Literature Review of Female Inmates engaging in Non-Suicidal Self-Injurious Behaviour

by

Johanna Rosales

A thesis submitted to the School of Community Services in partial fulfillment of the requirements for the degree of

Bachelor of Applied Arts in Behavioural Psychology

St. Lawrence College
Kingston, Ontario
Canada

March 13, 2014
ABSTRACT

Non-suicidal self-injurious behaviour (NSSI) is a daily problem faced within Correctional Services Canada (CSC) (Power, 2011). The following literature review focused on reviewing the literature. Areas of focus were non-suicidal self-injurious behaviour (NSSI); non-suicidal self-injurious behaviour in prison; self-harm in adolescents; gender differences amongst those who self-harm; correlation between sexual orientation and self-harm; helpful qualities for health care professionals; contributing factors; factors associated with the behaviour; appropriate alternatives and approaches to NSSI; the effects on staff of managing chronic self-harm; and policies that address this issue. This literature review attempted to find a common definition of NSSI, its etiology, management of individuals who engage, and the current policies and supports available for women federal offenders within CSC and in the community upon their release. Although the focus was primarily on the women offenders who engage in NSSI, the impact on those who treat and manage people engaging in NSSI was also researched. CSC’s approach to this problem and the policies that address it were discussed. It was identified that CSC has many resources in place for both the women and the staff. It is recommended that further research be completed the correlation between sexual orientation and NSSI. Also it is recommended that further research be completed on adult women with NSSI because most of the literature available focused on youth who engage in self-harm. Although CSC has a lot in place for inmates in the prisons, future research should focus on offenders on parole who are engaging in NSSI, as this is an area neglected in the research.
ACKNOWLEDGEMENTS

I would like to thank my thesis supervisor Erin McCormick for her support and guidance throughout this thesis. I would also like to thank my family and friends for their support throughout this past year.
# TABLE OF CONTENTS

Abstract .................................................................................................................................................. ii
Acknowledgements ............................................................................................................................ iii
Table of Contents ................................................................................................................................. iv

CHAPTER

I. Introduction ...................................................................................................................................... 1

II. Literature Review .......................................................................................................................... 2
   Non-suicidal self-injurious behaviour (NSSI) .............................................................................. 2
   Adolescents ..................................................................................................................................... 3
   Gender Differences ....................................................................................................................... 4
   Sexual Orientation ........................................................................................................................ 5
   Health Care Professional and their roles with NSSI ................................................................. 5
   Contributing factors ..................................................................................................................... 6
   Factors associated with behaviour ............................................................................................. 7
   Appropriate alternatives and approaches to NSSI ................................................................. 8
   Non-suicidal Self-injurious behaviour in prison ..................................................................... 9
   Effects on staff managing chronic self-harm ........................................................................... 10
   Policies that address this issue ................................................................................................. 10

III. Method ....................................................................................................................................... 13

IV. Results ......................................................................................................................................... 14

V. Discussion ..................................................................................................................................... 16

References .......................................................................................................................................... 19
Chapter I: Introduction

Non-suicidal self-injurious behaviour is a growing problem within Correctional Services Canada (CSC) (Power, 2011). Supports and programs have been put in place for women in the prisons in hopes of managing the issue. Non-suicidal self-injurious behaviour (NSSI) is defined as deliberate self-harm or disfigurement with no intent of suicide for purposes that are not socially sanctioned (Power, 2011). Examples of these NSSI include cutting, burning, needle-sticking, head banging, carving on skin, severe scratching, punching oneself, or biting oneself, without the intention of suicide. It is a priority for Correctional Services Canada (CSC) to work towards the reduction of NSSI (Power & Riley, 2010). There has been an increased need for research in this area due to a lack of knowledge of NSSI among Canada’s federal offenders (Power & Usher, 2011). In order for CSC to provide proper support for federal offenders, there needs to be a clear understanding of the following: non-suicidal self-injurious behaviour (NSSI); non-suicidal self-injurious behaviour in prison; self-harm in adolescents; gender differences amongst those who self-harm; correlation between sexual orientation and self-harm; helpful qualities for health care professionals; contributing factors; factors associated with the behaviour; appropriate alternatives and approaches to NSSI; the effects on staff of managing chronic self-harm; and policies that address this issue. The purpose of this literature review is to identify the research, interventions and supports that are currently in place by CSC and comment about directions for future research. A literature review has been conducted in order gain an understanding of what CSC has in place for women living with non-suicidal self-injurious behaviour.
Chapter II: Literature Review

Non-Suicidal Self-Injurious Behaviour (NSSI)

NSSI is the act harming oneself without the intent of committing suicide (Selby, Gordon, Bender, Nock, & Joiner Jr., 2012). There are numerous methods that can be used to self-harm such as – poisoning with medication, cutting, burning, bruising, scratching, hitting, pulling hair, reopening wounds, breaking bones, face mutilation and amputation of different body parts (Smith & Kaminski, 2010). There are some practices that could be viewed as self-harm, but are currently socially acceptable such as tattooing and body piercings (Smith & Kaminski, 2010). Although suicide and suicidal behaviour is an increasing health problem in many countries, it continues to carry a lot of stigma and is little talked about and less understood (Sun, 2011).

