



## The reasons dissociative disorder patients self-injure

M. Shae Nester<sup>a</sup>, Cinzia Boi<sup>a</sup>, Bethany L. Brand<sup>a</sup> and Hugo J. Schielke<sup>b</sup>

<sup>a</sup>Department of Psychology, Towson University, Towson, Maryland, USA; <sup>b</sup>Traumatic Stress Injury & Concurrent Program, Homewood Health Centre, Guelph, Ontario, Canada

### ABSTRACT

**Background:** Most individuals with dissociative disorders (DDs) report engaging in self-injury.

**Objective:** The present study aimed to understand the reasons for self-injury among a clinical sample of 156 DD patients enrolled in the TOP DD Network study.

**Method:** Participants answered questions about self-injury, including a prompt asking how often they are aware of the reasons they have urges to self-injure, as well as a prompt asking them to list three reasons they self-injure.

**Results:** Six themes of reasons for self-injury, each with subthemes, were identified in the qualitative data: (1) Trauma-related Cues, (2) Emotion Dysregulation, (3) Stressors, (4) Psychiatric and Physical Health Symptoms, (5) Dissociative Experiences, and (6) Ineffective Coping Attempts. Participants reported that they were able to identify their reasons for self-injuring sometimes (60.26%) or almost always (28.85%), with only 3.20% unable to identify any reasons for their self-injury.

**Conclusion:** Results suggest that the vast majority of DD patients (92.31%) reported being at least partially unaware of what leads them to have self-injury urges, and many individuals with DDs experience some reasons for self-injury that are different from those with other disorders. The treatment implications of these findings are discussed.

### Las razones de las autolesiones en pacientes con trastorno disociativo

**Antecedentes:** La mayoría de los individuos con trastornos disociativos (DDs por sus siglas en inglés) informan realizarse autolesiones.

**Objetivo:** El presente estudio tuvo como objetivo el comprender las razones de las autolesiones en una muestra clínica de 156 pacientes con DD enroladas en el estudio TOP DD Network.

**Método:** Los participantes respondieron a preguntas sobre las autolesiones, incluyendo una pregunta sobre la frecuencia con la que son conscientes de las razones por las que se autolesionan, así como una pregunta que les pedía que enumeraran tres razones por las que se autolesionan.

**Resultados:** En los datos cualitativos se identificaron seis temas de motivos de autolesión, cada uno con subtemas: (1) Claves relacionadas con el trauma, (2) Desregulación emocional, (3) Estrés, (4) Síntomas psiquiátricos y de salud física, (5) Experiencias disociativas y (6) Intentos de afrontamiento ineficaces. Los participantes informaron que pudieron identificar sus razones para autolesionarse a veces (60,26%) o casi siempre (28,85%), y solo el 3,20% no pudo identificar las razones de sus autolesiones.

**Conclusiones:** Los resultados sugieren que la gran mayoría de los pacientes con DD (92.31%) informaron no ser, al menos parcialmente, conscientes de lo que los lleva a tener deseos de autolesionarse y muchos individuos con DDs experimentan algunas razones de autolesión que son distintas de las que padecen otros trastornos. Se discuten las implicaciones de estos hallazgos en el tratamiento.

### 分离障碍患者自伤的原因

**背景:** 大多数患有分离障碍 (DDs) 的人报告了自伤。

**目的:** 本研究旨在了解参加 TOP DD网络研究 (Brand 等, 2019) 的 156 名 DD 患者的临床样本中自伤的原因。

**方法:** 参与者回答关于自伤的问题, 包括一个询问他们多频繁意识到他们有自伤冲动的原因的提示, 以及一个要求他们列出其自伤的三个原因的提示。

**结果:** 在定性数据中确定了六个自伤原因的主题, 每个主题都有子主题: (1) 创伤相关线索, (2) 情绪失调, (3) 应激源, (4) 精神和身体健康症状, (5) 分离体验, 以及 (6) 无效的应对尝试参与者报告说, 他们有时 (60.26%) 或几乎总是 (28.85%) 能够确定自伤的原因, 只有 3.20% 的人无法确定自伤的任何原因。

**结论:** 结果表明, 绝大多数 DD 患者 (92.31%) 报告称至少部分不知道是什么导致他们有自伤冲动, 而且许多 DD 患者经历了一些与有自伤行为的其他障碍患者不同的自伤原因讨论了这些发现的治疗意义。

### ARTICLE HISTORY

Received 9 August 2021

Revised 30 December 2021

Accepted 30 December 2021

### KEYWORDS

Self-injury; dissociation; dissociative disorder; trauma

### PALABRAS CLAVE

Autolesión; disociación; trastorno disociativo; trauma

### 关键词

自伤; 分离; 分离障碍; 创伤

### HIGHLIGHTS

- Trauma-related cues, emotion dysregulation, stressors, psychiatric and physical health symptoms, dissociative experiences, and ineffective coping attempts are reasons that individuals with dissociative disorders self-injure.

Dissociative disorders (DDs) are trauma-related psychiatric conditions characterized by ‘a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior’ (American Psychiatric Association [APA], 2013). The majority of individuals with DDs report engaging in self-injury; up to 86% of dissociative individuals report a history of non-suicidal self-injury (NSSI) and up to 72% attempt suicide in their lifetime (Foote, Smolin, Neft, & Lipschitz, 2008; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross & Norton, 1989; Saxe, Chawla, & Van der Kolk, 2002). Self-injury is associated with depressive symptoms, dissociation, and emotion dysregulation among individuals with DDs (Engelberg & Brand, 2012; Nester, Brand, Schielke, & Kumar, 2022; Webermann, Myrick, Taylor, Chasson, & Brand, 2016).

