focus on deliberate, not socially sanctioned, behaviour without suicidal intent which causes injury to oneself.

The definition of NSSI

Understanding and defining NSSI has had a surge of research in the past decade (e.g. Bresin and Schoenleber, 2015; Dierickx et al., 2023; Kimbrel et al., 2018; Kimbrel, Calhoun, et al., 2017; Klonsky, 2011; Lengel et al., 2025; Simone, Yu, & Hamza, 2022). While there were discussions of NSSI through the early 20th century, the foundations for the modern definition were not described until the mid to late century (Slesinger et al., 2019). In 1965, Neil Kessel introduced the definition of deliberate self-injury and argued that the intention was not always suicide, which paved the way for current literature (Slesinger et al., 2019). Despite its clinical and public significance over the past few decades it was not until the publication of the American Psychiatric Association's (2013) Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) that NSSI was officially recognised as a condition in need of further study (Lengel et al., 2025; Selby et al., 2015). Prior, NSSI's only official recognition within the DSM was as a criterion for borderline personality disorder (BPD) but is now recognized as a transdiagnostic condition (Bresin and Schoenleber, 2015; Kimbrel, Calhoun, et al., 2017; Lengel et al., 2025). A study by Nock et al. (2006) found that 48.3% of participants who engaged in NSSI did not meet the criteria for BPD. However,

Selby et al. (2015) found that individuals diagnosed with BPD were found to have been more likely to engage in NSSI. A 2004 study by Grilo et al. found that NSSI was the single strongest predictor of a BPD disorder.

In current literature, NSSI is defined as deliberate and not socially sanctioned self-inflicted tissue damage without suicidal intent (e.g. Dierickx et al., 2023; Kimbrel et al., 2018; Klonsky, 2011; Lengel et al., 2025; Simone, Yu, & Hamza, 2022). There are important components to consider that, over time, have determined behaviour as NSSI and as distinct from other self-harm behaviours (Slesinger et al., 2019).

An obvious component is that the injury must be inflicted by the individual and not accidental or by another person. The type of self-injury is another important component that can differentiate NSSI from other self-injurious behaviours. St Germain and Hooley (2012) determined that immediate and deliberate damage to the tissue separates NSSI from other harmful behaviours such as disordered eating, substance abuse or reckless behaviour. The most common methods of NSSI are cutting and severe scratching of skin (Slesinger et al., 2019). A survey by Slesinger et al (2019) identified other commonly used methods such as hitting self, banging the head, preventing or picking injuries and burning skin. Less common methods included tattooing for pain, inserting or embedding objects, gouged skin and broken limbs (Slesinger et al., 2019). This was similar to the results of an earlier study by Klonsky (2011) which found the most common methods were "cutting and scraping the skin followed by burning, hitting, biting and interfering with wound healing" (p.1983). Results from across studies found that there is usually more than one method used (e.g. Klonsky, 2011; Selby et al., 2015; Slesinger et al., 2019).

Intention has been identified as a particularly important component for determination of behaviour as NSSI. Intention helps to separate NSSI from self-inflicted injuries for cultural, religious or beautification reasons and from suicidal self-injury (Slesinger et al., 2019). It is also important to determine the self-injury has not occurred in response to psychosis or during the use of substances (Selby et al., 2015). A suicidal intention would then classify the self-injury as a suicide attempt in accordance to the definitions from DSM-5 (2013) as opposed to NSSI.

Understanding ODI-type behaviour

To understand ODI-type behaviour, it is important to understand the types of aggressive behaviour that ODI could be comprised of. These outward-directed behaviours could appear in verbal and physical forms. These behaviours could include actions such as wall or object punching, violence directed towards others, name-calling or insulting others (Harford et al., 2017; Tao et al., 2021). These behaviours can also be indirect and cause damage to social relations (Tao et al., 2021). This is described as relational aggression and can include behaviours such as rejecting others. These are behaviours that are often described and understood as a type of aggression, and can also be understood as a type of NSSI, such as hitting the self, wall and object punching and banging the head (Kimbrel et al., 2017; Slesinger, 2019).

Therefore, to understand ODI-type behaviours it is important to understand aggression. Aggression is a cognitive, cultural and biological process and a part of natural human behaviour which is vital for survival and facing everyday adversities in life (Haidu & Vlaicu, 2020; Velotti et al., 2016). There are some common antecedents identified that could precede aggressive behaviour. Emotion has been identified as an important element by

numerous studies researching aggressive behaviour (Garofalo & Velotti, 2017; Velotti et al., 2016; Watts & McNulty, 2013). Normal aggression varies in intensity and severity but when it leads to destructive or antisocial behaviour it becomes maladaptive (Velotti et al., 2016).

A New Zealand context

In the following section, I will discuss the prevalence of NSSI and ODI-type behaviour both in the international population and in New Zealand. However, in order to understand the statistics in New Zealand, it is important to understand the cultural context.

Mental distress, disorders and substance abuse are serious and worsening issues in the New Zealand community (Theodore et al., 2022). According to the Mental Health Foundation (2025) New Zealand's youth suicide rate is the highest of the 41 OECD countries, with males twice as likely to die by suicide than females. A New Zealand large-scale representative survey of young people showed an increase in the prevalence of depressive symptoms from 13% to 23% between 2012 and 2019 (Sutcliffe et al., 2022). Similarly, Theodore et al. (2022) found an increase from 12% in 2012 to 23% in 2022 of youth experiencing depressive symptoms. Sutcliffe et al. (2022) also found that there was a relationship between socioeconomic status and mental health. Those with a higher socioeconomic status had less declines between 2012 and 2019 with overall lower rates of poor mental health. The largest increase for prevalence was the under 16s age group.

In New Zealand there are two predominant cultures, Western and Māori, which have different cultural values (Waitoki et al, 2021). The indigenous Māori population have significantly higher rates of mental distress and suicide (Theodore et al., 2022). Young Māori are persistently overrepresented for negative health outcomes compared to their New Zealand European peers (Sutcliffe et al., 2022). However, Māori are less likely to report

psychological distress and seek mental health support (Theodore et al., 2022). Levy and Waitoki (2015) found that support such as seeking a psychologist can been referred to as a tool of colonisation due to the dominance of the Western approach and the difference in cultural values. Sutcliffe et al. (2022) found that the disproportion of mental illness in New Zealand is so severe that it directly violates and breaches of Te Tiriti o Waitangi.

Traditional Māori society had a collective tribal culture and a reciprocity-based political economy (Liu et al, 1999). Māori lived in a whakapapa relational system which started with whānau or family groups, then hapū (sub-tribes) and iwi (tribes). The interactions between individuals and with the environment were guided by Tikanga, which was understood as the customary practice. Captain James Cook arrived in 1769 which began the arrival of European settlers. While early relationships between Māori and Europeans were predominantly peaceful and centred around trade, conflict began to arise in the 1830s as the European settlers became more intrusive of Māori land. This laid precedence to the signing of the most fundamental document in New Zealand history, Te Tiriti O Waitangi. In 1840 this was signed between Māori chiefs and the British Crown. Te Tiriti aimed to bestow full rights of British citizenship upon Māori and gave the British Crown authority to govern and rights to purchase land. The English version signed by the British Crown was not a direct translation of the Te Reo Māori version signed by the Māori Chiefs (Lythberg et al., 2021).

In the following decades, the fundamentals of Te Tiriti were not respected as a large scale immigration of Europeans took place. This resulted in land wars and spread of disease with a subsequent erosion of Māori population and dominance of the European settlers. In the early 20th century the efforts of leaders such as Te Rangi Hiroa, Sir Maui Pomare, Jame Carroll and Apirana Ngata were able to prevent complete loss of Māori culture. Over the 20th century there have been social activist movements to respect the fundamentals of Te Tiriti.

However, like other indigenous communities, colonisation continues to cause disproportional disadvantage for Māori (Lythberg et al., 2021).

Prevalence globally and locally

There is a substantial variation across the literature that details the prevalence rates of NSSI. Slesinger et al. (2019) highlight this variation by identifying studies which show the lifetime prevalence among adolescents, and others who show rates of NSSI, to be as high as 46.5% but as low as 3% amongst adults. Bresin and Schoenleber (2015) found that the rate of NSSI in various countries clinical samples range from 11.8% to 82.4%. Kimbrel, Calhoun et al. (2017) estimate that 6% of adults in the general population have engaged in NSSI at least once. Epidemiological research by Selby et al. (2015) consistently indicates high prevalence rates of NSSI. They found a prevalence of 13% and 45% among adolescents and 4% to 28% amongst adults. Voss et al. (2020) found a prevalence of 18% of adolescents who thought about hurting themselves and 13.6% who did engage in NSSI.

While it is not explicitly clear why there is variation in the prevalence of NSSI there are a range of operational or population factors which could influence these rates. This could include varied definitions and inconsistency across operational definitions which could introduce bias or uncertainty. As mentioned previously, Christoffersen et al. (2014) theorised that by specifying cutting they created an overrepresentation of females. The variance could also be through population bias due to the sampling pool of available participants. Kimbrel et al. (2017) theorised that females may be more likely to seek help or discuss their experiences which may explain some of the discrepancy between genders. This could also be similar for clinical and general populations when sampled. Clinical samples may be more likely to have

engaged if they are seeking support. The role of gender will be discussed in more depth in the following sections.

As mentioned above, NSSI is more prevalent among adolescents than older adult populations (Batejan et al., 2014; Moloney et al., 2024). The average age of onset across various NSSI community and clinical samples is between 12 and 14 years (Batejan et al., 2014). Individuals aged between 15-29 years have the highest rate of serious injuries from self-harm (Theodore et al., 2022). Moloney et al. (2024) found that 17.7% of school-based samples reported engagement in NSSI. These results are consistent with previous research finding a peak of NSSI among teenagers (Christoffersen et al., 2014)

A study by Garisch and Wilson (2015) found a high prevalence rate of 50% of New Zealand adolescents engaging in NSSI over their lifetime. There was no difference in gender noted in this study. This correlates to Fitzgerald and Curtis' (2017) findings of 38% in a university student population and another local study of a university student sample which found 69% prevalence in young people (Robinson & Wilson, 2020). The differences in these studies can be attributed to a variety of factors. Fitzgerald and Curtis (2017) tested the prevalence of NSSI over a 12 month period. Garisch and Wilson (2015) focused on a lifetime prevalence and consisted of a sample of secondary school students, in which adolescents are more likely to engage in NSSI. Robinson and Wilson (2020) had the highest prevalence and also covered a lifetime prevalence. Their sample was from students enrolled in psychology course and 76% were female. In contrast to the aforementioned health disparities, Fitzgerald and Curtis (2017) found that there are similar prevalence of rates of Māori to non- Māori New Zealand population reported for NSSI. This could be attributed to the fact that Māori are less likely to report psychological distress and seek mental health support (Theodore et al., 2022).

To understand the prevalence of ODI-type behaviour, this section will discuss the statistics on aggressive or violent acts. These statistics are only able to provide an indication of the prevalence of ODI-type behaviour as the term ‘ODI’ is a novel concept for the purpose of this research. However, this data represents a prevalence of these behaviours and the impact this has on the individual and community.

Statistics from New Zealand Police will provide an understanding of the more extreme end of these behaviours. According to the New Zealand Police website (2025), between January 2024 and January 2025 there have been 17,237 proceedings for acts intended to cause injury. Of those acts 61.13% were committed by an individual under the age of 34. There was a significant difference in gender with 76.94% of the total acts committed by males. However, Māori were significantly over represented at 49.9% of the total acts.

The number of these acts have overall decreased with a steady downwards trend over the past 10 years (NZ Police, 2025). However, this reduction does not necessarily mean there are less acts being committed. One factor that could influence data is the initiation of the police-school model introduced in 2014. This programme aimed to provide “prevention activities to help schools prevent the harm caused by crime and crashes that will affect students’ achievements” and “response services to support the school’s usual disciplinary and behaviour management practices when a serious offence is identified” (NZ Police, 2025). In this model police can support schools to manage incidents to avoid an escalation to a police intervention. In the period of July 2014 to July 2015 there were 10,641 acts intended to cause injury committed by individuals under the age of 30 compared to 7831 between January 2024 and January 2025 (NZ Police, 2025).

In contrast to the police data, the New Zealand Education Review Office's 2024 report found that there has been an increase in aggressive and disruptive behaviour. In the report, over half of teachers in New Zealand schools report that over the past two years student behaviour has worsened. This challenging behaviour includes aggression, physical and extreme violence, and fighting with other students (ERO, 2024). A quarter of principals reported seeing students physically harming others and damaging or taking property daily. Challenging behaviour was reported more frequently at schools in low socioeconomic communities (ERO, 2024).

These statistics were similarly reflected in the Ministry of Education's 2025 Education Indicator which found that stand-down rates increased across all behaviour categories in 2023. The report found that 31.1% of students were stood down for physical assaults on other students which had remained the main reason. Data from the report showed that between 2022 and 2023, physical assaults on other students has increased from 7,396 to 9,548 respectively. Māori students are experiencing stand downs, suspensions, exclusions and expulsions over twice the national rate.

The prevalence of NSSI and ODI-type behaviours show that there is an issue within the international and local community of behaviours which cause harm both to the individual and others. The experience and regulations of emotions, in particular negative, has been identified as playing a significant role in the function of these types of behaviours and will be discussed in the following section.

The role of emotion

Emotion, in particular shame, has been identified as playing an important role in both the engagement in NSSI and ODI-type aggressive behaviour (Garofalo & Velotti, 2017;

Sheehy et al., 2019). Engaging in NSSI can reduce negative affect states and may be accompanied by a sense of relief (Bentley et al., 2014). Garofalo and Velotti (2017) identified that there is a consistent link between negative emotionality and aggressive behaviour. They found that studies tended to focus on the link between anger and aggression but theorised that the link may extend to other emotions such as shame. Shame, which is typically related to internalizing behaviours such as avoidance or withdrawal, has also been associated with externalizing behaviours such as aggressive acting out (Garofalo & Velotti, 2017).

Sheehy et al. (2019) conducted a meta-analysis and systematic review of literature to understand the relationships between shame, guilt and engagement in self-harm. Shame and guilt are described as distinct yet overlapping experiences and were found to be moral or self-conscious emotions related to an evaluation of the self. Shame is more reflective of negative judgements of the self or how others perceive them whereas guilt is concerned with viewing one's own behaviour negatively. Guilt could be found to initiate corrective actions to amend perceived wrongdoings whereas reactions to shame are generally less constructive and could involve submission, rumination, avoidance, and hiding of perceived flaws. Both shame and guilt can be experienced as undesirable or distressing emotions. However, Sheehy et al.'s (2019) findings indicate that shame might be especially harmful due to its strong connection to an individual's self-identity. Shame was found to be closely and consistently associated with a range of psychological issues, such as psychosis, depression, post-traumatic stress disorder and eating disorders. Therefore when accounting for the overlap with shame, guilt could sometimes be found to no longer correlate with mental health issues. However, guilt could also be painful and was found to lead to feelings of regret or remorse.

Research by Sheehy et al. (2019) found that those who had engaged in NSSI reported greater feelings of shame than those who had not engaged in NSSI. Shame was also found to

positively correlate with the frequency of NSSI engagement. This was also apparent when adjusting for co-occurring feelings of guilt and mood-related symptoms. While there are few studies, Sheehy et al. (2019) found that overall evidence suggests that feelings of shame are positively associated with suicidal behaviour and other general constructs of self-harm. Guilt, however, had ambiguous results with being related to NSSI or suicidal behaviour. Curtis (2016) also found shame, anger and depression to be functions of NSSI. The research found that emotional pain could be lessened by the physical pain of NSSI. Engaging in NSSI was also found to ignite a sense of power and strength by proving an ability to endure pain and to channel emotions externally.