External hazards are life events that may be harmful or life threatening to a person (Sun, 2011). Hazards are either maturational or situational. Maturational hazards can occur at any point in a developmental sequence during childhood or adulthood. Situational hazards include life events such as the death of a friend or family member or the loss of a job. Depending on the number of hazards faced by an individual, she may be at an increased risk to engage in NSSI (Sun, 2011). A person may also be at an increased risk to engage in harmful behaviours after a hazardous event if they have an absence of coping devices or have developed maladaptive coping skills (Sun, 2011). Coping devices are behaviours developed throughout life, usually after a hazardous event has occurred (Sun, 2011). A coping strategies can be constructive or maladaptive (Sun, 2011). A constructive coping device is a behaviour which is beneficial to the individual or socially acceptable, such as talking to a friend or counsellor, sports, reading or seeking help from other people (Sun, 2011). A maladaptive coping device is a behaviour that may be destructive to the individual or to others in their lives, such as NSSI, or addiction (Sun, 2011). Many people face stressful and hazardous events throughout their lives (Sun, 2011). Individuals who do not engage in NSSI, despite facing stressful and hazardous events, have developed constructive coping strategies and may have people in their lives who are part of a support system (Sun, 2011). Therefore, if those who engage in NSSI can be taught new coping mechanisms through therapy, this may decrease their likelihood of engaging in NSSI (Sun, 2011).

Kokaliari and Berzoff (2008) interviewed 10 college women who engaged in NSSI and were considered psychologically healthy women, the authors considered the women healthy if they met their criteria of engage in in self-harm behaviour and were classified as securely attached, but did not have a history of post-traumatic stress disorder or borderline pathology. The women reported three main reasons for their behaviour: self-reliance and denial of feelings; self-injury as a western form of personal and social control; and self-injury as a quick fix (Kokaliari et al., 2008). The women explained that they felt the NSSI was not getting in the way of their lives but, rather, helping them maintain a healthy lifestyle. They viewed the NSSI as a coping mechanism when they felt a lack of control (Kokaliari et al., 2008). Some of the women explained that being raised in a society in which not having control of one’s emotions and lives was seen as negative, this was a means of controlling both emotions and daily life stressors (Kokaliari et al., 2008).
Adolescents

McMahon, Corcoran, McAuliffe, Keeley, Perry, & Arensman (2013) completed a cross-sectional school-based survey in Ireland among 3,881 Irish adolescents throughout thirty-nine schools. The purpose of this study was to identify coping styles used by adolescents and self-injurious behaviour (McMahon, et al., 2013). They focused on two types of coping skills - emotion-oriented coping skills and problem-oriented coping skills (McMahon, et al., 2013). The only gender-related difference they found was that girls reported more frequent use of both coping styles (McMahon, et al., 2013). Lastly, those that reported a higher use of emotion-oriented coping styles had more incidents of self-harm in their history (McMahon, et al., 2013).

Tsai and associates (2010), had 742 high school students in Taiwan complete a structured self-administered questionnaire survey in order to understand the prevalence rates for deliberate self-harm. The results revealed correlations with history of sexual abuse, drinking, running away from school, smoking, or suicidal attempts (Tsai et al., 2010). It was concluded that these are common factors among the adolescents who engage in deliberate self-harm and that school personnel should be aware of this, in order to provide more efficient help for the youth (Tsai et al., 2010).

Gindhu, Kimberly, and Schonert-Reichl (2005) completed a study of the reasoning behind adolescent self-harm. The study consisted of 424 school-based adolescents who completed self-report questionnaires that focused on self-harm, adjustment, history of suicide, one’s social desirability, and health behaviours (Gindhu et al., 2005). This study found that many of the teens lacked knowledge as to what self-harming behaviour was and those that knew about self-harm considered many different behaviours to be self-harm such as eating disorders (Gindhu et al., 2005). Due to the lack of understanding, Gindhu and associates (2005) felt that it is important for youth to be taught about self-harm and the help that is available.