Individuals engage in self-injury for a variety of reasons. Most commonly, self-injury is conceptualized as a mechanism of avoidance and escape – that is, it allows individuals to avoid their emotions, be distracted from their trauma-related symptoms and memories, and escape from their internal experiences and bodily sensations (Brand, 2001; Chapman, Gratz, & Brown, 2006; Connors, 1996; Smith, Kouros, & Meuret, 2014; Taylor et al., 2018). Unsafe behaviours can serve social, interpersonal functions (e.g., communicate with, establish autonomy from, and/or attempt to secure care from others) and/or self-regulating, intrapersonal functions (e.g., manage emotional distress, deliver self-punishment); intrapersonal functions are most common (Klonsky, 2007; Klonsky & Glenn, 2009; Taylor et al., 2018). For trauma survivors, including individuals with DDs, unsafe behaviours may also be used to regulate trauma memories, trauma-related emotions, and dissociative experiences (Bradley, Karatzias, & Coyle, 2019; Brand, 2001; Connors, 1996). A review by Connors (1996) stated that self-injury ‘enables people struggling with overwhelming and often undifferentiated affect, intense psychological arousal, intrusive memories, and dissociative states to regulate their experiences and stay alive.’ A systematic review of qualitative, self-reported reasons for self-injury found that individuals were most likely to self-injure to manage emotional distress, exert interpersonal influence (i.e., seek support from others), self-punish, and cause dissociation (Edmondson, Brennan, & House, 2016). Edmondson et al. (2016) also noted that individuals engage in non-suicidal self-injury to avert suicide, establish boundaries with others, demonstrate toughness, provide comfort, validation, or excitement, among other reasons.

There is overwhelming support that self-injury is a regulatory strategy to manage emotions, cognitions, and bodily sensations, and a wide range of triggers have been found (e.g., Klonsky, 2007). The

motivations for and functions of self-injury are well documented in a variety of populations (e.g., reviewed in Cipriano, Cella, & Cotrufo, 2017). However, the reasons for self-injurious behaviours among DD patients remain unexplored. Case studies and clinical review papers suggest that individuals with DDs may also experience unique reasons for self-injury, such as to reduce *or* induce dissociative experiences and/or manage flashbacks (Brand, 2001; Connors, 1996). Individuals with DDs may also experience specific self-states that take control of the individual’s behaviour to self-injure, sometimes resulting in amnesia for the self-injury (Brand, 2001; Connors, 1996).

Given the frequency of self-injury among dissociative individuals (Nester et al., 2022; Saxe et al., 2002; Webermann et al., 2016) and the unique experience of dissociation that may occur in the context of self-injury for these individuals (Brand, 2001; Connors, 1996), it is important to identify the reasons DD patients self-injure so that clinicians can individualize treatment to better target each patient’s specific reasons for self-injury and assist them in improving their safety. The present study investigates qualitative descriptions of reasons DD patients self-injure, as well as the frequency at which these reasons for self-injury are reported.

## 1. Method

### 1.1. Procedure

Participants in the present study participated in the TOP DD Network study, a two year online, psychoeducational programme used as an adjunctive stabilization intervention to individual psychotherapy for DD patients and their clinicians (Brand et al., 2019). The study was approved by the institutional review board at Towson University. The TOP DD Network study recruited clinicians from conferences, professional organizations and listservs, and from lists of prior TOP DD participants (Brand et al., 2013) who expressed interest in participating in future studies. Both DD patients and their clinicians participated by accessing password-protected websites which hosted educational videos and exercises and surveys. At intake into the study, patient participants completed an informed consent form, a demographic questionnaire, and a variety of surveys, including questions that assessed their understanding of their self-injurious behaviours if they had a history of self-injury. Only patient data from the initial survey is reported in the current study.

### 1.2. Participants

Patient participants were primarily female (89.10%) and white (86.5%), with an average age of 41.83 years old ( $SD = 10.38$ , range 19–64). A total of 66.03%

**Table 1.** Participant demographic information ( $n = 156$ ).

Baseline Characteristics		%	$n$	$M$	$SD$	Range
Age	Years			41.83	10.38	19–64
Gender	Female	89.10	139			
	Male	10.90	17			
Race/ Ethnicity	White	86.54	135			
	Latino or Hispanic	2.56	4			
	Asian	1.92	3			
	Black	1.92	3			
	Native American	3.85	6			
	Other	3.21	5			
Diagnosis	Dissociative identity disorder	66.03	137			
	Dissociative disorder not otherwise specified	23.72	37			
Education completed	Grade school	3.85	6			
	High school	6.41	10			
	Some college courses	14.10	22			
	College diploma	11.54	18			
	University degree (3 or 4-year)	28.85	45			
	Master's and/or Doctoral degree	26.28	41			
	Professional or Work Training	3.85	6			
	Other	3.21	5			

( $n = 103$ ) of participants were diagnosed with dissociative identity disorder (DID), 23.72% ( $n = 37$ ) were diagnosed with dissociative disorder not otherwise specified, and 16 patients' diagnoses were not reported. More detailed demographic information is presented in Table 1.

### 1.3. Measures

Following a series of questions assessing their self-injury history, patients were asked about their understanding of their self-injurious behaviours. Patients were asked to respond to the prompt, 'I know what leads me to have urges to be unsafe' by selecting 'not yet,' 'never,' 'sometimes,' 'almost always,' or 'always.' Then, participants responded to the prompt, 'I know at least three (3) reasons I become unsafe' by selecting 'not yet' or 'yes.' Participants who selected 'yes' were then asked to list three reasons they became unsafe in an open text box. This paper analyzes participants' responses to this open text box prompt and reports the frequency in which each reason for self-injury is reported.