Emotional awareness and regulation are other precipitating factors that can play a role alongside the type of emotion in engagement with NSSI and behaviour. To understand the link between emotion and aggression, Garofalo and Velotti (2017) use Baumeister's self-regulation theory (Baumeister, 1990). In this theory, self-regulation is the ability to choose actions that are not immediate impulses but are most appropriate for the circumstances. However, cognitive control can be impaired under states of negative emotional arousal. When this happens, there can be a disengagement from emotional awareness to focus on immediate considerations that can either be hedonic or instrumental. This can also be influenced by an individual’s belief in their self and their ability to make decisions. Therefore, it is not the experience of negative emotions but the way they are regulated that impacts aggression. This trait is referred to as negative urgency (Baumeister, 1990; Heatherton & Tice, 1994).

Emotion dysregulation and alexithymia working interchangeably have been theorised to precede aggressive behaviour (Velotti et al., 2016). Alexithymia is characterised by a poor awareness of emotions and a diminished ability to think or talk about feelings (Velotti et al., 2016). Emotion dysregulation can be conceptualized as a lack of understanding or

acceptance of emotional responses, difficulty in engaging with goal-directed behaviour and inability to counter impulsive reactions when under emotional stress, with a limited understanding of healthy adaptive emotion regulation strategies (Velotti et al., 2016). Therefore, individuals who have poor awareness of their feelings are more likely to struggle with emotion regulation, in particular reducing emotional arousal in stressful situations. When a threat is perceived such as emotional pain or stress and they are unable to recognise the source and nature, they struggle to find appropriate interpersonal skills to manage the situation and can lash out as a form of self-protection from the threat (Velotti et al., 2016).

Garisch and Wilson (2015) found a link between NSSI and several internal deficits in self-regulation such as reduced mindfulness, heightened impulsivity, limited emotional awareness, decreased cognitive reappraisal, emotional suppression and diminished resilience. Their research also shows that engagement with NSSI can be linked to exhibiting traits of alexithymia as well as difficulty with recognition of their own internal psychological processes, emotional intelligence and regulation. Garisch and Wilson (2015) also found that co-occurrence of depression and alexithymia were able to predict engagement in NSSI. In a literature review of alexithymia and self-harm, Iskric et al. (2020) found a strong association between adolescents engaging in NSSI and alexithymia. Those with more recurrent episodes of NSSI had higher levels of alexithymia than those who engaged in NSSI less frequently. Evidence also suggested that alexithymia was more common among female populations, in particular with a history of child abuse or hospitalization for mental health issues. A study by Baumann et al. (2025) also found a positive relationship between high levels of alexithymia and NSSI. Those that had more trouble identifying and describing their emotion would be more likely to punish themselves, end dissociation and achieve a desired state such as euphoria.

Impulsivity is another potential antecedent for aggressive behaviour (Velotti et al., 2016). Negative urgency could be considered as an aspect of emotion dysregulation and is key in Baumeister's theory of self-regulation (1990). However, impulsivity as a trait differs as it represents a more general behaviour of rash decision-making, lack of planning and immediate reactions to internal or external stimuli with an inability to consider possible consequences of these actions (Velotti et al., 2016). In scenarios where an individual may interpret a situation as a source of stress or discomfort and become negatively aroused, a person with a high level of impulsivity could struggle to resist an aggressive impulse or to act on self-protective aggressive thoughts. Garofalo and Velotti (2017) found that poor self-control was linked to aggression and plays a key role in comprehensive theories of aggressive and violent behaviour. In a study by Donahue et al. (2014), negative urgency became a mediating factor with the relationship of negative emotionality and physical aggression.

The experience, awareness and regulation of negative emotions are found to play an important role in the function and antecedent of both NSSI and ODI-type behaviour. Research also suggests that the type of negative emotions, such as shame and anger, can play a role in the engagement of NSSI and ODI-type behaviours (e.g. Curtis, 2016; Garofalo & Velotti, 2017; Sheehy et al., 2019). Emotion also plays a role in the predominant psychological theories in understanding these types of behaviours.

Theories

This section will start by discussing the main psychological theories for understanding NSSI. When looking at earlier theories of self-injury, there are a variety of functions which are suggested (Bentley et al., 2014). Numerous models of function emphasize the role of both intrapersonal and interpersonal factors (Bentley et al., 2014; Kimbel et al., 2017). These

include interpersonal influence, inhibiting suicidality, counteracting dissociation, control over sexuality, punishing self and externalising or controlling emotions (Bentley et al., 2014; Bresin & Schoenleber, 2015; Kimbrel et al., 2017). However, evidence suggests that the main reason for NSSI engagement is temporary relief from negative emotions (Bresin & Schoenleber, 2015; Klonsky, 2011). The four function model (FFM) and emotional cascade theory elaborates on these understandings (Bentley et al., 2014; Hasking et al., 2017).

The functional approach theorises that behaviours are controlled by antecedents and consequences of events (Bentley et al., 2014). The theory comes from a holistic approach which acknowledges that the theory may not be able to encompass all contributing factors but is still an advancement on the understanding of NSSI. Bentley et al. (2014) found that some previous research focused on psychosocial risk factors as opposed to understanding their function in causing and maintaining NSSI while others placed more of an emphasis on the effect of affect and minimised social functions.

Bentley et al. (2014) proposes that NSSI is reinforced by four distinct functional reinforcement processes with two further distinctions. These functions are separated into the following; automatic negative reinforcements (ANR), automatic positive reinforcements (APR), social negative reinforcement (SNR) and social positive reinforcement (SPR). ANR functions to reduce aversive emotional or cognitive states, while APR aims to elicit positive feelings or stimulation. SNR enables escape from social interactions or interpersonal demands, whereas SPR promotes facilitation or attention, resource access and to promote help-seeking behaviour (Bentley et al., 2014).

The emotional cascades theory by Hasking et al. (2017) provides a nuanced understanding of an individuals' experience of emotions and uses a constructivist,

experiential epistemology. The theory proposes that rumination can exacerbate the experience of negative emotion. Rumination is characterised by the repetitive allocation of attention to negative stimuli. This sustained focus fosters a re-experience of the negative emotional impact which results in an emotional cascade (Hasking et al., 2017). In turn, this emotional cascade creates further distress and develops a vicious cycle of intense emotion which becomes increasingly distressing. NSSI becomes a means of distraction to direct attention away from the negative stimuli, to reduce the intense emotion and over time becomes a conditioned response. This exacerbates a relationship between NSSI and negative affect. Hasking et al. (2017) found that individuals engaging in NSSI experience less positive affect and in some cases engage in NSSI to experience positive affect.

These theories share similarities to the afore mentioned Baumeister's (1990) theory of self-regulation, used by Garofalo and Velotti (2017) to understand aggression. Baumeister (1990) theorises that cognitive control can be impaired by the regulation of negative emotions and can lead to behaviour that is based on impulse rather than being most appropriate in the setting. Hasking et al.'s (2017) emotional cascades theory is similar as the behaviour is a way to escape or relieve from a negative state. Bentley et al.'s (2014) four function model theory, also identifies this escape or relief from emotion as a function for engaging in NSSI. The two functions, automatic negative reinforcements (ANR) and automatic positive reinforcements (APR), explain that engaging in NSSI is a way to reduce negative or to elicit positive emotions. Similar to this understanding of aggressive behaviour, these theories emphasis the role of emotion. The following section will discuss other theories of aggression and the influence of other factors.

Agnew's (1992) general strain theory (GST) was developed as an individual level social psychological explanation to support empirical data which suggested a correlation

between negative childhood and adolescence experiences and criminal or delinquent behaviour. Agnew (1992) based GST on the classic strain theory work of Merton (1938) Cohen (1955) and Cloward and Ohlin (1960) which came under criticism in the 1970s as being simplistic and not being able to explain factors such as why some individuals experiencing strain did not turn to crime. Agnew (1992) addressed these limitations by broadening the concept of strain and by incorporating other factors such as social control and negative emotions. This opens up the theory to behaviours that are similar but not necessarily criminal, such as ODI-type behaviours.

Agnew's (1992) theory argues that experiencing strains, caused by different types of negative relations and interactions with others, are fundamental as they lead to the development of negative emotions such as depression, anxiety, fear and anger. Individuals need to find ways to cope with experiencing strains and negative emotions and these are influenced by the coping mechanisms available to them. More harmful ways of coping correlate with the severity of strains, if they are perceived as unjust, and are associated with negative emotions, such as depression. Ways of coping can be influenced by how an individuals' peers and family cope as well as low impulse control. GST also suggest a difference in the way that females and males may experience and respond to strain. Childhood abuse experiences of females and males differ with males experiencing more physical abuse and sexual abuse being more prevalent among females. Watts and McNulty (2013) theorise that as physical abuse is much more common, males are more likely to experience abuse which could be partial causation for the greater offending rates of males than females. However, there is much more research required to understand gendered pathways.

Anderson and Bushman (2002) developed the general aggression model (GAM) as a social cognitive theory of aggression. GAM is a dominant theoretical perspective and provides a comprehensive framework which considers the role that social and cognitive factors play on aggression. Anderson and Bushman (2002) theorise that distal factors such as personality and proximate aspects such as provocation influence aggression. Internal processes of cognition, affect and arousal determine the aggression of the behavioural outcome. People with an inherent predisposition to aggression are more aggressive and this is reinforced by life experiences which prepare them to behave aggressively across different situations. GAM places an emphasis on the role of learning aggression related knowledge structures. These knowledge structures continue to influence an individual's understanding and responses to intrapersonal conflicts which continues to influence their likelihood of behaving aggressively (Anderson & Bushman, 2002; Allen et al., 2017; Gilbert et al., 2013).

GAM recognises knowledge structures as scripts, normative beliefs and maladaptive conditions. Scripts are behavioural and social problem solving guides that are established through observational learning and conditioning. The guides provide an indication of how a situation may unfold, how to respond and the likely outcome based on past experiences. Normative beliefs are a knowledge structure where an individual beliefs normalise and support aggression. An aggressive script can be filtered through normative beliefs to perceive aggression as the correct outcome. Maladaptive cognitions are pre-existing cognitive structures, such as maladaptive schemas or beliefs, that can influence their perception. These can increase vulnerability to negative affect and hostile interpretations and will increase the likelihood of engaging in aggression (Anderson & Bushman, 2002).

GST and GAM emphasise the importance that past experiences and learnt coping mechanisms have in the way that an individual manages stress or negative emotions. The

theories recognise that, similar to NSSI, aggression or outward directed behaviour is a way of managing negative emotions. The manner in which these emotions are managed or experienced can be influenced by a variety of social, cognitive, biological and development factors. The following section will explore some of these factors.

Co-morbidities and risk factors

NSSI and aggressive ODI-type behaviours have similar rates of co-morbidities for internalizing and externalizing disorders, substance abuse and poor coping mechanisms. Adverse childhood experiences (ACE) such as neglect, abuse and traumatic experiences are also risk factors for engagement in both types of behaviours (Guo et al., 2025). Social factors play a mediating role in the risk of engagement in NSSI (e.g. Christoffersen et al., 2014; Curtis, 2016; Wan et al., 2018).

NSSI is a stronger prospective predictor of suicide attempts than history of suicide attempts (Glenn & Klonsky, 2013; Harford et al., 2017; Kimbrel, Calhoun, et al., 2017; Selby et al., 2015). Voss et al. (2020) found that over 66% of adolescents who attempt suicide have a history of NSSI. While not all individuals who engage in NSSI meet criteria for a mental disorder, NSSI is predictive of a disorder (Gonzales & Bergstrom, 2013). NSSI is strongly associated with many externalizing and internalizing disorders such as major depressive disorder, generalised anxiety disorder, post-traumatic stress disorder (PTSD) and obsessive-compulsive disorder (Bentley et al., 2014; Christoffersen et al., 2014; Garisch & Wilson, 2015). NSSI has also been indicated as often co-occurrent with personality disorders (Bentley et al., 2014). Externalising disorders such as substance use disorders or antisocial personality disorder can also be risk factors for violence or aggression towards others (Harford et al., 2017). This is similar to Richard et al. (2022) who found that anger is related to substance

and alcohol abuse as well as suicidal ideation. Research by Pulay et al. (2008) indicates that approximately 8% of people with psychiatric disorders have engaged in outward directed violent behaviour. The risk for violence was significantly higher among those with substance use, mood and personality disorders.

A study conducted by St Germain and Hooley (2012), found that people who engage in NSSI are likely to also engage in indirect forms of harmful behaviours. For example, they found high co-morbidity rates between NSSI and substance use, as well as NSSI and eating disorders. Garisch and Wilson (2015) also found a strong connection between NSSI and the use of alcohol, tobacco and illicit substances. Adolescents who engage in NSSI are more likely to consume alcohol when faced with anger or distress. NSSI and substance abuse are both considered avoidant coping mechanisms and are linked to heightened impulsivity. Substance use can act to provide temporary relief but fail to address the root of the problem. NSSI has also been associated with poor self-perception and integration of identity as well as low self-esteem which are issues that are especially pertinent for adolescence (Garisch & Wilson, 2015).

NSSI can also provide an escape from trauma symptoms by acting as a negative reinforcement for relief from unwanted symptoms such as intrusive memories or dissociation (Garisch & Wilson, 2015). Liu et al. (2017), in a systemic review of childhood maltreatment and non-suicidal self-injury, describes ACE as significant risk factors for future health and social issues, including increasing the likelihood of NSSI. Childhood and adolescence experiences such as exposure to sexual abuse, physical acts of violence or threats to life and adolescent risky sexual behaviour are also associated with an increased risk of engaging with NSSI (Christoffersen et al., 2014; Garisch & Wilson, 2015; St Germain & Hooley, 2012). Experiencing bullying is found to be a risk factor, however youth may actively seek

persecution from their peers as an extension of their self-injury (Garisch & Wilson, 2015). A study by Watts and McNulty (2013) identified that childhood abuse is related to higher peer ratings of aggression, more disciplinary problems at school, increased dating violence and an earlier onset of violence.

Social support has been found to be a mediating factor for engagement in NSSI (Christoffersen et al., 2014; Curtis, 2016; Wan et al., 2018). Social support can include having people to turn to for material aid, advice or empathetic listening and reassurance of worth of self-worth and affirmation (Christoffersen et al., 2014). Low social support has been found to increase the risk of engagement in NSSI (Christoffersen et al., 2014; Wan et al., 2018). Similar to GAM and GST theories of aggression, Curtis (2016) found complex and often contradictory interpersonal and macro-social factors to precipitate and maintain cycles of harmful behaviours. The complex interpersonal factors included friends and family who could have inappropriate responses, be also engaging in self-harm and issues within the family. Macro social factors included a generalized sense of stigma surrounding mental health struggles. Commonly described was a disconnect from family which could range from poor emotional engagement and support to abuse and severe dysfunction. Wan et al. (2018) found that social support could have an independent effect on NSSI even after adjusting for other sociodemographic risk factors or psychological symptoms and even ACE. Christoffersen et al. (2014) found that adolescents who had an increased risk due to childhood maltreatment had a decreased risk if they had social support. This is consistent with findings that social support can facilitate the belief that the individual is cared about, loved, esteemed and valued (Christoffersen et al., 2014).

There are similar findings for co-morbidities such as mood disorders and substance and risk factors such as ACE for NSSI and ODI-type aggressive behaviour. However,

engaging in either type of behaviour can often be understood as risk factors for each other (e.g. Christoffersen et al., 2014; Harford et al., 2017; Richmond-Rakerd et al., 2019; O'Donnell et al., 2014) The co-occurrence of both types of behaviour is discussed in the following section.