Lundh and associates (2007) completed a study among 15-year-old Swedish adolescents. The purpose was to identify self-harm rates among the adolescents, gender differences, as well as any correlation with low self-esteem (Lundh et al., 2007). They found that there were no overall differences among the genders but the females did report higher rates wrist cutting (Lundh et al., 2007). Lastly they found that those with high rates of self-harm behaviour were correlated to low self-esteem (Lundh et al., 2007). Rodham, Karen, Hawton, Keith, Evans, and Emma (2005) conducted a school-based survey with over 6,000 adolescents from England ages, ranging from 15 to 16. They discussed the prevalence of self-harm among this population, which is usually examined by historical information from psychiatric samples, hospital admissions, and the general population (Rodham et al., 2005). They reported that hospital-based studies estimated that 25,000 adolescents are hospitalized annually in England and Wales (Rodham et al., 2005). In these studies, more males are reportedly engaging in self-harm than females. However, this may be reflective of the fact that males engage in more serious self-harm, which requires hospitalizations. Females typically engage in less serious self-harm that can be attended to without hospitalization (Rodham et al., 2005). This study also found a correlation between self-harm and an increase in cigarettes, alcohol, and drug consumption among the adolescent population (Rodham et al., 2005).

A strong correlation between NSSI and difficult familial relationships, poor peer relationships and poor academic performances among adolescents have been identified as risk
factors, as well as having known someone who has engaged in self-harming behaviour (Madge, et al., 2011). Hall and Place (2010) discussed two types of cutting behaviours that have been identified: first, young people who are emotionally troubled and secondly, young people who see this as part of their culture. Oam (2010) elaborates on these two types of behaviours, explaining that many young people who fall in the second category, will explain their actions by reasoning that they want to be part of a group or that they saw someone at school do it (Oam, 2010). This tells us that self-harming behaviour can be socially contagious and easy to copy, especially among a vulnerable group who may not have developed the appropriate coping skills (Oam, 2010). Emotionally troubled youth who frequently engage in self-harm, when faced with an event that is perceived as threatening, may find that the only coping mechanism they have developed is NSSI; this is the only way they feel they can regain self-control or even feel better (Oam, 2010). Oam (2010) described NSSI as a way of regaining control over one’s inner emotions in a way that is not achieved through other cognitive skills because they have not yet been learned.

Ryan, Heath, Fischer, & Young (2008) discussed Superficial Self-Harm (SSH); this is cutting, scratching or severe damage to the tissue which is not socially acceptable and is almost always a reaction to a psychological crisis. SSH is similar to NSSI because in neither case is there suicidal intent. Due to SSH being underreported, it is difficult to determine the prevalence of SSH (Ryan et al., 2008).

**Gender Differences**

Hawton and Harriss (2008) completed an analysis of a gender ratio by age group from a hospital data of 10 years. They found that, in early adolescence, self-harm is higher among females; they explain that, among females, self-harm typically appears around ages 12 and 13; this is, perhaps, related to the fact that girls reach puberty earlier than males (Hawton et al., 2008). Although Hawton and colleagues (2008) found that male self-injurious behaviour peaks around late teen years and into the early 20’s. Earlier puberty makes females more prone to mood disorders, as well as problems in relationships either familial or peer (Hawton et al., 2008). Males’ self-harm behaviour peaks in their later 20’s (20 to 24 years of age) (Hawton et al., 2008). Because males and females do not reach puberty and other developmental milestones at the same time, the ratio will always be uneven and it is difficult to say one gender engages in more self-harm than the other because of underreporting (Hawton et al., 2008).

Marchetto (2006) conducted a study to examine self-harm among women who have experienced trauma by recording a large sample of people who self-harmed in a general hospital. In this study he found no gender differences among those who self-harmed and experienced trauma (Marchetto, 2006). He found a number of factors that need to be considered when discussing gender differences among those who self-harm. Studies may have limited sample groups, a sample group may only be female, or a sample group may be made up of people with a disorder that is commonly seen in women such as an eating disorder (Marchetto, 2006).

Hawton (2000) stated one major gender difference when it comes to self-harm behaviour, that being that men are more likely to engage in more violent forms of self-harm behaviour. Men express more aggression and have less concern for bodily disfigurement. As a result, they have higher rates of suicide; some of these suicides may be accidental and may have been intended as NSSI (Hawton, 2000).
According to Craigen and Foster (2009), self-injurious behaviour has been found to be three to four times more common among men than women. Brown and Kimball (2013) reported that there are disparities between genders who suffer from self-injurious behaviours. Some studies have shown that females are more likely to engage in self-injurious behaviours (Rodham et al., 2005; Brown et al., 2013).

**Sexual Orientation**

Skegg, Nada-Raja, Dickson, Paul, and Williams (2003) studied the association between self-harm and sexual orientation. A birth cohort of 946 young adults from New Zealand took part in this study (Skegg et al., 2003). Results showed that both men and women who had a same-sex attraction had higher rates of self-harm behaviours (Skegg et al., 2003). One-quarter of men who experienced a same-sex attraction reported engaging in self-harm and one-sixth of women attributed their self-harming behaviour to same-sex attractions (Skegg et al., 2003).