### 1.4. Data analysis

The data was analysed using coding reliability thematic analysis that was inductive and semantic in nature, such that coding and theme development was guided by, and reflective of, the topical content of the qualitative data (Braun & Clarke, 2006). In

this approach, participants' words are considered the raw data, and are not altered or interpreted in the analysis. Rather, interpretation of their words and the themes that are identified from them is reserved for the discussion of the findings. Three members of a research team reviewed the data independently while considering potential organizing concepts. The research team then had two meetings to discuss salient themes, develop an initial coding structure, and create operationalized definitions for each theme. The two coding members of the research team (the first and second authors) proceeded to independently code the data to examine if the initial coding structure captured all key concepts in the data. Upon review, the research team adjusted the operationalized definitions to better capture all key themes identified, which resulted in six themes, each with subthemes (see Table 2). The two coding members independently coded the data into these categories, with the third/senior researcher (third author) serving as the external auditor in order to promote dependability in the coding (Nowell, Norris, White, & Moules, 2017). Prior to reaching consensus, the coders had 97% interrater reliability at the subtheme level, and 98% reliability at the theme level. The research team reached 100% consensus upon a discussion with the senior researcher. Finally, all members of the research team reviewed the data to identify participant quotes that reflect the themes and subthemes.

The research team members have varying professional clinical and research experiences with trauma

**Table 2.** Thematic analysis results: themes and subthemes.

Themes	Subtheme	% Endorsed ( $n$ )
<b>Trauma-related Cues</b>	Situational Context	40.38 (63)
	Intrusive and Arousal Symptoms	32.05 (50)
	External Sensory Input	10.26 (16)
<b>Emotion Dysregulation</b>	Specific Emotional Experiences	47.44 (74)
	Desired Consequences	9.62 (15)
<b>Stressors</b>	Social Stressors	32.69 (51)
	Work, Time Pressure, and Financial Stressors	4.49 (7)
	Change	4.49 (7)
	Unstructured Time	1.92 (3)
<b>Psychiatric and Physical Health Symptoms</b>	Psychiatric Health	18.59 (29)
	Physical Health	10.90 (17)
<b>Dissociative Experiences</b>	Self-fragmentation	14.10 (22)
	Dissociation	6.41 (10)
	Amnesia	3.85 (6)
<b>Ineffective Coping Attempts</b>	Coping	7.69 (12)
	High-risk Behaviours	7.05 (11)
	Treatment Barriers	5.77 (9)
<b>General Triggered</b>		<b>14.10 (22)</b>

survivors and dissociative patients. The range of experiences allowed us to approach our coding discussions with different perspectives. At the beginning and throughout our coding meetings, we actively reflected on our biases on the topic and reactions to the data, otherwise known as bracketing (Tufford & Newman, 2012). This, in addition to the process outlined above, allowed us to increase the rigour of our process and ensure the trustworthiness of our results (Nowell et al., 2017; Tufford & Newman, 2012).

## 2. Results

Participants reported being aware of what leads them to have self-injury urges sometimes (60.26%), almost always (28.85%), or always (7.69%). While only 3.20% indicated they did not yet know, or never know, their reasons for self-injuring, patients responses to the first prompt indicate that the vast majority of DD patients (92.31%) reported being at least partially unaware of what leads them to have self-injury urges. Thematic analysis resulted in the identification of six themes capturing the reasons<sup>1</sup> that DD patients self-injure: (1) Trauma-related Cues, (2) Emotion Dysregulation, (3) Stressors, (4) Psychiatric and Physical Health Symptoms, (5) Dissociative Experiences, and (6) Ineffective Coping Attempts. Table 2 describes the thematic structure, including the prevalence of each theme and subtheme. (Note that each response could demonstrate more than one theme.) Some participants made general references to being triggered without any other specifying details (e.g., ‘I was triggered’); this is documented as ‘General Triggered’ in Table 2.

### 2.1. Trauma-related cues

The first theme described by participants is that of self-injuring because of trauma-related cues. This theme was expressed in three ways, as participants described self-injuring because of: situational context, intrusive and arousal symptoms, and external sensory input. Trauma related cues was the most frequency endorsed theme and was reported by 62.18% of participants.

#### 2.1.1. Situational context

Approximately 40% of participants described being triggered by reminders of their trauma through people, places, times, and situations (i.e., situational context). For one participant, all three of their reasons for self-injuring fit into this subtheme, as they listed, ‘people that trigger, situations that trigger, and places that trigger.’ Multiple participants mentioned types or characteristics of people, such as ‘men,’ ‘certain family members,’ ‘[the] person who perpetrated my trauma,’ ‘adults who are drunk/loud/violent/arguing,’ or ‘angry people.’ Other participants described being triggered by times of day or year. For example, one individual

shared that ‘anniversary dates, lunar and seasonal cycles, [and] holidays’ were triggering. Several other participants noted they were triggered by night-time and darkness.

There were a variety of different situations that participants reported caused them to self-injure. Some individuals shared feeling triggered to self-injure when they were in situations that were similar to, or were reminders of their trauma. For example, one participant shared being triggered in any ‘situation in which there’s yelling, fighting, abuse and/or trauma bonds exist.’ Another individual shared that ‘seeing/reading anything related to sex (like advertisements for strip clubs)’ was a reason they had urges to self-injure. Another DD patient noted feeling triggered by ‘things on the news that reminds me of what hurt me.’ Three other participants shared feeling triggered to self-injure when they were in contact with their family.

#### 2.1.2. Intrusive and arousal symptoms

Around 32% of individuals reported self-injuring because of their intrusive and arousal symptoms, including frequent reports of intrusive thoughts, images, and traumatic memories. Some participants detailed experiences of feeling triggered due to their intrusive experiences, such as ‘when I can’t tune out voices or intrusive thoughts in my head’ or when ‘dealing with racing thoughts/nightmares/flashbacks.’ While some reported intrusive experiences related to thoughts and memories, a subset of participants reported intrusive experiences in the form of flashbacks and nightmares. Some individuals reported self-injuring to manage arousal-related symptoms, such as when feeling hypervigilant, as described by one participant as ‘not being vigilant enough.’ Several other participants mentioned feeling triggered when being startled unexpectedly.