Dual harm

Plutchik et al. (1989) developed a two-stage theory that aggression leads to violence towards self and others. When a trigger event happens such as a threat, insult, challenge, loss of control or perceived loss of hierarchical position there are two stages which determine the outcome of the aggressive impulsive. In stage one, the situation is experienced based on the interpretation of the situation. In stage two, the target of either self or others is determined by a pattern of risk factors. For aggression towards others the risk factors can include impulsivity, recent life stressors, psychopathy, substance abuse, and history of hospitalization for psychiatric conditions. The risk for aggression towards the self is increased by factors such as depression and hopelessness (Harford et al., 2017; Richmond-Rakerd et al., 2019).

Research by Christoffersen et al. (2014), Harford et al. (2017), Richmond-Rakerd et al. (2019), O'Donnell et al. (2014) and Shafti et al. (2021) supports a theory of co-occurrence of aggression against self and aggression against others. Co-occurrence of self-harm and aggression is termed dual-harm. A systematic literature review by O'Donnell et al. (2014) found aggression and self-harm to be positively associated and that individuals identified through one behaviour were found to exhibit more of the other behaviour compared to those who engaged in neither. The prevalence of aggression in those with a history of self-harm was above 20%.

Richmond-Rakerd et al. (2019) in a longitudinal cohort study looked at individuals who engaged in dual harm. They found that the risk of committing a violent crime was three times higher for individuals who engaged in self-harm and that self-harm could be an indicator of violence. Dual harm risk was increased by low childhood self-control and maltreatment. The study also found that those rated by caregivers and teachers in childhood as having self-regulation difficulties were more likely engage in dual harm than the self-only harm group as adolescents. Dual and self-only harmers reported similar frequencies of self-harm behaviours. Dual harmers were more likely to engage in more extreme behaviours and aggressive acts such as hitting themself or an object or hitting their head against a wall. They also had similar rates for depression and PTSD but dual harmers were more likely to experience psychosis and alcohol and drug abuse. Dual harmers were also more likely to have experienced multiple victimizations during adolescence as well as ACE. Dual harmers also had a greater resistance to change, poorer impulse control and more rude or aggressive behaviour. Both dual and self-harmers were distressed more easily and lower in conscientiousness and agreeableness than those who did not engage in either behaviours. In comparison to the participants who had committed violent crime only, dual harmers had higher rates of childhood self-harm and depression, higher rates of adolescent mental health struggles, and were more likely to have experienced victimization. They were also lower in conscientiousness and higher in neuroticism.

The findings on dual harm suggest a co-occurrence between behaviour that causes harm to the self and harm to others. While these findings do represent a cohort that have engaged in different forms of self-harm and violent crime, rather than specifically NSSI and ODI-type behaviour, they are important in showing the relationship between the behaviours

and to facilitate understanding as to the extant they are ways of dealing with the same issues. A common theory to understand the difference in behaviours is the role that gender plays.

The role of gender and sexuality

In this section, the differences and similarities in gender and sexuality will be explored in relation to NSSI and ODI-type behaviours. As discussed, there is literature that supports a theory that gender could influence the type of behaviour that an individual engages in. However, there also are studies that find no difference in gender across NSSI and ODI-type behaviours. An important factor to consider is that gender can be understood as a psychosocial construct (Winter, 2015). There are societal, cultural and environmental factors that construct meaning making in the way that individuals understand the role of gender which can influence the way they engage in research. This is important to consider at not just an individual level but as an influence on the epistemologies informing the methodology of the researchers.

Studies by Bresin and Schoenleber (2015) and Klonsky (2011) found that epidemiological research for NSSI prevalence has inconsistent findings for gender differences. While in older studies such as Miller (1994), NSSI was believed to be largely restricted to females psychiatric patients, more recent research suggest NSSI is present across genders (Kimbrel et al., 2017). Slesinger et al. (2019) found that across a range of studies those of a clinical population showed NSSI more common in females but no gender difference across a general population. Voss et al. (2020) found that female prevalence rates were twice as high as males. This gender discrepancy could be understood when looking at the historical context of NSSI being associated with BPD. BPD diagnoses are comprised of 75% females (Lepkowsky, 2020). NSSI is a strong predictor of BPD but 48.3% of

participants who engaged in NSSI did not meet the criteria for BPD (Nock et al., 2006). Christoffersen et al. (2014) found that there was an overrepresentation of females, but believed this reflected the way in which NSSI was operationalized in their study. When asking about engagement in NSSI, participants were asked if they had deliberately overdosed or if they had engaged in cutting or burning themselves. They believed that there would have been a different representation of genders if they had asked whether participants had engaged in hitting or instigating a fight.

An observation within Kimbrel et al.'s (2017) research details further the discrepancies between sexes. They conclude that it could simply be due to the fact that females tend to seek out psychiatric treatment more often than men. Kimbrel et al. (2017) studied the prevalence of wall/object punching as an under-recognized form of NSSI. They found that a "failure to systematically assess wall/object punching has also likely biased previous estimates of the prevalence of NSSI among men" (p.503). The study found that males were significantly more likely to engage in wall/object-punching than females and that if that was not identified in their study it would have resulted in 14% of participants not identified as engaging in NSSI. Richmond-Rakerd et al. (2019) also found that females were more likely to engage in self-harm and males were more likely to engage in violence.

There is other research which also suggests that males and females engage at similar rate but that behaviours take different forms (Christoffersen et al., 2014; Fitzgerald & Curtis, 2017; Kimbrel, Calhoun, & Beckham, 2017; Kimbrel, et al., 2018; Voss et al., 2020). Females are found to be more likely to engage in behaviour that is explicitly self-injurious, such as cutting or scratching whereas males are found to be more likely to engage in behaviour such as instigating fights, hitting or banging their heads or striking objects with the intention of causing self-injury (Bresin & Schoenleber, 2015; Christoffersen et al., 2014;

Fitzgerald & Curtis, 2017; Voss et al. 2020). Fitzgerald and Curtis (2017) found that both genders' primary reason for their behaviour was to relieve stress and deal with uncomfortable emotions. Due to the type of injury, females appear to be precise and more controlled, whereas males are more explosive and less controlled. Further analysis revealed that females were significantly more likely to indicate the function being to gain control and manage emotions where males were more likely to injure themselves for the energy rush, excitement, anger or not liking themselves (Fitzgerald & Curtis, 2017).

Bresin and Schoenleber (2015) suggest that there are gender differences in how males and females regulate their emotions and therefore differential expressions of psychopathology. Females tend to use preservative self-focused thinking which may result in higher levels of depression and anxiety. In comparison, males tend to use alcohol and aggression for emotion regulation which may result in a higher prevalence of externalising disorders. Donahue et al. (2014) describe aggressive behaviour as falling under an externalising factor of the personality spectrum. Negative affect can play a vital role in reactive aggression when experiencing emotions such as shame, disgust and anger, particularly in males. Males can be found to have challenges with recognizing emotions and managing impulsive behaviours during times of emotional distress which contributes to the aggression. For females, controlling impulsive actions when in distress was the only aspect of emotion dysregulation that showed a mediating effect which was less pronounced compared to males. Males are more likely to have difficulties in emotion awareness which can lead to further dysregulation and risk of aggression (Donahue et al., 2014).

Individuals who identify as non-heterosexual and are a sexual minority are at an increased risk for a variety of negative health conditions including poorer mental health, experiencing suicidal thoughts and suicide attempts (Batejan et al., 2014; Liu et al., 2019).

Whitlock et al. (2011) reported significantly increased risk of NSSI associated with sexual orientation in their sample of college students. This can be understood through the minority stress theory in which a difference in values causes conflict between a minority and dominant group (Batejan et al., 2014). There are three main stressors which can contribute to the distress experienced by a member of the minority, in this case an individual who identifies as a sexual minority. These stressors include internalized negative beliefs, perceived stigma and events of discrimination or prejudice (Batejan et al., 2014). Zhao et al. (2021) and Guo et al. (2025) found that individuals who identify as a sexual minority were also more likely to have experienced childhood maltreatment or ACE. In particular, Guo et al. (2025) found that adolescents reporting four or more ACE alongside sexual minority identification were at the greatest risk of engaging in NSSI. This can be found to compound with the stressors identified in the minority stress theory to create a greater vulnerability to engaging in harmful behaviour such as NSSI (Guo et al., 2025; Zhao et al, 2021).

A study by Fitzgerald and Curtis (2017) found an increase in risk between engagement in NSSI and non-heterosexual participants, in particular for female participants. In a systematic review Liu et al. (2019) also found that individuals identifying as bisexual, as well as transgender individuals, were most likely to engage in NSSI. Those that identified as a sexual minority were less likely to engage than those who identified as transgender. Sexual and gender minorities were found to be two to three more times likely to engage in NSSI than heterosexual or cisgender individuals. A study by O'Brien et al. (2025) reaffirms that those identifying as a sexual minority were more likely to have a lifetime prevalence of NSSI and to engage more frequently. They also found that this link was due to self-defective beliefs.

There is research which suggests that there is a difference in the way that males and females regulate emotions and this could be influential in the type of behaviour that they

engage in (e.g. Christoffersen et al., 2014; Bresin and Schoenleber, 2015; Donahue et al., 2014; Fitzgerald & Curtis, 2017). However, further research is required to determine if there is a gendered pathway and to understand to what extent these behaviours are ways of dealing with the same issues.

Current interventions

There are several interventions that are used for reducing NSSI which include therapies such as cognitive behavioural, dialectical behaviour, emotion regulation as well as mindfulness and development of interpersonal coping skills (Garisch & Wilson, 2015; Gonzales & Bergstrom, 2013). Psychotropic medication such as antidepressants can be a common intervention, but in research has been perceived as counterproductive by recipients (Gonzales & Bergstrom, 2013). While the focus of psychotherapeutic approaches is often on motivation for change, directly addressing NSSI behaviours seem to be more effective (Gonzales & Bergstrom, 2013; Emelianchik-Key & La Guardia, 2019). Garisch and Wilson (2015) found that developing positive self-esteem appears to help prevent NSSI therefore interventions focusing on self-esteem, resilience, and mindfulness may be useful. However, due to the ethical constraints of this research being done on vulnerable populations which limits factors such as a control groups, there is no treatment which can be identified as fully empirically supported (Emelianchik-Key & La Guardia, 2019).

Gratz et al. (2019) devised emotion regulation group therapy (ERGT) especially for women diagnosed with BPD and who were engaging in NSSI. This therapy is based on acceptance-based conceptualization of emotion regulation which identifies the role that emotion dysregulation plays in NSSI. The 14 week programme helps participants to understand emotion regulation as a multidimensional construct which involves the awareness,

understanding, intensity, duration and acceptance of their emotions (Gratz et al, 2019). The programme also focuses on the ability to control impulsive behaviour, engage in goal-directed behaviour when experiencing negative emotions and flexible non- avoidant strategies.

A study by Hasna and Fajri (2023) examined the effect of acceptance and commitment therapy (ACT) as an intervention for NSSI. ACT is a therapeutic process which aims to increase psychological flexibility and reduce avoidance to improve outcomes during intense or overwhelming emotion. ACT utilises mindfulness techniques, acceptance, attention and behaviour change to avert attention towards internal processes. The study found that there was a significant reduction in NSSI behaviours following ACT. However, this study still needs to be replicated on a larger scale over a longer period of time.

Dialectical behavioural therapy (DBT) has been developed by Marsha Linehan (1993) from a framework of cognitive behavioural therapy, zen Buddhism and skills based problem solving techniques to facilitate treatment of individuals with BPD. DBT focuses on the acceptance of balance and change using skills such as mindfulness, emotion regulation, interpersonal effectiveness and distress tolerance. DBT has been found to be effective for the adolescents and helping to reduce urges to engage in NSSI (Linehan, 1993).

In a systemic review of recent literature Richard et al. (2022) found that the most common interventions for anger and aggression are cognitive behavioural therapy (CBT) and mindfulness-based therapy. CBT has been found to be an effective way to manage and reduce feelings of anger and associated behaviours (Richard et al., 2022). This can be achieved by challenging negative beliefs which lead to anger when the circumstances do not align with the beliefs. Mindfulness-based therapy aims to increase the awareness to the present and to

disengage from external stimuli which may be causing feelings of anger and associated behaviours (Richard et al., 2022). Mindfulness has been found to be negatively related to anger and aggression (Richard et al., 2022; Tao et al., 2021). A combination of both interventions with mindful based cognitive therapy has been found to be more effective than just CBT or mindfulness-based therapy (Richard et al., 2022). This intervention has been found to be negatively related to impulsivity and positively related to emotional regulation.

CBT and mindfulness share similarities for the intervention of both NSSI and aggressive type behaviours. ERGT, ACT and DBT are also found to specifically be successful in the intervention of NSSI behaviours. A better understanding of the extent in which ODI-type behaviours are ways of dealing with the same issues could facilitate better tailored intervention programmes and wellbeing outcomes.

Conclusion

NSSI and aggressive behaviour are often treated as distinct in literature and clinical settings, however, there are similarities across the theories, functions, co-morbidities and risk factors. There are types of behaviour which can be understood as both NSSI and as aggressive behaviour. These can include behaviours such as hitting the self, wall and object punching and banging the head.

Research on aggression highlights the significance that negative emotion plays in causing engagement in the behaviour (Garofalo & Velotti, 2017). Similarly NSSI can be understood as a way of dealing with uncomfortable emotions and distress (Fitzgerald & Curtis, 2017; Klonsky, 2011). Research also shows that similarly to aggression, engagement with NSSI can be linked to exhibiting traits of alexithymia as well as difficulty with recognition of internal psychological processes, emotional intelligence and regulation

(Garisch & Wilson, 2015). There are similarities across co-morbidities with internalised and externalised disorders and substance abuse as well as risk factors such as ACE (Bentley et al., 2014; Christoffersen et al., 2014; Garisch & Wilson, 2015; St Germain & Hooley, 2012). There is also substantial literature which shows dual harm, aggression against the self and others, as having a positive relationship (Christoffersen et al., 2014; Harford et al., 2017; Richmond-Rakerd et al., 2019; O'Donnell et al., 2014; Shafti et al., 2021).

Theories for understanding NSSI and aggression also share similarities. GST theorises that coping mechanisms are learnt from prior experiences and that this is reinforced to continue to provide relief from strains (Agnew, 1992). Another theory of aggression, GAM, highlights the role of knowledge structures which perpetuates and influence the likelihood of continuous aggressive behaviour (Gilbert et al., 2013). Similarly, FFM, theorises different reasons for engaging with that engagement in NSSI (Bentley et al., 2014). These include reducing negative emotional states, elicit positive emotion, escapism from negative emotions or stresses or to promote help-seeking behaviour (Bentley et al., 2014). Engaging in NSSI enables achievement of one of these functions therefore creating an ongoing cycle. Hasking et al.'s (2017) emotional cascade theory describes the function of NSSI to alleviate an overwhelm of negative emotions.

There is limited empirical research into effective intervention strategies for NSSI and for aggressive behaviour. Yet, these are critical issues that are facing adolescents. The implications of this behaviour is associated with numerous detrimental consequences such as lasting injuries; scarring, nerve damage, risk of disease as well as accidental death and an increased risk of suicide (Bresin and Schoenleber, 2015; Selby et al., 2015). Understanding the underlying motivations and the purpose of injurious behaviours could lead to a better understanding and create more positive intervention methods to reduce suicide mortality.

However, even with the similarities between NSSI and aggression, as well as the crossover of some behaviours, there is a gap in research in understanding to what extent these behaviours are ways of dealing with the same issues. This gap in the literature could means that populations, as shown by Kimbrel et al. (2017), are misrepresented or misunderstood. Therefore, this research will aim to understand the differences, commonalities and relationships between self- and outward-directed injurious (ODI) type behaviour and look to understand the underlying motivations and purpose. If, there is a significant overlap in antecedents for NSSI and ODI-type behaviour, then interventions for NSSI should be applicable to ODI-type behaviour. In addition to intervention, there will be a better understanding in identifying this behaviour to ensure adolescents are understood and more preventative measures are able to be developed. The research seeks to answer the question: to what extent are self-injury and ODI-type behaviour ways of dealing with the same issues, especially managing negative emotions?

Chapter Three: Method

In this chapter I will discuss the methodology, participants, research methods, data analysis and ethical considerations. This research was conducted as part of the wider Self Harm and Injury Exploration (SHInE) Project. The SHInE Project is led by Dr Curtis, Senior Lecturer for the Division of Arts, Law, Psychology and Social Sciences at the University of Waikato. The project aims to investigate the differences, commonalities and relationships between NSSI and ODI-type behaviour. The methodology of this study is guided by the epistemology of the SHInE Project.

Research design

The epistemological stance underlying this research design is social constructionism (Curtis & Curtis, 2011). Social constructionism understands knowledge as constructed through interactions between people and the world and that the process of meaning-making is as significant as the content of what is expressed (Burr, 2015; Curtis & Curtis, 2011; De Gialdino, 2009). Social constructionism evolved alongside postmodernism in the mid 20th century and similarly rejects truth as an objective observation (Burr, 2015). Instead, an individual's understanding of truth is a product of social processes and perceptions (Burr, 2015). With a social constructionist epistemological stance this research therefore lends itself to the qualitative phenomenological design as it aims to understand the process of NSSI and ODI-type behaviour with the participant as the expert in their own experiences.

The intention of qualitative research is to provide a deep, comprehensive and detailed analysis of non-numerical data to explore intrapersonal and interpersonal experiences, relationships and meaning-making (De Gialdino, 2009; Oranga & Matere, 2023). In comparison, quantitative research uses measurable or numerical date to quantify and test

hypotheses (Oranga & Matere, 2023). However, quantitative data can be limited to the scientific knowledge which has previously been defined as knowable. This can limit the potential for concepts outside of the accepted method of understanding (De Gialdino, 2009). This is more associated with the positivist epistemological stance as opposed to social constructionism (De Gialdino, 2009). Phenomenological research design understands the lived experience of the participant as the ultimate source of value and meaning to understand phenomena (Oranga & Matere, 2023). This is especially important in the understanding of ODI-type behaviour, as a novel concept, to acknowledge the participant as the knower as opposed to the researcher.

In-depth interviews are found to be an optimal way to collect data about an individual's experiences, in particular for sensitive topics such as self-harm (Oranga & Matere, 2023). The current study aims to gather in-depth information using semi-structured interviews within a case-centric framework. While there is only a small number of cases this allows and recognises participants as experts in their own experiences. Semi-structured interviews provide a flexible framework that allows participants to articulate their experiences in their own words which gives voice to their unique perspectives (Curtis & Curtis, 2011). A semi-structured process allows guidance of relevant key ideas to develop without constricting the conversation to a pre-conceived narrative. Each interview is recognized as a dynamic interaction where knowledge is co-constructed between the researcher and the participant. A semi-structured approach also allows the use of open-ended questions which enables participants to respond freely (Oranga & Matere, 2023). Open-ended questions are found to bring forth a richer explanatory answer which may not have been anticipated and gives an opportunity for the researcher to probe (Oranga & Matere, 2023). The interview structure also allows the researcher to observe non-verbal cues that help

to interpret spoken material. This epistemology aligns with the chosen method, as semi-structured interviews allow for the exploration of how participants construct and interpret their experiences of self-injury within their social contexts.

Participants

There were 10 participants who were interviewed for this study. Of these interviews, five were conducted in-person and five online. Three of the in-person interviews were held in the University of Waikato library rooms and the other two in bookable community rooms in Auckland. The age range was 20-30 with a median age of 24 and a mean age of 24.6. While the age range went above typical adolescence, participants spoke about experiences they had had throughout their adolescence and as a young person. Table 1 below shows the range of ages, ethnicities, occupations and genders. While there was a diversity of gender types, there were no participants who identified as male.

Table 1

Participant Demographics and Pseudonyms

Pseudonym	Age	Gender	Ethnicity	Occupation
1AO	21	Gender Queer	MELAA	Student
2MNL	23	Non Binary	New Zealand European	Student
3BU	30	Female	New Zealand European	Unemployed
4MV	26	Non Binary	New Zealand European	Student

5MM	25	Female	New Zealand European	Student
6AO	30	Female	Māori/European	Administration
7SO	26	Trans Man	New Zealand European	Unemployed
8SU	22	Female	New Zealand European	Student
9BU	23	Female	New Zealand European	Student
10CO	20	Non Binary Trans	Māori	Student

Participant recruitment

The SHInE project used a variety of recruitment methods. Flyers (see Appendix A) were distributed as a hard copy around the University of Waikato Hamilton campus. The flyer gave a brief introduction to the project and advised interested participants to email the research team for further details. There was also a social media campaign which provided the same information and directed interested participants to the project website. The project website included general recruitment material, background research on the project, ways to contact the researchers and links to helplines or support for those facing emotional distress. Participants who were part of a SHInE online survey were asked at the end if they would also like to participate in the interview. If they selected "yes" then their email address was provided in a spreadsheet and I contacted them to set up an interview. During this preliminary contact I sent the information sheet (see Appendix B) and the consent form (see Appendix C) to ensure the criteria was met and that the participants had a comprehensive understanding of the content of the interviews. Preliminary contact also ensured that the interviews were

logistically possible with timing, whether they would be held online or if they were in-person within a reasonable distance for both parties.

Participants were recruited with criterion sampling through the wider SHInE project. The criteria on the information sheet (see Appendix B) included the age range of 16-30 years and that the interview would be discussing potentially difficult topics such as self-harm, anti-social behaviour and suicide.

Research methods

All participants received an information sheet (see Appendix B) and consent form (see Appendix C) prior to the study. These included background information on the SHInE Project as well as this study, the content that the interviews would be discussing, contact information for the researcher and ways to reach out for help if they needed support following the interview. The interviews were guided by an interview question schedule (see Appendix D) developed by Dr Curtis and informed by the extant literature and Dr Curtis's previous research. The question schedule was used as an initial guide for the interview to occasionally redirect the conversation. Starting the interview with a guide also ensured each interview started with the same general overview and an offer of a Karakia. This also provided an opportunity to reaffirm that participants had read and understood the previously provided documents. The guide also reminded me to gather other relevant information such as date of birth, gender, occupation and ethnicity. The interviews were each booked to allow for an hour but the time spent varied in length ranging between 25 and 60 minutes. I ensured I was available immediately after the interview in case they went over the allocated time or participants needed support. The length of the interviews was dependent upon the participants' openness to sharing their experiences, the length of the responses to the

questions from the schedule and the extent to which the conversation expanded from these questions.

From a social constructionist epistemology both the interviewer and interviewee are active participants and co-creators of knowledge (Curtis & Curtis, 2011). To be an active participant I felt it was essential to build rapport and trust before discussing more sensitive elements of the interview. To do this, I started by asking participants for further details about work or study which they shared with the initial questions or asked them about their day. When they reciprocated the questions I was open and shared some personal details. In order to facilitate an openness I utilised my skills as a victim support worker and likened the interview to an engagement with a client. A support worker is there to be a comforting presence and be in the uncomfortableness as the client navigates their emotions. They are there to uplift and not to dictate how the client manages these emotions. During the interviews I ensured that I guided the conversation as opposed to dictate and allowed space for participants to talk, even if it deviated from the topic. I used active listening skills to create trust and made sure not to offer advice, judgement or solutions to maintain a sense of co-creation. At the end of each interview I asked about self-care, often relating it back to their emotional wellbeing discussed earlier, and offered my appreciation and gratitude at the sharing of their experiences and knowledge.

The in-person interviews were recorded through a voice memo app on my laptop from which a transcript was created using the Microsoft Word dictate function. As a safeguard I also video recorded the interview on my phone. The online interviews were conducted via Microsoft Teams with an automatic recording and transcribing process put in place. During the interviews I took notes on the question guide of the participant's answers. At the end of the questions in the schedule (see Appendix D), I would take some time to read through and

reflect on my notes in order to identify any misunderstandings or elaborations required. Following the interview the transcripts were personally edited to allow further reflection and understanding of the contents. The transcripts had columns to note down key ideas and observations as they began to develop during editing and analysis. I revised the notes taken during the interview and added any observations to the transcript.

Participants were advised that they had three weeks after the interview to email if they would like to withdraw. They were emailed the edited transcript and were offered the opportunity to make changes or additions. No participants withdrew or asked to make changes to any of the transcripts. All participants were asked if they would like to receive a summary of the findings from the interviews and all but one said yes. Participants all received a $40 Warehouse voucher as a thank you. The participants who attended an in person interview also received a $10 Mobil voucher. Participants signed a voucher acknowledgement form (see Appendix E) either at the in-person interviews or sent out through the mail with the vouchers post interview.

Data analysis

The method of data analysis was thematic analysis. Thematic analysis is a method commonly used for qualitative research to recognise, evaluate and report patterns within data (Curtis & Curtis, 2011; Braun & Clarke, 2006). While there were criteria and a guide for the interviews, there were no preconceived data categories developed prior. This was to allow an open dialogue with participants as the experts in their own experiences.

Post interviews, analytical induction was used to draw themes and patterns from the data to guide thematic analysis (Curtis & Curtis, 2011). After transcription each interview was listened to twice. This allowed one to focus on the dialogue and one to observe non-

verbal cues. Observations and key ideas were noted in the columns on the transcripts. On a spreadsheet using Microsoft Excel, I created headings based on the question guide and wrote key ideas for each participant with quotes to observe and develop themes. This format allowed a collation of themes in the answers to the questions to be more apparent.

From here, I wrote down each of the common themes which had come from the interviews and broke down into subthemes. From this point, I was able to incorporate quotes and examples from the interviews to corroborate the themes. When writing about the theme, and reading the quotes, I was able to analysis the meaning from these themes and how could facilitate answers to the research aims.

Ethical considerations

Ethical approval for the current study was received from the University of Waikato Human Research Ethics Committee (HREC (Health)2023#16. Dr Curtis received ethical approval for the SHInE project and this thesis was under that approval. There was a process to ensure informed consent was gained for this study as it involves a vulnerable population. Informed consent is an important cornerstone of the modern research process and is an important factor to develop trust between both parties (Waitoki et al, 2021).

The participant information sheet (see Appendix A) outlined the purpose of the study and ensured that participants understood the nature of the sensitive topics being discussed. The sheet also provided information and encouragement for support services if needed and suggested that participants could bring a support person to the interviews. In the communication before the interview the participants were also sent a consent form (see Appendix C) to sign prior to the interview. The consent form outlined the timeline participants had to withdraw and acknowledged that the knowledge shared was theirs to be

used in the study. All participants were happy to sign the consent form and have the interviews recorded. There were no participants that brought a support person or reached out after needing support.

At the start of the interview, I confirmed with participants that they had read both documents. During the online interviews I checked that participants had returned the signed consent form and asked them to confirm verbally that they had understood and if they had any questions. For the in-person interviews I gave them a copy to read and sign, even if they had emailed it previously, to provide an opportunity to ask questions. I informed participants that they could choose not to answer any questions that they felt uncomfortable with. In the broad overview included in the question schedule (see Appendix D) there was a sentence where I shared my appreciation and acknowledged their vulnerability. I also informed participants that I was recording the interview and that I would only be keeping relevant conversation in the transcript.

Chapter Four: Findings

This chapter will outline the findings from the interviews and the subsequent thematic analysis. The interviews provided an opportunity to discuss the differences, commonalities and relationships between non-suicidal self and other-directed injurious behaviour and to try to understand the underlying motivations and purpose from those with a lived experience. With this research I hope to help answer the question: to what extent are self-injury and ODI-type behaviour ways of dealing with the same issues, especially managing negative emotions?

A thematic analysis of the transcripts was conducted. The questions on the interview schedule (see Appendix D) were left open ended to facilitate openness of the type of behaviours participants engaged in. Overall, each participant had engaged in cutting, with almost all engaging in another type of NSSI as well. These findings are reflective of data from literature which found that most people engaged in more than one form of self-injury with the most common being cutting (Klonsky, 2011; Selby et al., 2015; Slesinger et al., 2019). Other forms of NSSI identified were hitting their head on the wall, punching their head, pulling hair and burning. Overall, each participant had engaged in a type of ODI behaviour as well. Six participants had engaged in relational aggression by verbally lashing out or starting arguments with others and one started physical fights. Four participants engaged in punching a wall.

As there was not a preconceived criteria for types of injurious behaviour participants were able to discuss a wider variety of behaviour. However, there were still similar behaviours identified across the interviews. In addition to direct injury, risky behaviours

identified included engaging in risky sexual behaviour substance or alcohol use, overeating and reckless behaviour.

Through a thematic analysis I have identified five themes which are broken into smaller subsections. The first theme that will be discussed is the role of emotion. This has been broken down into understanding the role of different emotions and how they affect the type of behaviour and experiencing emotion as an overwhelm. The next theme is interpersonal relationships. This theme will explore the role that others play in the type of NSSI or ODI-type behaviour that participants engaged in. In particular, this will focus on how guilt caused by worrying about the impact on others plays an important role in perpetuating or inhibiting the cycle of injurious behaviours. This theme will also focus on the role the support and influence family has. The next theme is self-punishment. This will explore the use of these behaviours to validate engagement in injurious behaviours and the cycle this elicits. Following this theme, the next will focus on situational factors such as circumstances and resources that influence the type of behaviour. Finally, I will discuss the role and impacts of gender and sexuality. These themes identify patterns which help to understand to what extent injury to the self and outward are ways of dealing with the same issues, especially managing negative emotions. The themes explore the similarities and differences between the antecedents and triggers.

The role of emotions

As discussed in the previous chapter, emotion has been identified as playing a key role in function for both NSSI and ODI-type behaviour. In particular, NSSI has been identified as a behaviour that is used to assist externalising and controlling difficult emotions with temporary relief from negative emotions identified as one of the main reasons for

engaging in NSSI (Bresin & Schoenleber, 2015; Curtis; 2016; Klonsky, 2011). Emotion is also believed to be a key element in the understanding of aggressive behaviour (Garofalo & Velotti, 2017; Velotti et al., 2016; Watts & McNulty, 2013). Aggression, similar to NSSI, has been theorised to be an externalising behaviour for negative emotions, most noticeably anger (Garofalo & Velotti, 2017). The main theories for aggression focus on emotional dysregulation, alexithymia and impulsivity as interplaying factors in the engagement of aggressive behaviours (Velotti et al., 2016). NSSI has also been associated with alexithymia and deficiencies with emotional awareness, intelligence and impulsivity (Garisch & Wilson, 2015).

To understand the extent of how NSSI and ODI-type behaviour are ways of dealing with the same emotions, particularly negative emotions, the interviews started with opening a discussion about emotions and the participants experiences with them. To facilitate this discussion, the first question in the interview schedule (see Appendix D) asked participants what type of things made them upset followed by what they type of things they do (risky and non-risky) to make themselves feel better. This lead to discussing harmful behaviours more generally and so the next question aimed to create more understanding of the role of emotions asked participants; Some people do different things according to the emotion. Do you do that too? Maybe if you're really angry, you do different things to if you're sad or anxious? Or does that not make a difference?