#### 2.1.3. External sensory input

Around 10% of participants described experiences in which they were triggered by external sensory input, such as sounds, smells, and physical touch, which served as trauma-related cues. The most commonly mentioned triggering sensory experience was related to sounds. While several participants noted ‘sounds’ vaguely, others listed specific sounds that were triggering. For instance, participants mentioned sounds associated with people, like ‘male voices,’ and the ‘tone of voice of someone talking to me.’ Some people shared feeling triggered to self-injure due to other sound-related experiences, like hearing ‘suddenly high noise,’ ‘being in a loud and noisy environment,’ or after ‘walking outside when I can’t see [people], just hear them.’ Several participants explicitly associated their sensory experiences to specific traumatic experiences, as exemplified with one participant describing feeling



triggered by ‘smells and sounds associated with the trauma I experienced.’

Several participants noted that sexual sensory experiences triggered them to self-injure. For instance, one individual shared feeling triggered by ‘noises that are of sexual nature.’ Several other individuals described various forms of physical contact as triggering. One participant described this as ‘being touched by others,’ while for several others, this included examples such as having sex.

## 2.2. Emotion dysregulation

The second theme described by participants was emotion dysregulation. This theme was endorsed by 51.92% of participants and was expressed in two sub-themes: specific emotional experiences and desired consequences. Participants described specific emotions, intensity of emotions, and desired emotional consequences from engaging in self-injury.

### 2.2.1. Specific emotional experiences

Nearly half of participants (47%) articulated that specific emotions or intensity of emotions were reasons they self-injured. The three most common emotions listed were anger, feeling overwhelmed, and shame, endorsed by 15, 14, and 12 participants, respectively. Participants endorsed feelings of anger as triggering in several different contexts. For example, some participants noted experiences of anger directed towards the self (e.g., ‘self-anger’). More specifically, one participant detailed ways in which their limited ability to express anger in childhood transformed into self-directed anger during adulthood by stating that, ‘because anger and ways to protect myself was not allowed when I was a kid . . . when feeling unsafe we turn the anger towards us/me.’ Other participants shared feeling triggered due to experiences of anger from others, such as ‘when I detect anger in people I respect.’

In addition to anger, shame, and feeling overwhelmed, participants noted emotions such as anxiety, fear, panic, sadness, despair, and hopelessness. For one participant, no specific emotion was listed, but rather, they described self-injuring when having ‘feelings I don’t think I’m allowed to have.’ In addition to listing specific types of emotions, participants often referred to the intensity of their emotions as a factor that contributed to their self-injury. For example, one participant described self-injuring when they experienced ‘intense emotions I feel like I cannot tolerate.’ Others described their emotional states as ‘strong,’ ‘intense,’ and/or ‘overwhelming.’

### 2.2.2. Desired consequences

Some participants (10%) described emotion-related consequences they hoped to accomplish by self-injuring. One participant described self-injuring ‘t[o]

feel “real” PAIN,’ reflecting their desire to transform their emotional pain into a more tangible, physical form of pain. A recurring pattern within this subtheme was participants’ description of their perceived need to punish themselves. One participant described that ‘I want to feel pain. I feel I deserve it.’ Participants also reported wanting to ‘numb emotions,’ ‘escape,’ ‘release the pressure,’ or ‘block painful memories/emotions’ by self-injuring, highlighting the function of their self-injury.

## 2.3. Stressors

The third theme that participants described as a reason for self-injuring was stressors. This theme was expressed by 39.74% of participants and was made up of four sub-themes: social stressors, work, time, and financial stressors, change, and unstructured time.

### 2.3.1. Social stressors

Approximately 33% of participants reported social stressors as triggering. For many, feelings of rejection, abandonment, and loneliness were salient. One participant noted self-injuring when they were ‘feeling abandoned or betrayed by those presently close to me (real or perceived).’ Many participants reported feeling rejected by their family and friends, which in turn, led them to self-injure. Some participants noted anxieties related to social interactions, such as concerns about ‘people hating me’ or fearing ‘what the person in front of me must be thinking.’ Other forms of social stressors included confrontations, conflict, invalidation, and disbelief from others.

### 2.3.2. Work, time pressure, and financial stressors

Nearly 5% of participants reported self-injuring due to work, time pressure, and financial stressors. Several participants mentioned being triggered by work demands, by stating that they self-injured after ‘failing to cope with work’ or due to ‘overwhelming feelings of work demand.’ Other participants mentioned financial and economic stressors. One participant mentioned self-injuring in response to situations where they were ‘under time constraints to get a task done.’

### 2.3.3. Change

Around 5% of participants reported that experiencing change or encountering new situations was a reason for their self-injury. For many, this included sudden changes in schedules or unplanned events, otherwise stated by one participant as ‘when something unexpected or a deviation of plans happens.’ Another participant noted that doing new things and being in new surroundings was triggering. One participant very broadly stated that ‘all kinds of changes . . .’ led them to self-injure.

### 2.3.4. *Unstructured time*

Three participants (2%) mentioned that they self-injured during unstructured time because they felt bored. One participant described that they self-injured to ‘get away from boredom, discover something new.’

## 2.4. *Psychiatric and physical health symptoms*

A fourth theme that was identified within the sample were psychiatric and physical health symptoms, split into two subthemes: psychiatric symptoms and physical health. Around 26.92% of participants endorsed psychiatric and physical health symptoms as reasons for their self-injury.

### 2.4.1. *Psychiatric symptoms*

A total of 19% of participants reported that their psychiatric symptoms were a reason for their self-injury. The research team noticed themes in reported psychiatric symptoms, and further defined them as ‘depression-, suicidality-, perfectionism- and self-esteem-related difficulties, excluding specific PTSD symptoms or emotional experiences captured elsewhere in the coding structure.’ Many individuals reported poor self-esteem and feeling like a burden to others. For example, one participant described ‘feeling shameful/guilty/unachieving/like nothing matters anyway, feeling like a burden to others.’ Another participant described experiences of perfectionism and a lack of self-compassion, sharing they self-injure when they are ‘not being kind to myself/holding myself to an impossible standard.’ Several participants reported feelings of worthlessness and inadequacy, with a number of participants explicitly stating that they hated themselves. Multiple individuals also described that feeling suicidal or a ‘wish to be dead’ further triggered them to self-injure.