From the answers, there were two key themes which developed and will be discussed in the following section. The first theme focused on the type of injurious behaviour engaged in differing depending on the type of negative emotion experienced. This theme included four of the participants. These participants were able to identify the emotion they were feeling but struggled with emotional dysregulation and impulsivity. The type of behaviour was

influenced by the negative emotion they were experiencing. The second theme found that there was no difference in the type of negative emotion and type of injurious behaviour. These six participants described an overwhelm preceding injurious behaviour and a relief following engagement. This theme suggests that these participants could be experiencing alexithymia alongside impulsivity and emotional dysregulation.

Different emotions underlying different behaviours

This theme discusses four participants who identified that the type of injurious behaviour they engaged in was influenced by the type of emotion they were experiencing. The emotion experienced played a role in determining the type of NSSI, such as cutting or burning, and could also influence whether the behaviour was self-injurious or outwardly directed.

1AO would engage in different types of NSSI which was determined by the type of emotion they were struggling to process. 1AO also participated in an ODI-type of behaviour by punching items but it was not specified which type of emotion this was related to.

> “I would cut myself more often when I was feeling really anxious. I don't know if there's something lonelier feeling almost about it, cutting myself, whereas I think the burning feeling was, well, most helpful with anger and I try to rip stuff up instead of that now.”

This is similar to Plutchik et al.’s (1989) two-stage theory of aggression which found aggression can lead to violence towards the self and others and is determined by different factors. Stage one focuses on the experience of the event and whether it is interpreted to be a stressor. Stage two the target of either self or others is determined by a pattern of risk factors.

Similar to 1AO's experience, aggression towards the self is increased by factors such as depression and feelings of hopelessness. Aggression outwards can be influenced by impulsivity and life stressors. 2MNL found that they would hit their head on items when they were experiencing frustration or shame about life stressors. When they were sad they found they would ruminate and this would lead to cutting.

> "Yeah, but I think hitting my head was probably more when I was like, really frustrated. Yeah. Or like, you know, really mad at myself…I think if I did badly on a test or something like that. Or like felt that I'm, like, embarrassing myself in front of people."

3BU found that they were able to recognise the emotion they were experiencing but were unable to regulate it. Garisch and Wilson (2015) found a correlation between deficits in self- regulation such as impulsivity and engagement in NSSI. This was also identified as an antecedent for engagement in aggressive behaviour and an important factor in Baumeister's (1990) self-regulation theory. Similar to these findings, as well as Plutchik et al. (1989), 3BU found that anger caused an impulsive reaction and would lead to behaviours such as hitting their head, punching and kicking items as well as lashing out at others. When they were experiencing depression or sadness they would feel a numbness and engage in avoidant behaviours such as isolating themselves from their friends and family.

> "If I get suddenly intensely angry I, it scares me. But I at times can't stop myself from not punching the wall or things like that. And then when I become extremely overwhelmed, I become very tearful and sad and not sad, but extremely overwhelmed. And I start crying and yeah, I can't regulate myself."

3BU also found that they would engage in hair-pulling as a way to bring them back to the present and process emotions such as panic and anxiety. They described engaging in behaviours as a way to avert their focus from overwhelming negative emotion instead of a way to process the emotion. This aligns with Hasking et al.'s (2017) emotional cascade theory which identifies NSSI as a way of distraction from overwhelming rumination.

5MM found that when they experienced sadness they would withdraw and struggle to process the emotion. Sadness, as well as guilt or shame, would be more likely to lead to cutting or hitting their head. However, for 5MM, anger would feel more like a 'burst' and not lead to any type of injurious behaviours. Similar to 3BU, 5MM was able to identify the emotions they were experiencing but were unable to regulate the intensity.

> "Yeah. It's this intense beam of guilt and shame. It's very uncomfortable, and I'm not good at dealing with guilt and shame and rejection, real or perceived. So that's a fun one. It just... Yeah, it's just an automatic thing. It's never like a... For me, it's not a planning thing. I don't plan to do it. It's just in the moment and it happens."

For these participants, the negative emotion they were experiencing guided the type of injurious behaviour that they engaged in. This could determine the type of NSSI such as cutting or burning or whether the behaviour was directed outwards. These findings, while limited with a small number of participants, support Plutchik et al.'s (1989) two-stage theory of aggression. While NSSI and ODI-type behaviours were ways of dealing with negative emotions, the type of behaviour engaged in was influenced by the type of negative emotion participants were experiencing and how they were able to regulate this emotion.

Emotion as an overwhelm

Six of the participants described a sense of overwhelm preceding engagement in NSSI or ODI-type behaviour. Unlike the other four participants they did not identify a negative emotion such as sadness or frustration but rather an accumulation that lead to a feeling of overwhelm. 8SU describes this feeling; “I think it all accumulated in the same way. Yeah, there was no really, if I was angry, I'd do something I wouldn't do when I was sad, it just manifested in the same way.” 4MV also described this overwhelm and dysregulation of emotion. They would engage in cutting, picking of the skin or hitting their arm on a wall but could not specify what would determine which behaviour they would engage in.

> “It's hard for me to distinguish between sadness and maybe frustration. Like whatever it is, it's more like I get that urge and at the time, it's like when either of those two feelings is, like, way more intense than it usually is. It's kind of like, you know, I can deal with it totally fine up to a point. But then when it reaches that point, it's just intense… the self-harm was basically just a way to, like, reset my brain. And I don't know how it works, but it, you know, brought that the emotion below that intensity point to the point where I could deal with it again.”

6AO found that they struggled to regulate and identify their negative emotions to process them, “I think by way of dealing with all the negative emotions in our body was to hurt myself. I didn't know how to let the emotions out.”

This could be experiences of alexithymia. Alexithymia is a personality trait which is characterised by a poor awareness of emotions and a diminished ability to think or talk about feelings (Velotti et al., 2016). As mentioned earlier, an interplay of emotional dysregulation and alexithymia is an important factor in understanding aggressive behaviour. Individuals

who have poor emotional awareness are more likely to struggle with the regulation of their emotions, particularly under stress, and they struggle to find appropriate interpersonal skills (Velotti et al., 2016). This also plays a role in Baumeister's (1990) theory of self-regulation in which the regulation of negative states of emotional arousal impair cognitive control. The focus is then on immediate hedonic or instrumental behaviour and not on emotional awareness.

Research has also found to predict a co-occurrence of alexithymia and NSSI (e.g Baumann et al., 2025; Garisch and Wilson, 2015; Iskric et al., 2020). Hasking et al.'s (2017) emotional cascade theory of NSSI also describes an intense and often unidentifiable overwhelm of emotion prior to engagement. Similar to Baumeister's (1990) theory, when experiencing this overwhelm of negative emotion, the focus becomes on relieving this with immediate hedonic or instrumental behaviour and not on identifying or regulating the emotion. 10CO felt that the emotion did not make a difference and that engaging in injurious behaviour would just come from a sense of overwhelm. 8SU and 9BU both described that it would not be one emotion but a range of negative emotions before they would lead to an overwhelm. 8SU describes how the focus would then be on relieving this overwhelm.

> "Because you, I guess, suppressed it for so long that when it bubbles up, it's too big to ignore. And so, yeah, definitely, like cutting or things like that, I felt like, was my only escape from my emotions was trying to, I guess, top it with pain instead of emotions. It was like, well, if I feel more pain than the pain in my emotions right now, then hopefully those will leave."

7SO would describe a tsunami of emotion; "it's a release of whatever that emotion is. Sometimes I can't identify it. I don't really understand or can figure out what it is. It's just like

a ball that needs to get out." When experiencing negative emotions 7SO would isolate in their bedroom to try and disassociate from their negative emotions. Over time, this would cause a build of emotion and would lead to an engagement in cutting to release this overwhelm they were experiencing. 7SO also found that they would lash out at others and purposely start physical fights to release their emotion. 8SU and 10CO also described punching objects as a way of releasing the overwhelm over emotion. Velotti et al. (2016) and Iskric et al. (2020) found that individuals who have poor awareness of their feelings are more likely to struggle with emotion regulation, in particular reducing emotional arousal in stressful situations. Velotti et al. (2016) found that individuals can lash out as a form of self-protection from the perceived threat. 8SU describes this feeling of lashing out.

> "I would just try to ignore them until it was too much, and then it would just be too much emotion. And I think I'd lash out when it just all boiled up. Didn't know how to cope with how I was feeling… And then everything would build up on to each other. And I guess even if something mundane happened, it would just create an explosion because of all these things that, just sitting inside, and then I just couldn't hold it anymore. Yeah. That's come to a point."

All six participants identified that they would lash out verbally, start verbal arguments and isolate themselves from friends and families. 8SU also described this as a way of validating their negative feelings. They did not feel that they deserved to be loved and when their friends and family argued back this validated these feelings. Similarly, 4MV describes starting arguments to explain their overwhelm of emotion.

"That was like being like deliberately argumentative, so that you know someone else would like, get angry with me and I could kind of have a reason for those feelings, like those intense feelings to be above the threshold in a way."

The findings of experiencing an overwhelm are consistent with Hasking et al.'s (2017) emotional cascade theory of NSSI and Baumeister's (1990) self-regulation theory of aggression. In both these theories, when experiencing this overwhelm of negative emotion, the focus becomes on relieving this with immediate behaviour and not on identifying or regulating the emotion. This sense of overwhelm alongside experiences of alexithymia and deficits in emotional regulation causes participants to engage in NSSI and ODI-type behaviour. There seems to be a similar antecedent, and these are just different ways of dealing with the same issue.

Feelings of guilt

After engaging in either NSSI or ODI-type behaviour participants described feeling guilt, shame, relief, numbness or better. 1AO describes the short-term immediate relief, "in the short term, they make me feel reasonably better, it feels nice knowing how to express emotions for once." 6AO described the feeling of relief. "Yeah, it made me feel a lot of relief after I would do it. Sometimes I would feel really numb, which at that stage I thought was better than feeling anything. And then it's not because it's just masking the issue, but yeah. No, it always felt like everything was going to be OK once I had done it." When describing how they felt after engaging in risky injurious behaviours, four participants used the word 'better'. Other participants described the feeling as more of a relief. 5MM described feeling as though the experience of pain had 'reset' their brain and "as though it was right thing to do."

Guilt was identified as an important factor and having the biggest impact for seven of the participants and their experiences. The feeling of guilt was found to be either a contributing factor in the engagement of NSSI or prevented participants from continuing to engage. Instead of providing relief from the antecedent of the behaviour, guilt was found to cause a further engagement in a negative emotional spiral therefore perpetuating the cycle. 9BU would feel like they were letting people down when they continued to engage in these behaviours which further added to the cycle of negative emotions.

> "Yeah, I think for me it made me feel bad that they were concerned or worried about me which made it worse. Yeah, that was like, a vicious cycle like oh are they mad at me? Or were they concerned or worried? So now I have to like punish myself for making them feel like that, and then it wouldn't just stop. "

Sheehy et al. (2019) described guilt as concerned with viewing one's own behaviour negatively and causes corrective actions to amend perceived wrongdoings. This was reflected as participants would feel guilt over the effect that their actions had over others. 9BU found that the feelings of guilt after engaging in NSSI resulted in the continuation of the cycle as they contributed to the overwhelming negative emotions.

> "The guilt. Yeah, pretty much once I stopped cutting or burning and kind of looked at what I had done and thought about what other people are going to think about it or like if other people find out, then I would start feeling worse. I guess immediately afterwards."

Interestingly, these findings differ to the findings of the meta-analysis and systemic review by Sheehy et al. (2019) which looked at the relationships between guilt, shame and self-harm. Sheehy et al. (2019) did not find a significant link between guilt and engagement

in NSSI. Guilt as a negative emotion could contribute to a negative state but not as its own function in self-harm. However, the current study participants found that guilt played a significant role in the continuation of the cycle of negative emotion and engagement in NSSI and ODI-type behaviour as well as acting as a deterrent for some. While experiencing the intense overflow of emotion prior to engaging in NSSI, 4MV they would still consider their work with children and worry what they would ask or see. The guilt of the impact that their actions would have on others impacting the type of behaviour they would engage in.

> "Myself being who I am now and what I do for work it's very much like I don't want anything to be visible and you know anything that is visible like picking the skin around the fingernails is quite visual. It's quite minor, you know. And you can, like, put a plaster over it and be like, oh, no, like, I've cut myself on a grate or whatever. If a kid asks you, what did you do, it's easy to, come up with an excuse or a reason or something. And I guess it was the same. Back about, seven years ago, when I was self-harming and different methods again it was like, OK, what is going to be? Invisible, not visible. What can I explain versus not explain? Yeah. I mean, at least facing the consequences myself, because obviously like, I'd have to look at it no matter what, it's more about like I don't. Yeah, like I don't want other people's perceptions of me to change. And I also work with kids, like, very frequently."

Guilt played a significant role in participants cycles of injurious behaviour, and could add to the cycle of negative emotions. There were different factors which influenced how guilt was perceived and therefore influenced the type of injurious behaviours participants engaged in. Interpersonal relationships was an important factor and will be explored in the following theme.

Interpersonal relationships

An important theme throughout the analysis was the participants interpersonal relationships. When answering the question asking participants what made them upset, all 10 participants said the perception of others. This could be the relationships with their friends and families, how their actions affected others and the guilt that resulted. The influence of how participants were perceived by others and the impact that their behaviour had on other people influenced whether participants engaged in NSSI or ODI-type behaviour. Most participants spoke about how they would rather harm themselves than others and would share remorse and concerns for people they may have impacted when they have lashed out.

Rejection and criticism from others and social anxiety ranked highly as reasons for being upset for many participants. 4MV spoke about rejection playing a role in feeling upset.

> "I mean a big one for me is any perception of rejection in a way. You know, so like if, I mean this particular example hasn't happened in a while, but for example, if I apply for a job and I don't get a job or, you know, like I do an interview and I don't get the job. If, like, in terms of relationships as well, if for whatever reason my partner was like I need some space, I'll kind of take that kind of, you know, not badly, but you know it sticks for a bit and I'll like think about it too much."

5MM described their social anxiety and how this could lead to rumination.

> "I am a quite socially anxious person. So getting into funky social situations can be difficult. I tend to ruminate on any particularly bad social situations that have happened in the past. I really focus on them without intending to, and it just kind of winds up a lot, and then I get really stressed out."

Research on NSSI also shows an association with poor self-perception, integration of identity and low self-esteem (Garisch & Wilson, 2015). This is also reflected findings by Sutcliffe et al. (2022) in a Survey on New Zealand's youth mental health. Sutcliffe et al. (2022) found that the increase in social media awareness and technology use has meant an increase in contextual factors causing distress. All though the current study did not find an association between distress and social media use, it could play a role in factors such as comparing the self to others. 3BU spoke about comparing where they were in life and where they felt they should be compared to others as a contributing factor to their engagement in NSSI and ODI-type behaviours. 8SU also described being hard on themself.

> "I have to do the best and nothing's ever good enough. I've always been like, I need to be the top of the class. Yeah, and just very hard on myself. But I think that's since when my dad's very hard on himself. And I think me also, not in an intentional way, but yeah."

These findings could correlate to how the perception of others can have such a significant impact on determining how to respond to these intense emotions. This could also account for an understanding of one of the reasons that individuals choose to engage in NSSI or ODI-type behaviour. Plutchik et al.'s (1989) theory of aggression highlighted the different risk factors in each stage. These risk factors could be influenced by the social support available. Plutchik et al. (1989) found that having a large social network acted as a negative correlate of risk of violence.

Research by Garisch and Wilson (2015), Liu et al. (2017) and St Germain and Hooley (2012) have identified that adverse childhood and adolescence experiences, such as exposure to physical acts of violence or threats to life are also associated with an increased risk of

engaging with NSSI. Interpersonal factors and relationships with others have also been shown to have an impact on aggressive behaviour. The general aggression model highlights the importance of life experiences as knowledge structures to influence future behaviour (Anderson & Bushman, 2002). GAM theorises that people with an inherent predisposition to aggression are more aggressive and this is reinforced by life experiences which prepare them to behave aggressively across different situations. These aggression related knowledge structures continue to influence an individual's understanding and responses to intrapersonal conflicts which continues to influence their likelihood of behaving aggressively (Gilbert et al., 2013).

Understanding the impact that these factors can have on NSSI as well as aggressive behaviour can help enable understanding of the engagement in both NSSI and ODI-type behaviour. The impact of a supportive versus a non-supportive family was apparent in the cycle of engaging in injurious behaviours how it manifested as well as the participants' understanding of their emotional wellbeing and what they would like others to know about this type of behaviours. The following section will look at the commonalities among the participants who described their family as supportive, the commonalities among those with unsupportive families, the impact that guilt had and the difference between both of these groups. While they are divided into two groups, it is important to note that family relationships are not linear. While a family may have been supportive overall, this can be shown through different ways and there are still negative experiences within that support. The participants in the unsupportive family group have experienced family harm but still have experienced some support from their family members.

The role of guilt

As guilt played such a significant role for most of the participants, it was interesting to note that there were three participants that did not identify guilt as a significant factor. The difference in these participants was their relationship with their families. The guilt and the effect it had on others was an aspect that impacted participants to try and engage in less harmful behaviours. However, guilt could also add to the cycle of overwhelming negative thoughts. The impact of supportive family relationships can also be understood incorporating the role of emotions and of guilt. The three that did not report feelings of guilt also identified poor family relationships as a reason for engaging in NSSI and ODI-type behaviours. The participants who identified guilt as an important function in the cycle of their NSSI and ODI-type behaviour had close or supportive relationships with their families. The guilt was therefore in relation to how their behaviour would impact others. 3BU did not have a supportive family relationship and only identified guilt when they damaged property.

> "Once I kicked a, what was it? Bottom drawer in a metal cabinetry thing and it dented it and that was at work. I felt really guilty about that because I damaged property at work. It felt like I was going to get in trouble, possibly lose my job, never owned up to it, but they never asked. So, I Just kind of left. It wasn't important to them. But I still felt extremely bad and guilty about that. Because I couldn't control my emotions at the time and like I just found out, really what would be considered good news. But I felt angry at the same time."

While the findings suggest a link between supportive families and guilt, 3BU shows that guilt could just be in relation to the impact on anything that was important in the lives of those engaging in injurious behaviours. Participants who had experienced harmful or unsupportive behaviour from their families were less concerned about perception of others

when lashing out or self-harming. Participants who were concerned about how their actions would affect others had supportive family or partners and the guilt could play a role in the type of injurious behaviour they engaged in. Even when they were struggling with an intensity or overwhelm of negative emotions, they would consider their guilt and worry for their loved ones and would try to engage behaviours that would cause less harm to them.

Supportive family relationships

Social support has been found to be a mediating factor for engagement in NSSI (Christoffersen et al., 2014; Curtis, 2016; Wan et al., 2018). Curtis (2016) found that interpersonal and micro social factors play an important role in precipitating and maintaining self-harm. Low social support has been found to increase the risk of engagement in NSSI (Christoffersen et al., 2014; Wan et al., 2018). There were five participants who spoke positively about their relationships with their families or partners. One participant, 4MV did not speak about their relationship with their family in regard to their behaviour but that they had a good relationship with them. While there may have been some difficult times throughout their experiences, overall their families were described as being supportive. Having a support system seemed to have the biggest impact and influence of the types of behaviours participants engaged in. Overall, supportive family relationships were found to be positively associated with emotional wellbeing.

1AO described how unsupportive their mother was. Their mother's response to 1AO engaging in NSSI or ODI-type behaviours was to yell at them and so they no longer have a relationship. However, 1AO continues to have a good relationship with their other family members and this plays a significant role in their engagement in behaviours now. 1AO described their father as incredibly supportive, calm and helpful. This has helped 1AO to have other preventative things in place such as sensory items. When engaging in NSSI, they

would feel comfortable enough with their father to go to him if they felt they needed first aid treatment. 1AO felt guilt around their sibling who had observed a bad incident as well as the impact their behaviour may have on their father.

> “I've tried so hard to stop this because I don't want people close to me having to do stuff like that for me. It makes me feel a lot worse in the long term. It makes me feel guilty and knowing other people might see it.”

2MNL felt that they did not have a strong support system with friends or at school. However, they had support from their parents and now partner as well. 2MNL would feel an intense guilt for upsetting their mother and partner which would prevent them from lashing out and to try and stop engaging behaviours that could cause upset to their loved ones.

> “I know it's made my mum upset in the past. Yeah. And it makes my partner upset, which is the reason that I haven't done it. Yeah, in a long time. Not really because I don't want to, but just because I don't want to make my partner upset.”

When talking about whether they had engaged in any ODI-type behaviour, 2MNL felt that causing harm to others would make them feel worse and so would direct the harm at themself.

> “Ah I think it's more about like punishing myself? Like because I'd hit my head against the wall. I've never really tended to like lash out at other people because that makes me feel worse. Yeah, I find like that makes me feel worse or guilty.”

5MM has good supportive relationships with their mother and partner. These relationships have impacted their engagement in self-injurious behaviour and has encouraged them to find other coping mechanisms. They found that talking to either their mother or

partner were ways that they could seek out some support if they were struggling with negative emotions. 5MM details how the impact of an incident of NSSI resulting in a hospital trip affected their mother and partner; "It wasn't just me, it was him as well. I had to call my mum and tell her what I've done. She was obviously really upset. It's not just risky, it's this big flow-on effect."

5MM was also using alcohol as a coping mechanism. Their partner had a talk about their future plans and how the destructive behaviour around drinking could not be a part of this. This changed 5MM's behaviour around drinking and they sought out other ways of coping with overwhelming emotions that would not cause harm to their relationship

8SU no longer engages in NSSI or ODI-type behaviours and has a good relationship with their family whom they still live with. At the time during their adolescence they often felt that their family "swept what was happening under the rug". However, they have now realised that their family was probably scared and concerned with what was happening and did not know what to do.

> "But we're fine now. All of my relationships now with my parents and my brother are good. I still live at home, and I literally sit down and talk just about my day and stuff with them. I think it was just a hard time for everyone. Yeah. They tried to go to parenting courses and stuff and tried to help me. I just think it was just a very chaotic time. I did feel bad for them. They had to deal with it, but especially for such an extreme depression for me, that it wasn't just 'I feel sad'. It was just me running around drinking going crazy. Yeah. So for them, but we all made it through it. I think that it's important that there is an end to it. And when I was in the mix, I couldn't see it."

Even though the relationship was not positive at the time, they did not physically lash out at their family. They would often get short or angry as a reflection of how they were feeling rather than because of the behaviour of their family.

> "I used to get very, I was very short with my parents. We had a very bad relationship probably in those times. I think it was probably because I was just angry and I wouldn't necessarily say bad things to them, but I wouldn't, I guess I just tried to push them away, not want to talk and just tell them to leave me alone. But, I was never really... My feelings never manifested, I guess, in anger, per se. It was more just sadness and, yeah, just very sad feelings rather than angry."

9BU had a complicated relationship with their family. For 9BU, the main cause for engagement in NSSI and ODI-type behaviour was change. However, family would also cause feelings of guilt which added to the cycle of injurious behaviour. They often found that, unintentionally, family were one of the causes of harm. Consequently, they found that they would push people away and try to isolate themself.

> "Family...Complicated. Like wanted to be helpful but also wanted me to stop, but yes. So it was kind of bit more guilt with them. Like they put guilt onto me. Yes, but they were also there when I was having like a not good time. They've also made sure like I could go stay with them and, you know, keep me safe or come with me to the hospital if I needed that kind of thing. But I think there is just one time in particular, like a few months or I think it was like a year after, like just anything that would happen kind of thing, where I would have bandages on. And they, that was more of a why are you doing this? You have this plan kind of thing. Why aren't you sticking to it? Why

didn't you call us kind of thing? Just you know how, like a little blame rather than empathetic."

Similarly, 10CO also had a complicated relationship with their family but overall, their family and friends were described as very supportive. However, they did not find their mother to be supportive and felt that this relationship perpetuated the cycles of injurious behaviour.

Overall, the support from 1AO, 2MNL, and 5MM's families played a role as a preventive measure for their engagement in injurious behaviour. For these participants, as well as 8SU, this prevented them from engaging in ODI-type behaviour as they would not want to cause harm to their loved ones. They would experience guilt for the way that their behaviours impacted their loved ones and this could act as a preventative measure. However, the guilt from family could also add to the cycle of negative emotions.

A difference was also observed in answers to two of the questions asked as part of the interview schedule (Appendix D). These questions asked what they thought was important for people (parents, teachers, mental health professionals) to know about these types of behaviours and what was important to them in terms of their emotional wellbeing. The participants who had supportive family relationships had similar answers which differed from the answers given by the participants who did not have a supportive family. Below I will discuss the answers of the participants with supportive families and in the next section will discuss the difference in the answers of those who described their families as unsupportive.

Overall, the participants with supportive families described that a strong support system was important as well as having the right resources to be safe. 2MNL noted that a strong support system is needed. Similarly, 5MM highlighted the importance of having a

strong support system as well as it being acknowledged by addressing it openly and compassionately while not avoiding the seriousness. 5MM believes that it is important to need to know who you can go to for support and having access to a good therapist.

9BU described the importance of not placing shame or guilt onto people as they felt that adds to the cycle of negative self-beliefs and punishment.

> “Not to place blame guilt or shame onto people as that because I mean, for me personally, that makes me feel like punishing myself more. Which, not good. And it doesn't sit well, so it's more to be supportive and encourage safer behaviour. Get them resources to try different things or if they're going to do it help them be safe with it so they don’t do serious damage or anything like that. Because then that proves that you're a safe space for them and that builds that relationship.”

8SU, on describing being sent to respite care, away from their family support; “Or just bring in, I guess, community support and getting parents and siblings and family and community. Just more of a community-based approach than trying to send you away to fix you. I don't know. It seems like a lot of people don't come out of those places feeling better.”

1AO spoke about having the right people and resources around you to keep you safe.

“Yeah, it can be quite habitual, but also quite addictive. And it's difficult when like having all of the things I would self-harm was taken away, wasn't necessarily helpful. That would just mean that I would…I found a smashed bottle on the street once and used that. Umm it led to more uncontrolled and dangerous situations for me and so I think if people get to a live in a level enough headspace that you can talk to them about.”

When asked about what was important in terms of their emotional wellbeing, 1AO, 2MNL, 4MV, 5MM, 8SU and 9BU had good understandings of themselves and their needs. They could also outline healthier coping mechanisms which they had learnt from their support networks. They all spoke about the importance of having the right resources and support around them. This included their hobbies such as arts and crafts, being in nature, having someone trustworthy to talk to and having the space to sit, process and accept any negative emotions that they were experiencing. This was similar to factors found to describe good support by Christoffersen et al. (2014).

Unsupportive family relationships

Participants who had experienced family harm and were unsupported by their families were more likely to engage in ODI-type behaviour than people who were supported by family. This correlates with the two main theories of aggression which were discussed in the literature review. General strain theory (GST) was developed to from research data which suggested a correlation between negative childhood and adolescence experiences and aggressive behaviour (Agnew, 1992). According to GST that it is fundamental to experience strain in order to find ways to cope with experiencing negative emotions. These are heavily influenced by the coping mechanisms available throughout the development years. The participants have negative beliefs about what they deserve and are using learnt scripts to respond to this. The General Aggression Model (GAM) finds that maladaptive pre-existing cognitive structures, such as schemas or beliefs, can influence the perception and preconceived idea of how a situation may unfold, how to respond and the likely outcome based on past experiences (Anderson & Bushman, 2002).

There were three participants who identified their family as one of the primary things that made them upset and was a factor in their engagement in NSSI and ODI-type behaviour.

All three of these participants experienced some form of family harm. Individuals who have had exposure to violence and childhood abuse are found to be congruent with aggressive behaviour such as verbal aggression and physical aggression against others or destroying property (Harford et al., 2017; Watts & McNulty, 2013). These three participants were the only ones who shared that they had experienced this as it was not asked directly in the interview. There were several noticeable differences observed in all three of these interviews compared to the seven others which will be discussed in the following section. These differences include noticing that their behaviour was learnt from family as well as a higher level of aggressive behaviour shown than participants who had a supportive family.

3BU described a volatile relationship with their parents. This has been a primary factor for their engagement in NSSI and ODI-type behaviours.

> "Yeah, my dad can be very verbal, loud, verbally and. And he's quick to anger. And while I don't really, I don't remember like the earlier parts of my childhood, but from what I've heard from my brothers, it was a lot of negative interactions and police were involved, and I don't know if there was violence, but it wasn't a healthy place to be. But I know that I've learned a lot of his negative lot, learned a lot of his negative traits in terms of yelling and being quick to anger as well which definitely scares me."

3BU also talked about struggling with intense anger; "if I get suddenly intensely angry, it scares me. But I, at times, can't stop myself from not punching the wall or things like that." 3BU felt as though this behaviour was learnt from their childhood experiences with their family. This correlates with theories of both GAM and GST who emphasise the importance of learnt behaviours in development years. This behaviour amongst the family

continues when 3BU does try to re-engage and spend time with them. They described the relationship with their stepmother and how they reacted during a recent interaction.

> “My step-mum also makes like comments to everyone every now and then and I've taken to like biting and lashing back at those which is kind of which is making like a rift in the family and making me more to be seen as the black sheep.”

When asked the question how people (such as friends and family) react when they do a potentially harmful thing, 3BU expressed that they are unable to talk to their family.

> “I can’t talk to my family, otherwise this happens. Otherwise, my dad gets defensive and lashes out basically and my mum passed away last year and there was never a good relationship there, so I didn’t get to talk to her about stuff like that. I've got in total, seven siblings and my older three brothers, who are from my mum and a different dad, I can talk to them kind of about it, but I still feel a bit of a sense of judgement.”

Therefore when talking about their emotional wellbeing, 3BU focused on what they felt had been lacking from their support network.

> “What’s important for me is that I would like to be able to have a family and not feel as if I'm going to cause more generational trauma. That's the most important thing for me, actually.”

When asked about what they felt professionals should know, their answer differed to the answers of those with supportive families. 3BU’s answer focused on not being judged, as they had often felt, being able to trust the reaction from the people they sought out for support

and ensuring that families were offered help. 3BU described a suicide attempt and the reaction from their family which has impacted how they believe support should look.

> "There's a lot of judgement that comes from it just from yourself. And so, the fear of reaching out. I find that I'm scared of judgement, but I'm also scared of being told that there's nothing wrong with me and that I'm just making up things. So, there's definitely, I wouldn't say mistrust, but a hesitancy to trust. I think it should actually be compulsory if a young person tries to commit suicide that the family tries counselling cause my parents were offered it, but they never took it up and that's something I'm quite upset about."

6AO also identified their family as a reason for their engagement in NSSI and ODI-type behaviour. 6AO experienced family violence and was unable to express their emotions throughout their childhood and adolescence. They found that injurious behaviour was the safest way to cope with what they were experiencing and that this was learnt from their home environment.

> "We're always getting growled, always getting a hiding. I think by way of dealing with all the negative emotions in our body was to hurt myself. I didn't know how to let the emotions out like you couldn't get angry because if you got angry at Mum, she'd just beat you. But it would be like, OK, you like, hide in your little shell, you know, until you're ready to explode. And that was, in my mind, the healthiest way to deal with it. Yeah, it was the safest way for me to cope with the living conditions that I had at the time. I know where to seek help or how to get help without my mum finding out at the time and then when I eventually reached out and got help from a counsellor at high school, of course they went and told Mum, right, and then

everything went…when my mum found out and I got tested for depression she took me to her church to give me an exorcism because she thought that I had the devil in me. So it didn't go so well for me.”