### 2.4.2. *Physical health*

Around 11% of participants indicated feeling triggered by physical health symptoms. The most common physical symptom was sleep deprivation; 13 participants listed lack of sleep as a reason for their self-injury. For one participant, their lack of sleep was associated with physical pain. Multiple patients noted feelings of physical exhaustion and fatigue were reasons for their self-injury, with one individual adding that ‘ignoring physical symptoms’ led to self-injury. One participant also noted they were more likely to self-injure when they did not eat or nourish their body.

## 2.5. *Dissociative experiences*

The fifth theme of reasons for self-injury that was identified was dissociative experiences. About 22.44% of DD patients described a myriad of dissociative experiences

as reasons for their self-injury resulting in three subthemes: self-fragmentation, dissociation, and amnesia.

### 2.5.1. *Self-fragmentation*

A total of 14% of participants reported feeling triggered to self-injure after experiences involving self-fragmentation, switching from one dissociative self-state<sup>2</sup> to another (henceforth referred to as self-states). Half of these participants mentioned having self-states whose purpose, role, or habits were to self-injure. For example, participants shared that they self-injure when ‘switching into someone who is unsafe,’ a ‘suicidal part takes over,’ or ‘when specific parts who were programmed to self harm are forward.’ Several participants reported that their self-states had specific motivations for self-injuring. One participant described self-injuring when a ‘part in my system who is a “protector” believes that I need to be “punished” for something I said.’ Another participant mentioned self-injuring when ‘an alter swaps in that needs to numb or punish.’ Another shared that ‘the littles get triggered and the bigger ones want to protect them and me,’ as they described that some self-states within their dissociative system self-injure as a mechanism of protecting other parts; this protection may be from trauma memories, seemingly intolerable emotional experiences, or other painful experiences.

For another subset of participants, there was an interaction between self-fragmentation and their emotional experiences. Some participants expressed self-injuring after specific self-states experienced emotions. One participant shared they were triggered ‘when my littles are disappointed/let down.’ Another patient shared that they self-injured when ‘my dominant adult self who runs most things in my life gets overwhelmed by powerful emotions of a young part.’ Another participant shared they self-injure when they experience conflict within themselves and their self-states, such as when ‘I get angry with someone “inside” and I want to hurt them.’

### 2.5.2. *Dissociation*

About 6% of individuals made general references to experiences of dissociation, depersonalization, or derealization as reasons for their self-injury. One participant noted self-injuring when ‘the voices in my head becomes stronger . . . I have trouble with “being here now.”’ Another individual noted that ‘having to be in my body’ was difficult. Others reported dissociative experiences such as ‘feeling no s[ens]e of self,’ ‘inner voices,’ or times when they ‘zone out’ as reasons for their self-injurious behaviours.

### 2.5.3. *Amnesia*

Approximately 4% of participants reported that experiencing dissociative amnesia was a reason they self-injure. For some participants, this included losing

time and/or having periods of time pass in their day without being able to remember what occurred during that time. For others, an increased awareness of events that were highly traumatic was a cause for their self-injury. For example, one participant stated that, 'I am triggered by a part leaking trauma information into my awareness and it feels scary and disorienting.' Another patient mentioned being triggered when, 'I get exposed so something I have forgotten that was traumatic or reminiscent of something and I leave and a young part is left running the show.' One other participant mentioned that 'flashbacks w/ or w/o fragmented memories that I can't make sense of' led them to self-injure. From these examples, it is apparent that the experience of amnesia shifting to awareness, such that there was a sudden exposure to traumatic material, can be difficult to manage for DD patients.

## 2.6. Ineffective coping attempts

The sixth and final theme was ineffective coping attempt and includes three subthemes: coping, high-risk behaviours, and treatment. This theme was expressed by 16.67% of the sample.

### 2.6.1. Coping

Approximately 8% of participants described self-injuring as a result of difficulties with coping in healthy and adaptive ways. Some participants described experiences where they did not use healthy coping skills. For example, participants reported 'neglecting self care,' 'not grounding,' or 'not asking for help.' Others described times they used coping skills but did not experience sufficient relief. Another patient noted that they engaged in self-injury because it 'prevents me from doing worse (overdose/very risky behavior).' In this way, self-injury appears to serve a harm reduction purpose.

### 2.6.2. High-risk behaviours

Another group of participants (7%) reported that engaging in other high-risk behaviours triggered them to self-injure. The most common triggering high-risk behaviour was alcohol use. One participant shared they get triggered 'when I drink to[o] much or take to[o] much of my prescribed medication,' and another participant reported feeling triggered 'when I have too much alcohol and get sad.' Another individual mentioned that risky sexual behaviours, such as 'looking for/entering risky sexual relationships ... masturbating while driving' were triggering. Several other participants reported that episodes of excessive spending or binge eating were triggering.

### 2.6.3. Treatment barriers

About 6% of the sample described treatment barriers as reasons for their self-injury. In these cases, it was not treatment that was triggering. Rather, it was the patients'

lack of access to care, not following their recommended treatment plan, and/or not making as much progress as they expected that was distressing. In several cases, these reasons for self-injury were related to not taking medication as prescribed (e.g., 'skipping my meds'). For one individual, this also included 'not ... doing therapy homework everyday.' Two participants described situations in which they self-injured because of losing and/or moving away from their treatment providers. One participant noted that 'feeling like I'm failing at getting better' was a reason for their self-injury.

## 3. Discussion

The present qualitative study was the first examination of reasons for self-injury among a clinical sample of DD patients. Patients detailed accounts in which Trauma-related Cues, Emotion Dysregulation, Stressors, Psychiatric and Physical Health Symptoms, Dissociative Experiences, and Ineffective Coping Attempts were salient reasons for their self-injury. Participants were aware of their reasons for self-injuring sometimes (60.26%), almost always (28.85%), or always (7.69%), with only 3.20% indicating they were unaware of their reasons for self-injuring. The study resulted in the identification of both triggers and functions of self-injury. Triggers of self-injury are the antecedent events precipitating self-injury (e.g., exposure to a trauma reminder; experience of painful or intense emotions), whereas functions are the reasons why individuals self-injure (e.g., to 'block' emotions, to punish themselves, to reduce risk of engaging in more dangerous behaviours). Given the high frequency of self-injury among this population (Nester et al., 2022; Saxe et al., 2002; Webermann et al., 2016), clinicians' awareness of the reasons for self-injury among their clients may be useful in both the prevention and treatment of self-injury among dissociative individuals.

Trauma-related reminders were the most frequent reasons for self-injury in this sample of dissociative disorder patients. Researchers have found that exposure to traumatic events and trauma-related symptoms are associated with self-injury (Smith et al., 2014) and this study supports that in DD patients. Clinical review papers have theorized the functions of self-injury as mechanisms of re-enacting trauma, expressing or finding relief from difficult emotions, inflicting self-punishment, reorganizing the self (i.e., self-soothing, regaining control, creating a tangible form of pain), and regulating dissociative experiences among severely traumatized populations (e.g., Brand, 2001; Connors, 1996; Putnam et al., 1986). This study provides empirical support for these theories and posits that self-injury may be used to regulate, avoid, and/or escape trauma-related reminders and/or the emotions evoked by such reminders. Trauma can overwhelm an individual's capacity to process the experience(s), resulting in later

triggers, which can result in hyper- and hypo- physiological and emotional arousal (Corrigan, Fisher, & Nutt, 2011). This dysregulation can lead to individuals relying on maladaptive strategies to cope and regain homeostasis, such as through self-injury.

Intrapersonal functions, where the aim of the behaviours is to manage or change one's internal state (e.g., emotions, thoughts, memories, bodily sensations), were notably prevalent across participants' self-reported reasons for self-injuring. In many cases, patients reported a desire to avoid or escape their unwanted internal state, particularly distressing emotional states, which is congruent with the most commonly reported functions of self-injury and with various aetiological models of self-injury (e.g., Andover & Morris, 2014; Klonsky, 2007; Stänicke, 2021; Taylor et al., 2018). Research has indicated that self-injurious behaviours can be used to regulate aversive emotions, such as anger, shame, sadness, fear, and disgust, including among survivors of childhood abuse (e.g., Bradley et al., 2019; Klonsky, 2007). Further, individuals who engage in self-injury report more intense emotional experiences than those without a history of self-injury, which is consistent with the present study demonstrating that patients were burdened, and self-injured, because of the intensity of their emotions (Anderson & Crowther, 2012).

Another pattern was participants' perceived need to punish themselves, which is consistent with literature finding that nearly half of individuals report self-punishment as a function of self-injury (Stänicke, 2021; Taylor et al., 2018). Many trauma survivors and dissociative individuals believe that they are 'bad' or 'defective' or that they somehow 'wanted' or 'deserved' their abuse; therefore, they wrongfully believe they deserve to be punished (Brand, 2001; Connors, 1996; Steele, Boon, & van der Hart, 2017). Meanwhile, others believe they need to self-inflict punishment to account for their day-to-day behaviours and mistakes (Stänicke, 2021). To combat self-hatred and self-punishment, treatment directed at increasing self-understanding about trauma and increasing self-compassion may be integrated into the prevention and treatment of self-injury.

A salient reason for self-injury in this sample was their dissociative experiences. In many populations, anti-dissociation is an identified function of self-injury, meaning that individuals will self-injure in order to end a state of depersonalization or numbness (Klonsky, 2007; Klonsky & Glenn, 2009). In contrast, in the present study, self-injuring typically served the opposite purpose: it allowed individuals to dissociate and therefore avoid or escape their unwanted and aversive internal states, namely those of emotional distress, hyperarousal, and internal conflict. The present study offers support for self-fragmentation as a unique feature of self-injury among some severely dissociative individuals, which has been previously

documented in case studies and clinical reviews (e.g., Brand, 2001; Connors, 1996; Putnam et al., 1986). Participants noted having specific self-states which were responsible for self-injuring. In some cases, patients indicated that was the primary function and behaviour of that respective self-state. Sometimes, the self-state communicated specific purposes for self-injuring, such as to punish or protect the individual. For some individuals with self-states, self-injuring can feel protective. For example, it can foster a sense of perceived control over one's self and body and/or create a sense of mastery over a previously uncontrollable situation (e.g., 'This time I'll be able to control what happens' or 'This time I'll be in charge of the pain and decide when it's too much;' Connors, 1996).

There were also distinct interactions between self-fragmentation and emotion dysregulation. In these cases, when one self-state became highly overwhelmed by emotions, another self-state would act out, sometimes resulting in self-injury. In many situations, these behaviours can further trigger or cause significant internal conflict within the individual and/or between self-states. Beyond self-fragmentation, the experience of amnesia and increased awareness for trauma memories or life events, were also triggering to patients. The apparent triggering nature of trauma- and dissociation-related symptoms highlight the need for grounding and containment skills to be an essential focus of treatment for dissociative individuals who self-injure. Further, safety and stabilization, accompanied by working towards internal cooperation between dissociative self-states, may enhance one's ability to better manage triggers and regulate internal experiences, therefore decreasing self-injury.