Similar to the participants that had supportive families, 6AO did talk about trying not to lash out at others that they cared about. Instead of expressing that this was out of guilt, they felt that they should keep their emotions inwards to avoid further conflict. This was often perceived as being rude rather than a way of protecting themselves.

“Rude, snobby. Yeah, which wasn't like I just didn't know how to…. when you were upset and you don't want to lash out at someone you care about. So you think that it's better to keep it in, right? So you don't hurt them by saying the wrong thing, but then they still take it as, Oh well, she's just been a bitch.”

When talking about what is important to their emotional wellbeing, 6AO focused on the self, not impacting or hurting others and being happy and healthy. When asked about what people should know they spoke about a lack of resources and that engaging in injurious behaviour was not for attention.

“At the time, I think, well, at the time it happened I went to the counsellor and then got sent to get tested. They acted like you're only doing it for attention, it's not. Like it's not actually a problem like you could stop if you wanted to. And it doesn't matter what you said about you know how you feel or that you actually physically can't stop it. Like you need to do this to feel better. Because you don't have any other coping mechanism. They tell you, no, you do you just have to figure it out. And it's like, well, what do I replace it with? That is a healthy alternative. No one even gave you a straight answer. Wasn't fun.”

7SO talked about their family being a factor in their engagement in NSSI and ODI-type behaviour. They described that when they were younger, they would take out their emotions on other people. However, 7SU did not want to cause harm to others so they took it out on themself. At times, 7SU would physically fight their older brother as a way of lashing out to process their anger. They talked about an ACE where their father was careless with their safety.

> “Because when I was about three, I almost got shot in the head when I was staying at my dad's place. He was teaching my six-year-old brother how to shoot an air rifle. He got my brother and I to draw pictures of our mother as monsters so that he could use him as I got to practice, and he let me wander around the backyard. Just stay off to the side, you're three years old, you'll listen to me. I went in front of the barrel, and he hit the barrel up, so it just missed my head by that much.”

7SO described the difference between being at their mother’s house and their father’s house and the impact this had; “what we saw living with him and then coming back and living with my mum, completely different. And so as I got older, I heard a lot more stories about what was going on behind the scenes when I was growing up, even before I was born. And so I didn't want to end up like it.” 7SO’s mother provided a more supportive and caring environment. Similar to the participants with supportive families, the relationship with their mother was not without its own challenges.

> “My mum, it's a bit of a mixed bag of how she can respond. When I was younger as a teenager, she got really mad. And I remember after one of my (suicide) attempts, she told me, do it right or stop doing it.”

7SO understood that their mother reacted like this because they were worried. Similar to the guilt expressed by the participants who had supportive family relationships, 7SO described how their relationship with their mother impacted how they managed their behaviour.

> “I didn't want to be that person. I didn't want to be a threat to others. And I know that as I got older and bigger, I was scaring my mum a lot more because my mum was quite small. I never hurt her, but I did yell at her a lot as a teenager because at that point, I wasn't in therapy, I wasn't on any medication. So it was a bit of a loose cannon. But I think at one point, we were having a fight, yelling at each other. And I moved to go leave the room, and she flinched. And I was like, fuck, okay, I won’t do that anymore. I didn't want to turn out like my dad.

7SO identified being able to take their time and not be pressured is important for their emotional wellbeing.

Overall, interpersonal relationships have an impact on the cycle and type of NSSI and ODI-type behaviours. In the current study, family relationships appear to have some impact on the type of injurious that one chooses to engage in. The participants who had unsupportive family and experienced family violence as a child spoke of engaging in aggressive behaviour such as fighting and uncontrolled anger. While there were some that have supportive family who engaged in behaviour such as hitting objects or lashing out, they often felt immense guilt about the effects of their actions. This meant that they sometimes chose to engage in NSSI to protect their loved ones. These relationships also acted as a deterrent as they worried about the impacts this behaviour had on their family. The worry about their family also played a

role in their discontinuation of injurious behaviours as they tried to find ways to cope that did not impact the ones that they loved.

When participants were asked about their emotional wellbeing, the participants who had supportive family relationships were able to talk about how they took care of their emotional wellbeing and ways that others such as professionals could improve understanding. This demonstrated a good emotional awareness and understanding of healthy coping mechanisms to work to prevent cycles of injurious behaviours. Their examples all included having a good support system. The participants who had unsupportive family relationships could also identify healthier coping mechanisms and had a good understanding of their emotional wellbeing. However the focus in their answers was on what they had lacked in their engagement in services and they did not identify a support system as important in their or others wellbeing.

Self-punishment

The next theme to be discussed is self-punishment. Seven participants identified self-punishment as a reason for engaging in NSSI and ODI-type behaviours. This is similar to findings across the research literature which identify self-punishment as being a reason for engaging in self-harm behaviours, specifically NSSI (Bresin & Schoenleber, 2015; Kimbrel et al., 2017). Theories of self-injury often suggest a variety of functions and include punishing the self as a common function (Bentley et al., 2014; Bresin & Schoenleber, 2015; Kimbrel et al., 2017).

9BU described how they used NSSI as a self-punishment; “the burning came after and that was when I was going through a lot more and, again, I wanted to punish myself more.” 10CO used NSSI as a punishment for existing as they felt they were not worthy and did not

feel that they deserved to engage in better coping strategies. 5MM described it as punishing themselves for their perceived bad behaviour from rumination over social situations they had taken part in that day.

> “Yeah. It was like, I literally do not know how I'm going to fix this, and I don't want to face it. But I feel like I have to make some payback on it somehow. I have to do something to make it even or even a bit more right, even though obviously that is not the case with self-harming but it's this big tunnel vision. I have to make it right. I have to make it even. Hopefully, that will help ease some of the guilt or the shame. Obviously, it didn't, and it made it worse in different ways. But yeah.”

Self-punishment was not just with engagement in NSSI but experienced through other forms of harmful behaviour. Negative self-belief could be expressed by placing themselves in risky situations, acting in a reckless manner to cause harm and causing others to harm them to affirm these negative self-beliefs. 8SU described putting themselves in high risk of harm as they felt they deserved what happened to them.

> “The drinking and things, I got myself into bad situations. I was sexually assaulted a few times because I'd literally just go out or be with people who weren't good. Then even after the assault and stuff, I would still, I don't know, feel good that it happened because I wanted to feel terrible in a way that I don't know. I felt like I deserved it. Actually, I wouldn't care that I put myself in these situations and it happened because I don't know, I just felt like, what if it happens, you deserve this pain. I always used to have boyfriends that were not kind to me. I knew, even at that time, I was only with them because I liked feeling hurt. I felt like I deserved to be hurt by them. I could see that it wasn't good for me. But I actually liked that because I felt like I deserved that. I

> guess it did make me feel worse, and it probably perpetuated, like continuing to feel that. But I guess it also felt good to, I guess, have the punishment that I thought I deserved at that time and what I was thinking at the time and what I thought as a person I deserve to be treated like. I don't know if it made me feel better, even the… I think it was more I felt validated that my feelings were true, that I was shit because these shit things would happen. I felt like that's who you are. That's what you deserve. It was affirming my beliefs about myself."

Most participants identified that they acted in a manner to be treated in a way that they felt they deserved. 8SU found that they chose to not engage in better coping strategies as they felt they were not worthy of this; "I just think I didn't like myself. I didn't love myself. So, trying to do a strategy that was helpful, not harmful or anything, I think was not an option because I felt like I didn't deserve help or a good way to deal with my emotion." The participants also identified some behaviour that they engaged in to perpetuate self-punishment that were outward directed or could be interpreted by others as aggressive. These included relational aggression such as isolating themselves from supportive relationships, lashing out and starting arguments, and hitting objects or others.

4MV spoke about antagonising and starting arguments with their loved ones; "so that was like being like deliberately argumentative, so that you know someone else would like, get angry with me and I could kind of have a reason for those feelings, like those intense feelings to be above the threshold in a way." However, they would not physically injure others; "nothing like that. It was mostly focused at myself but I would push people away and isolate myself, pretty much just punishing myself."

Participants described how this behaviour was about causing their own pain as a punishment and not as aggression against others or objects. Similar to the General Aggression Model (GAM) where maladaptive pre-existing beliefs influence participants perception and how to respond to the situation. (Anderson & Bushman, 2002). The participants hold negative beliefs about what they deserve.

Participants also described using NSSI to prevent hurting others. 7SO detailed how they tried to prevent causing harm to others, “I think if I don't get it out, I would just combust and probably hurt someone close to me.” 9BU often felt undeserving of kindness and supportive relationships; “I didn't want people to be worried and I didn't want them, yeah, being kind to me cause I think I thought that I didn't deserve that.”

2MNL engaged in hitting their head to avoid hurting others; “ I think it's more about like punishing myself? Like because I'd hit my head against the wall. I've never really tended to like lash out at other people because that makes me feel worse.”

While there are limited examples, this suggests that ODI-type behaviour could also be a form of self-punishment which could be misconstrued as aggression. With NSSI, the intent is more obvious as self-punishment, but with ODI-type behaviours it is more likely to be interpreted as aggression towards others. This can result in a focus on the individual as aggressive or violent and wanting to cause harm to others. Recognising outward-directed behaviours as self-punishment could help to understand this as a way of dealing with the same issues as NSSI. This behaviour can often cause guilt, shame and perpetuate negative self-beliefs which add to the cycle of -injurious behaviours.

Situational factors

This section focuses on the different factors that influence the type of injurious behaviour that participants engage in. When trying to look at why an individual chooses to engage in NSSI or ODI-type behaviour, the deciding factor could be the availability of the resources available to them at the time. A study by Harford et al. (2017) supports a theory of co-occurrence of aggression against self and aggression against others. This could be supported by theories such as the Plutchik et al.'s (1989) two-stage theory. This theorises that aggression is aimed at either the self and others dependant on the co-occurring risk factors and their patterns. Bentley et al.'s (2014) functional approach theory for NSSI theorises that the behaviour could also be controlled by antecedents and consequences of events, as opposed to an emphasis on psychosocial risk factors effect of affect and minimised social functions.

4MV describes the urgency felt in the need to release an overwhelm of emotion and how the type of behaviour is just dependant on the current situation.

> "It's not something that you have to put a lot of mental thought into. You don't really have to prepare anything like it's quite an impulse thing that you can act on in the moment. And I mean it's kind of, it's not the best way of phrasing this, but it's almost like monkey brain takes over. You don't want to have to plan anything or think ahead. It's just like, OK, what can I do right now? That is a single step, action. Whereas coping mechanisms like distraction it's like a multi-step process and sometimes it's just like hard to actually think through multiple steps."

Similarly, as afore mentioned, 3BU spoke about kicking a metal cabinet at work and described this feeling as a reflex that they were unable to control in that moment. 1AO spoke

about using a broken bottle to engage in NSSI as it was the only resource available to them. 8SU shared an incident where they just used the immediate resources to try and engage in injurious behaviour.

> “I used to ride horses and I used to be quite reckless with riding and the things that I'd be scared of something and not want to do it but then I'd be like, well, if I break my leg, if I fall off, it's fine. Actually, that might be good. So I'd go and do risky things on a horse just to be like, well, if I break my leg, it's going to be fun.”

This example shows that there is behaviour that may not be perceived as intending to be injurious by others. Throughout the findings of the study this was the only mention of positive feelings elicited by engaging in injurious behaviours. Bentley et al. (2013) identified one potential function of NSSI as automatic positive reinforcement (APR). This shares a similarity to this function and could demonstrate the similarities in engaging in NSSI and other types of injurious behaviours.

10CO was told a story by their counsellor of someone punching a fence and permanently moving two of his knuckles. After hearing this, 10CO explained that they never punched an object again and instead would turn more frequently to other behaviours such as NSSI. Participants that had engaged in hitting their head or lashing out at objects were conscious of the noise or damage this would make and would cause them to engage in other behaviours which were more discreet.

While psychosocial risk factors can play a role in determining the type of behaviour individuals can engage in, this theme shows that similar to Bentley et al.’s functional theory, there can be a variety of functions and influences for engagement in NSSI and ODI-type behaviour.

Impact of gender and sexuality

An interesting observation was that there was little to no variation in behaviours between genders. However, there was a limited sample size so while this is observed it is not necessarily generalisable. Overall, there were five different genders in this study. These genders included female, gender queer, non-binary, non-binary trans and trans man. Interestingly, there were no participants who identified as male. While a common belief associates NSSI with females, more recent literature suggest that males and females may engage at similar rates, but it may be in different forms (Fitzgerald & Curtis, 2017; Kimbrel et al., 2017). The lack of male participants may correlate to research, such as Kimbrel et al.'s (2017), which suggests males are less likely to reach out for support and therefore could be less likely to engage in research.

The findings, however, reflect research which suggests that individuals who identify as non-heterosexual are at an increased risk of depression, experiencing suicidal thoughts and suicide attempts and are at a significantly increased risk of engaging in NSSI (Batejan et al., 2014; Liu et al., 2019). Zhao et al. (2021) and Guo et al. (2025) found that individuals who identify as a sexual minority were also more likely to have experienced childhood maltreatment or ACE. Liu et al. (2019) also found that individuals identifying as bisexual, as well as transgender individuals, were most likely to engage in NSSI. Those that identified as a sexual minority were less likely to engage than those who identified as transgender. However, these three studies were findings from a Chinese population and findings may differ with cultural differences. A local study by Fitzgerald and Curtis (2017) had similar findings to the current study. Fitzgerald and Curtis (2017) found an increase in risk of engagement in NSSI for participants that were identified as non-heterosexual, they concluded that the link is complex and requires further research.

There was only one participant who spoke about their sexuality and the relevance this had on their experience of engaging in NSSI and ODI-type behaviour. 10CO described how one of the primary reasons for engaging in NSSI and ODI-type behaviour was directly related to the global attitudes of the world towards the LGQBT community, as well as their own dysmorphia, as they navigated their own journey in gender and sexuality. Their mother also had a negative reaction to their sexuality and they felt that this caused a strain on their relationship and perpetuated cycles of injurious behaviours.

Therefore, these findings do corroborate literature that finds individuals who identify as a sexual minority are at an increased risk of engaging in NSSI. However, there is not substantial findings that can be drawn from this current study which links identifying as a sexual minority as a reason for engaging in NSSI or ODI-type behaviour. There could be a link between identifying as a sexual minority and the perception of others being identified as an important factor for many participants, but this would require further research.

Limitations

There are several limitations that could be acknowledged in this qualitative study. Seven of the participants were current tertiary students and the other three had been recently studying at a tertiary level. Therefore, the sample may not fully represent the range of experiences and viewpoints across all young people, especially those that have not engaged in tertiary education. While there was a variety of genders, there were no males in this study which presents a limitation to the findings. This could correlate with beliefs that males are less likely to seek help and be willing to discuss difficult emotions.

Another limitation is the potential for selection bias. Participants who volunteered for the study may have characteristics or opinions that differ from those who did not participate.

The people that are more open to being part of an interview may have a different understanding of injurious behaviours than those who were not privy to recruitment efforts or felt able to talk about their experience. If there was a more general population representation, and a larger number of participants, there could be more of a range of types of behaviour engaged in and different understandings of these behaviours.

The findings may also be influenced by the specific time period during which the interviews were recruited and conducted, as well as the time period during which the behaviour was experienced. Experiences and understandings can vary based on current events or other temporal factors. The participants were predominantly of New Zealand European culture which could limit the generalizability of the findings to other cultures. The qualitative nature of the study, while providing rich and in-depth insights, may also limit the ability to draw definitive conclusions.

Finally, it is important to note that the subjective nature of qualitative data analysis and interpretation could be influenced by researcher bias or influenced by the researchers paradigm. The interview was guided by the participants being the experts in their own lived experience which provides a rich narrative. This semi-structured process, which allowing key ideas to develop without a constrictive pre-conceived narrative, can be affected by aspects such as the participants willingness to open up and trust the interviewer and what they are willing to share as well as recall of their experiences.

Further research

As this is a small study, there could be a replication on a larger scale with a more diverse range of participants to further focus on clarifying the extent of NSSI and ODI-type behaviour. This would be able to identify more of a range of types of injurious behaviours

and a richer more comprehensive understanding of the reasons. With a more diverse population, the study may be generalisable and able to draw more conclusions.

Further research could look further into different functions which precede behaviour, how emotion can impact this, the role of guilt and the experience of alexithymia. Research could also focus more on the impact of interpersonal relationships and the experiences of childhood. There could also be further research which could look to understand the complexities of the role of gender and sexuality. The results of a larger study may be able to further identify themes and patterns of behaviours which will help in understanding and looking at preventative measures.

In particular, research could open up an understanding of other outward directed or aggressive behaviours as similar to NSSI and change the perception of young people who could be deemed as wanting to harm others or as violent. The participants had engaged in lower level types of ODI-type behaviour and not aggressive or violent acts. It would be important to replicate the study with those that are engaging in more extreme aggressive behaviours to see if there were different factors and how this could be ways of dealing with the same issues as NSSI. Further research can also work to identify young people at risk of both NSSI and ODI-type behaviour. The current research that has already established and developed interventions for NSSI should be looked at as applicable to ODI-type behaviour. The use of education, prevention and early intervention for these critical issues facing young people has the potential to positively impact the lives of thousands of young New Zealanders.

Chapter Five: Conclusion

NSSI and aggressive behaviour share commonalities in comorbidity, function and risk factors. There is a crossover of this behaviour with lower level aggressive behaviour such as wall and object punching, hitting the head or hitting items also being understood as a type of NSSI behaviour (Christoffersen et al., 2014; Fitzgerald & Curtis, 2017; Kimbrel, Calhoun, & Beckham, 2017; Kimbrel, et al., 2018; Slesinger et al., 2019; Voss et al., 2020). However, even with the similarities between NSSI and aggressive behaviours, as well as this crossover, there is a gap in research in understanding to what extent outward-directed injurious (ODI) type behaviours could be ways of dealing with the same issues.

Emotion was identified as playing a key role in the type of injurious behaviours that were engaged in. This was reflective of the main theories and understandings in literature. Similar to wider research, the findings identified NSSI as a way to externalise and control difficult emotions (Bresin & Schoenleber, 2015; Curtis; 2016; Klonsky, 2011). This was similar to the findings for aggressive behaviour which helped to manage difficult emotions (Garofalo & Velotti, 2017; Velotti et al., 2016; Watts & McNulty, 2013). The findings identified different emotions as being a factor in determining which type of behaviour they engaged in. This correlated with Plutchik et al.'s (1989) two-stage theory of aggression which found that sadness and depression are more likely to manifest in harm against the self while anger can lead to more outward directed behaviour.

The findings also strengthened research found in Velotti et al., (2016) and Iskric et al. (2020) that had identified alexithymia as playing a role in both NSSI and aggression. Participants were unable to identify a particular emotion and therefore the sense of overwhelm was found to be a factor in engaging in NSSI and ODI-type behaviour. This

correlated to Hasking et al.'s (2017) theory of NSSI which found an on overwhelm of emotion to precede engagement.

While shame had been previously identified by Sheehy et al. (2019) as playing a role in NSSI, this was not reflected in the findings. Instead, guilt was identified as a major role and this was linked to the effect that the behaviour has on others and impacted the way that behaviour was expressed. Similar to previous findings, such as Christoffersen et al. (2014) and Wan et al. (2018), supportive family relationships were found to have a negative relationship with ongoing NSSI and also decreased the level of aggression engaged in by participants. ACE and unsupportive family relationships increased the level of aggression shown by participants.

Self-punishment was another factor that was identified as causing engagement in NSSI and ODI-type behaviours. This was also used as a way to reaffirm negative self-beliefs, with ODI-type behaviours used as a way to cause self-punishment by the reactions of others. Other situational factors such as availability of resources and ways to elicit positive feelings were also identified as ways of determining the type of injurious behaviours engaged in. This suggested that the manner of injurious behaviour could sometimes be determined by situational factors and not necessarily just factors that are shown to influence behaviour previously.

In contrast to common beliefs found in literature such as Christoffersen et al., (2014), Fitzgerald & Curtis (2017) Kimbrel, Calhoun, and Beckham (201) and Voss et al. (2020), gender was not found to be a mitigating factor in determining what type of behaviour is engaged in. However, this finding could be due to the limitation of sample size and population. The findings did however correlate with research that suggest sexual minorities

are more at risk of engaging in NSSI, but there was no consistent findings that this caused the engagement in injurious behaviour (Guo et al., 2025; Zhao et al, 2021).

Therefore, the current research has found that the NSSI and ODI-type behaviours are ways of dealing with the same issues, particularly managing negative emotions, but the type of behaviour can influenced by different factors. These can be the type of negative emotion, the experience of the emotion, interpersonal relationships, functions such as self-punishment and situational factors.

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Appendix A- Information Flyer

The SHInE Project: Emotional Well-Being Research

Tēnā koe, Talofa Lava, Bula Vinaka, Malo e Lelei, Fakalofa Lahi Atu, Nihao, Namaste, Chao, Kia orana, as-salām alaikum, warm greetings.

You are invited to take part in a study about emotional health and well-being, and the ways in which people deal with difficult emotions. There are three types of research; you can take part in one, two, or all three.

1. **The first part of the study is an online survey which takes 20 minutes on average to complete (though this can vary from about 5-30 minutes).**
2. **In-depth interviews, which take about an hour and can be face to face in Hamilton, Tauranga or Rotorua, or Zoom.**
3. **Completing a very brief (<two minutes) questionnaire on your phone, multiple times. You can decide how many times you do this, but if you do it every time it will take no more than two hours.**

Participants receive Warehouse or petrol vouchers to compensate them for their time.

Please note that the research includes questions of a very sensitive nature, including self-harm. All information provided is confidential.

This research has been approved by the University's Human Research Ethics Committee [Approval numbers HREC(Health)2023#16 and HREC(Health)2023#32].

For more information, please contact:

The project team: shine.project@waikato.ac.nz or

Dr Cate Curtis, the research leader: cate.curtis@waikato.ac.nz

Or see the project website: https://theshineproject2023.wordpress.com/

Appendix B- Information Sheet

The SHInE Project: Emotional Health Research (young people interviews)

Tēnā koe, Talofa Lava, Bula Vinaka, Malo e Lelei, Fakalofa Lahi Atu, Nihao, Namaste, Kia orana, as-salām alaikum,

Sometimes life gets difficult, and people cope with this in different ways. Some people have friends, family or other people who can help them, some seek professional help such as counselling or therapy, some use drugs or alcohol to cope, some self-harm and there are lots of other ways of coping. This research is about the difficult emotions that young people (16-30 years of age) face, and how they cope with them. The project is led by Dr Cate Curtis, of the School of Psychology at Waikato University. Cate has worked at the university for 15 years, and was a youth worker before going to uni, as well as various other things before that. She's NZ-born of Dutch descent.

Research Project Leader: Dr Cate Curtis

This information sheet is to tell you more about one aspect of the research, one to one interviews. You can find out about the other aspects of the research, such as a survey, here: https://theshineproject2023.wordpress.com

Who could take part?

People aged between 16 and 30 who would be interested in talking about the difficult emotions they face, and how they deal with them. Cate's previous research has been on self-harm, anti-social behaviour and suicide among young people, and these are the sorts of problems we're particularly interested in finding out more about.

We hope that through better understanding problems and the ways young people cope with them, it will be easier to offer helpful services and support.

What do research participants do?

One of the researchers on this project meets with individual research participants for about **one hour** or so to talk about problems and difficult emotions, ways of coping and getting past those problems. All the information is usually **anonymous** (though sometimes people prefer to have some aspects of their identity known – this is always by individual choice), and the meeting is arranged at a place and time to suit the research participants – in person if in Auckland or Hamilton, or via Zoom. We would like to make a recording of the discussion, so that it can be written about accurately. Interviews will take place somewhere that suits you and the interviewer, such as a private room at the University, or a room in a community centre.

Sometimes talking about problems can be upsetting, so please think carefully about whether taking part is right for you. We don't want this research to cause another problem for you! ☺ If you think it might be upsetting but want to take part anyway, you might like to arrange a fun thing to do afterwards. You can also bring a friend or support person with you – but please let us know beforehand, if you would like to do this.

If you choose to participate, you can refuse to answer any questions, or stop the interview. You can also contact the research administrator, Nicky, up to three weeks after the interview if you change your mind and don't want your information to be used.

Researcher: Summer

We would also like to send you a written copy of what you said, to make sure it's correct. If you would like, we will send you a summary of the findings from all the interviews combined. You would also receive a $40 Warehouse voucher to say 'thank you' and if appropriate, a $10 voucher to acknowledge any costs (e.g. childcare, travel).

Who are the researchers?

There are several people on the research team, in addition to Dr Curtis. Summer Aykroyd will be conducting many of the interviews. Summer was born in England but has grown up in the Waikato. She has a Bachelor of Arts with a Major in Psychology and a Post graduate Diploma of Arts with Merit in Psychology from Massey University. Summer is currently living in Auckland and is a support worker for victims of crime.

Face-to-face interviews in Hamilton will be conducted by Summer or Cate. Summer will additionally conduct face-to-face interviews in Auckland, or you could choose to take part via Zoom.

What happens next?
Once the research is complete, all the information will be combined and written up into reports and published – but your information will be anonymous.

Some other things you should know:
You can contact the research team by emailing: shine.project@waikato.ac.nz

This research has been approved by the University of Waikato Health Research Ethics Committee; application number 2023#16. If you have concerns about the ethics of this research, you can contact the committee secretary: humanethics@waikato.ac.nz.

If you agree to take part you will be asked to complete a consent form, to make sure that you know everything about the research that you need to, and that you are happy to take part. You will receive a copy to keep.

Emergency Help Services:
If you find taking part in this research upsetting, you might like to contact one of these support services:

Depression Helpline	0800 111 757 http://www.depression.org.nz/
Lifeline (all ages)	0800 543 354 http://www.lifeline.org.nz/corp_Need-Help_555_2001.aspx (also has links to other services)
The Lowdown (depression help for young kiwis)	free text 5626 http://www.thelowdown.co.nz/#/home/
Victim Support	0800 842 846 http://www.victimsupport.org.nz/get-help/your-help-lines/
Whats up	0800 942 878 http://www.whatsup.co.nz/teens
Youthline	0800 376 633 http://www.youthline.co.nz/ free text 234

Appendix C- Consent Form

Emotional Health Research: The SHInE Project

INTERVIEW CONSENT FORM

In signing this consent form, you are stating that:
You have received a copy of the Information Sheet describing the research project. Any questions relating to the research, have been answered to my satisfaction. You understand that you can ask further questions about the research at any time during your participation and can withdraw my participation at any time ***up to four weeks*** **from today**.

You understand that you can stop taking part at any time, and that compensation depends on how many times you complete the questionnaire (which will take 2-3 minutes each time).

When you sign this consent form, you will retain ownership of your information, but you give consent for the researchers to use that information for the purposes of the research outlined in the Information Sheet.

Please complete the following checklist. Tick [✓] the appropriate box for each point.	**YES**	**NO**
I have read the Participant Information Sheet, or have had it read to me in a language I understand, and I fully understand what it says.		
I have been given sufficient time to consider whether to participate in this study.		
I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.		
I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study (unless I request otherwise).		
I wish to receive a summary of the findings.		

Participant : ______________________ Researcher : ______________________

Signature : ______________________ Signature : ______________________

Date : ______________________ Date : ______________________

Contact Details : ______________________ Contact Details : ______________________

______________________ ______________________

______________________ ______________________

Appendix D- Interview Schedule

Appendix 9
INTERVIEW SCHEDULE

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

1. **Introductions: whakawhanaungatanga**

2. **Refreshments**

3. **Check with participant, and if approved, start recording**

4. **Review Participant Information Sheet**

5. **Consent form process**

6. **Invite opening Karakia (in English or te reo Māori)**

7. **Broad overview of the interview structure**

'There are some things that I'm interested in about your wellness, emotions, and risky behaviours – things that could harm you. This could be things like what you do to feel better if you're unhappy or anxious. I have some questions, but you don't have to answer any that you don't want to. At the end I will summarize some of the key points that I've heard from what you've shared, and you can add anything that you think I may have missed. Please feel free to ask me any questions at any time or provide any feedback that you think may be useful. I hope at the end of the interview you feel that you've been heard and know that your participation in this study is valued and greatly appreciated.'

MAIN AREAS TO COVER:

The questions below will change according to the individual conversation and answers given. The following questions are intended as a guide to ensure key areas are covered.

8. **What types of things make you feel upset?**
   - Are there particular things or people in your life?

9. **When you're feeling upset (sad, anxious, angry, overwhelmed), what sort of things do you do to try to make yourself feel better? (both risky and non-risky)**
   [If necessary, 'Thinking about the last time you felt upset, what did you do?]

10. **Some people do different things according to the emotion. Do you do that too? Maybe if you're really angry, you do different things to if you're sad or anxious? Or does that not make a difference?**

11. **Do you think any of the things you do are potentially dangerous or risky?**
    - How do these things make you feel better?
    - Do they ever make you feel worse?

12. **Why do you think you use these risky behaviours?**
    - Why do you use these behaviours over other strategies?

13. **Some people self-harm, deliberately hurting themselves. Have you ever done anything like that?**

14. **Other people might lash out at others, verbally abusing, picking fights or punching things. Have you ever done anything like that?**

15. **Do your friends do these things too?**

16. **How do people react when you do potentially harmful things? – Friends? Family?**

17. **What do you think is important for people (parents, teachers, mental health professionals) to know about these types of behaviours?**

18. **What's important to you in terms of your emotional wellbeing?**

19. **[Review:]**
    - Is there anything else you would like to add?
    - If you think of anything else, you have my email address from when I confirmed our meeting today, and also on your copy of the consent form.
    - I'm just going to take a couple of minutes to check through my notes to make sure that what I've written makes sense.

20. **And I just need to check that I've got all the information about you that I need: [confirm age, ethnicity, if at school/uni/working/other, gender]**

21. **Do you have any questions?**

22. **Ok, I think that's everything. If you do think of anything else though, you can email me. Also, if you know anyone else who you think might be interested in this research, they can contact me too.**

23. **Invite closing Karakia**

Appendix E- Voucher Acknowledgement Form

The University of Waikato
Private Bag 3105
Hamilton, New Zealand
Phone +64 7 856 2889
www.waikato.ac.nz

[Recipient]

[Date]

Receipt of Voucher Acknowledgement

Dear [recipient]

For your [participation in/assistance with] [activity/event] the University is pleased to offer you the enclosed [type and value of vouchers]. In accordance with University financial reporting policy, we are required to obtain your acknowledgement of your receipt of these vouchers.

Please provide your acknowledgment in writing below and return by email to nicky.kanade@waikato.ac.nz .

Name: ______________________________

Signature: ______________________________

Date: ______________________________

Thank you for your [participation/assistance].

Regards

[name of staff member]