### 3.1. Clinical implications

Establishing and improving dissociative disorder patients' safety is imperative (Brand et al., 2012). Although there is debate about the need for patient stabilization prior to beginning trauma-focused treatment (De Jongh et al., 2016), expert consensus guidelines and surveys of experts recommend prioritizing safety and stabilization in the beginning and throughout treatment with individuals who have DDs (Brand et al., 2012; ISSTD, 2004). Research suggests that clinicians may under-attend to stabilization and safety, and may under-emphasize the importance of the use of grounding and containment skills (Myrick, Chasson, Lanius, Leventhal, & Brand, 2015). It is important that clinicians regularly assess patients' engagement in self-injury, become familiar with their DD clients' reasons for self-injuring, and educate patients about healthy ways of helping themselves when feeling too much or too little, including incorporating the use of grounding, separating past from present, and containment (see, for example, the Finding Solid Ground Workbook by Schielke, Brand, &



Lanius, *in press*). These skills appear to be particularly important among DD patients because dissociation and traumatic intrusions are primary reasons for their self-injury.

Clinicians should assess for the presence of self-injurious behaviours in a shame-reducing and nonjudgmental way. As part of this process, clinicians should communicate that they understand the patient is engaging in these behaviours as an attempt to manage difficult, painful experiences. To assist patients towards stabilizing these behaviours, the TOP DD Network study approach included teaching patients about the functions of self-injury and risky behaviours, helping them identify their triggers for self-injury, and encouraging them to find healthy alternatives to address the triggers, along with fostering a sense of self-compassion about the impact of trauma, when applicable (Brand et al., 2019). The TOP DD Network study also taught coping and grounding skills which was associated with decreased self-injury, dissociation, and PTSD symptoms (Brand et al., 2019). Clinicians and the patient may need to increase internal cooperation and communication as part of this process, as it is clear that self-states are often involved in self-injury.

### 3.2. Future directions and limitations

Future research should investigate characteristics, functions, and predictors of self-injurious behaviours among DD patients. The reasons for self-injury identified in the present study should also be tested in longitudinal analyses to test their ability to predict future self-injurious behaviours.

The results of the present study must be interpreted in light of several considerations. First, participants were queried early into the psychoeducational intervention programme and were only asked to provide three reasons for self-injuring, so participants' awareness of their reasons for self-injuring and listed responses may have been limited. The question prompt also did not clarify what was meant by 'unsafe behaviors.' The questions proceeding this prompt were about self-injury, implying this question was about self-injury, however. Lastly, there was some overlap between themes that could not be disentangled, but further enlighten the nuanced nature of patients' reasons for self-injuring.

### 3.3. Conclusion

Although almost all DD patients reported being aware of at least some reasons for their self-injury, many reported being unaware of some of their reasons for self-injuring. Trauma-related Cues, Emotion Dysregulation, Stressors, Psychiatric and Physical Health Symptoms, Dissociative Experiences, and Ineffective Coping Attempts were identified reasons for self-injury. Given the high

frequency of self-injury among individuals with DDs, clinicians' awareness of their clients' reasons for engaging in self-injury may be useful in the prevention and treatment of self-injury among dissociative individuals.

## Notes

1. The prompts given to participants queried 'urges' and 'reasons' participants become unsafe. The responses resulted in the identification of both triggers and functions of self-injury. As such, the terms 'reasons,' 'triggers,' and 'functions' are used to describe the participants' responses, as applicable. While the term 'reason' may be used to describe responses that are either triggers and/or functions, the terms 'triggers' and 'functions' are not used interchangeably.
2. There have been discussions among researchers, clinicians, and individuals with lived experience of dissociative identity disorder regarding terminology used to refer to self-states. The term self-states was selected for use in this manuscript based on language used in the Diagnostic and Statistical Manual of Mental Disorders – 5<sup>th</sup> edition and that which is used in most research literature. Self-states can also be referred to as parts, alters, dissociative identities, or a system, among other terms.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

## Funding

The work is supported by Michael Hemmer, ANS Research, Anne Bartoletto and family, and Constantinidas Family Foundation.

## ORCID

M. Shae Nester  <http://orcid.org/0000-0001-9012-9278>  
 Bethany L. Brand  <http://orcid.org/0000-0003-0377-2770>  
 Hugo J. Schielke  <http://orcid.org/0000-0002-4786-8080>

## Data availability statement

The data are not publicly available to ensure the anonymity and confidentiality of participant responses.

## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders DSM-5* (5th ed.). Washington, DC: American Psychiatric Press.
- Anderson, N. L., & Crowther, J. H. (2012). Using the experiential avoidance model of non-suicidal self-injury: Understanding who stops and who continues. *Archives of Suicide Research, 16*(2), 124–134. doi:10.1080/13811118.2012.667329
- Andover, M. S., & Morris, B. W. (2014). Expanding and clarifying the role of emotion regulation in nonsuicidal self-injury. *Canadian Journal of Psychiatry, 59*(11), 569–575. doi:10.1177/070674371405901102

- Bradley, A., Karatzias, T., & Coyle, E. (2019). Derealization and self-harm strategies are used to regulate disgust, fear, and sadness in adult survivors of childhood sexual abuse. *Clinical Psychology & Psychotherapy*, 26(1), 94–104. doi:10.1002/cpp.2333
- Brand, B. L., McNary, S. W., Myrick, A. C., Classen, C. C., Lanius, R., Loewenstein, R. J., ... Putnam, F. W. (2013). A longitudinal naturalistic study of patients with dissociative disorders treated by community clinicians. *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(4), 301–308. doi:10.1037/a0027654
- Brand, B. L., Myrick, A. C., Loewenstein, R. J., Classen, C. C., Lanius, R., McNary, S. W., ... Putnam, F. W. (2012). A survey of practices and recommended treatment interventions among expert therapists treating patients with dissociative identity disorder and dissociative disorder not otherwise specified. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(5), 490–500. doi:10.1037/a0026487
- Brand, B. L., Schielke, H. J., Putnam, K. T., Putnam, F. W., Loewenstein, R. J., Myrick, A., ... Lanius, R. A. (2019). An online educational program for individuals with dissociative disorders and their clinicians: 1-year and 2-year follow-up. *Journal of Traumatic Stress*, 32(1), 156–166. doi:10.1002/jts.22370
- Brand, B. L. (2001). Establishing safety with patients with dissociative identity disorder. *Journal of Trauma & Dissociation*, 2(4), 133–155. doi:10.1300/J229v02n04\_07
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. doi:10.1191/1478088706qp063oa
- Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behavior Research and Therapy*, 44(3), 371–394. doi:10.1016/j.brat.2005.03.005
- Cipriano, A., Cella, S., & Cotrufo, P. (2017). Nonsuicidal self-injury: A systematic review. *Frontiers in Psychology*, 8. doi:10.3389/fpsyg.2017.01946
- Connors, R. (1996). Self-injury in trauma survivors: 1. Functions and meanings. *American Journal of Orthopsychiatry*, 66(2), 197–206. doi:10.1037/h0080171
- Corrigan, F., Fisher, J., & Nutt, D. (2011). Autonomic dysregulation and the window of tolerance model of the effects of complex emotional trauma. *Journal of Psychopharmacology*, 25(1), 17–25. doi:10.1177/0269881109354930
- De Jongh, A., Resick, P. A., Zoellner, L. A., van Minnen, A., Lee, C. W., Monson, C. M., ... Bicanic, I. A. (2016). Critical analysis of the current treatment guidelines for complex PTSD in adults. *Depression and Anxiety*, 33(5), 359–369. doi:10.1002/da.22469
- Edmondson, A. J., Brennan, C. A., & House, A. O. (2016). Non-suicidal reasons for self-harm: A systematic review of self-reported accounts. *Journal of Affective Disorders*, 191, 109–117. doi:10.1016/j.jad.2015.11.043
- Engelberg, J. C., & Brand, B. L. (2012). The effect of depression on self-harm and treatment outcome in patients with severe dissociative disorders. *Psi Chi Journal of Psychological Research*, 17(3), 115–124. doi:10.24839/2164-8204.JN17.3.115
- Foote, B., Smolin, Y., Neft, D. I., & Lipschitz, D. (2008). Dissociative disorders and suicidality in psychiatric outpatients. *Journal of Nervous and Mental Disease*, 196(1), 29–36. doi:10.1097/NMD.0b013e31815fa4e7
- International Society for the Study of Trauma and Dissociation. (2004). Guidelines for the evaluation and treatment of dissociative symptoms in children and adolescents. *Journal of Trauma & Dissociation*, 5, 119–150. [https://doi.org/10.1300/J229v05n03\\_09](https://doi.org/10.1300/J229v05n03_09)
- Klonsky, E. D., & Glenn, C. R. (2009). Assessing the functions of non-suicidal self-injury: Psychometric properties of the Inventory of Statements About Self-injury (ISAS). *Journal of Psychopathology and Behavioral Assessment*, 31(3), 215–219. doi:10.1007/s10862-008-9107-z
- Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*, 27(2), 226–239. doi:10.1016/j.cpr.2006.08.002
- Myrick, A. C., Chasson, G. S., Lanius, R. A., Leventhal, B., & Brand, B. L. (2015). Treatment of complex dissociative disorders: A comparison of interventions reported by community therapists versus those recommended by experts. *Journal of Trauma & Dissociation: The Official Journal of the International Society for the Study of Dissociation (ISSD)*, 16(1), 51–67. doi:10.1080/15299732.2014.949020
- Nester, M. S., Brand, B. L., Schielke, H. J., & Kumar, S. (2022). An examination of the relations between emotion dysregulation, dissociation, and self-injury among dissociative disorder patients. *European Journal of Psychotraumatology*. Advance online publication. <https://doi.org/10.1080/20008198.2022.2031592>
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1), 1609406917733847. doi:10.1177/1609406917733847
- Putnam, F. W., Guroff, J. J., Silberman, E. K., Barban, L., & Post, R. M. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *The Journal of Clinical Psychiatry*, 47(6), 285–293.
- Ross, C. A., & Norton, G. R. (1989). Suicide and parasuicide in multiple personality disorder. *Psychiatry: Interpersonal and Biological Processes*, 52(3), 365–371. doi:10.1080/00332747.1989.11024458
- Saxe, G. N., Chawla, N., & Van der Kolk, B. (2002). Self-destructive behavior in Patients with dissociative disorders. *Suicide and Life-Threatening Behavior*, 32(3), 313–320. doi:10.1521/suli.32.3.313.22174
- Schielke, H. J., Brand, B. L., & Lanius, R. (in press). *Finding Solid Ground Workbook*, Oxford: University Press.
- Smith, N. B., Kouros, C. D., & Meuret, A. E. (2014). The role of trauma symptoms in nonsuicidal self-injury. *Trauma, Violence, & Abuse*, 15(1), 41–56. doi:10.1177/1524838013496332
- Stănicke, L. I. (2021). The punished Self, the unknown self, and the harmed self – Toward a more nuanced understanding of self-harm among adolescent girls. *Frontiers in Psychology*, 12. doi:10.3389/fpsyg.2021.543303
- Steele, K., Boon, S., & van der Hart, O. (2017). *Treating trauma-related dissociation: A practical, integrative approach*. New York: W W Norton & Co.
- Taylor, P. J., Jomar, K., Dhingra, K., Forrester, R., Shahmalak, U., & Dickson, J. M. (2018). A meta-analysis of the prevalence of different functions of non-suicidal self-injury. *Journal of Affective Disorders*, 227, 759–769. doi:10.1016/j.jad.2017.11.073
- Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work*, 11(1), 80–96. doi:10.1177/1473325010368316
- Webermann, A. R., Myrick, A. C., Taylor, C. L., Chasson, G. S., & Brand, B. L. (2016). Dissociative, depressive, and PTSD symptom severity as correlates of nonsuicidal self-injury and suicidality in dissociative disorder patients. *Journal of Trauma & Dissociation*, 17(1), 67–80. doi:10.1080/15299732.2015.1067941