In Canada, women involved in same-sex relationships in the community and federally-sentenced women with same-sex partners have been found to engage in NSSI more frequently than those involved in heterosexual relationships; this is thought to be brought on by lack of support of or lack of coping skills (Power & Usher 2011).

**Health Care Professionals and their roles with NSSI**

Most of the time, when people are involved in self-harming behaviour, they are seen by non-mental-health staff (Butler & Longhitano, 2008). A patient may then receive a mental status assessment which is typically made up of an observational period, as well as a screening questionnaire in order identify the patient’s history of self-harm (Butler & Longhitano, 2008). When the health care provider is asking the patient about their history with self-harm, they should ensure that they identify details of the self-harm episode, background stressors and triggers, past psychiatric and medical history, alcohol and substance abuse, as well as their social history (Butler & Longhitano, 2008). In order for the health care provider to be able to provide a management plan for the individual’s needs, related to risk, the assessment should include information about the triggers and motivations that precipitated the behaviour that led to the patient engaging in this harmful behaviour, as well as identification of factors that can affect short-term risk of recurrence (Butler & Longhitano, 2008). Williams and Padmanabhan (2008), provide a list of items that should be gathered in an initial assessment what method was used; where and how; what circumstances preceded the behaviour; were tablets used; was there any attempt to hide the act; was anybody informed of the act; have any mental health professionals been involved in the past; has any form of therapy been put in place or recommended; are there any mental health problems present or have they been present in the past (Williams & Padmanabhan 2008). Once these factors are taken into consideration and the assessment has been completed, the determination can be made about risk for further self-harm and treatment options to mitigate the risk. (Williams & Padmanabhan, 2008).

Unfortunately when a person seeks help they can encounter professionals who react with shock, fear, horror, guilt, anger, sadness and even disgust (Macdonald, 2009). If a professional reacts in any of these ways, it may reinforce the person's low self-esteem and support their belief that professionals are unsympathetic and unhelpful (Macdonald, 2009). As professionals, we need to keep in mind that even though self-harm is a destructive behaviour which is viewed in a
negative light, almost everyone engages in some form of a self-destructive behaviour such as smoking, drinking, eating too much or working long hours, the researchers suggest all professionals keep this in mind when working with clients who self-harm in order to avoid being judgemental (Macdonald, 2009).

**Contributing Factors**

Some factors were identified as contributing factors which means they have happened before the self-injurious behaviour began (Power & Usher, 2010). The following studies have found a significant number of correlations among patients of NSSI; this becomes important when predicting the risk for future self-harm. Power and Usher (2011), found evidence of a correlation between Borderline Personality Disorder (BPD) and NSSI. This is not a surprising correlation to be made since self-harm is one of the diagnostic criteria for BPD (American Psychiatric Association, 2000). Power and Usher (2011) determined that male offenders have often been victims of physical and sexual assault as children. This history of abuse may lead to Post Traumatic Stress Disorder (PTSD) (Power & Usher, 2011). PTSD is not uncommon among offenders and it is not surprising that NSSI could be later seen among this population or that they may be at higher risk for NSSI (Power & Usher, 2011).

A positive correlation has been found between a history of childhood abuse and NSSI (Power & Usher, 2011). Those who have experienced childhood abuse may demonstrate a deficiency in coping with stressful situations. This may explain why NSSI, self-injurious behaviour and suicide are common in this population (Power & Usher, 2011). Power and Usher (2011) compared ninety-five men who had a history of NSSI to 104 men who did not have a history with NSSI. They found that 41% of the men with a history of NSSI met the criteria for BPD and only 7% of the men without a history of NSSI met the criteria for BPD (Power & Usher, 2011). In this same group of men, they found that the participants who engaged in NSSI were at higher risk for major depressive disorder, substance abuse, and a history of childhood abuse. The childhood abuse model theorizes that those who have experienced childhood abuse may be at increased risk for psychological disorders such as PTSD, BPD, depression, and substance abuse, which may increase the risk for NSSI (Power & Usher, 2011). They found that those engaged in NSSI were rated as significantly more impulsive by their parole officers at intake (Power & Usher, 2011). Power and Usher (2010) reported that anger, aggression, and emotional instability is commonly found among those who engage in NSSI.

Hoffman and Kress (2008) found that those who engage in NSSI commonly have a variety of mental health diagnoses such as PTSD, depression, BPD, personality disorders, specifically cluster B, as well as a history of experiencing childhood abuse. Hoffman et al., (2008) noted that NSSI can evolve and change with new experiences and, over time, the individual may learn to generalize the behaviour across new situations, for example an individual who engages in NSSI due to stress in relationships may learn that this method of coping stress is helpful therefore they begin to use NSSI to cope with all stressful situations in their lives, and may later apply NSSI towards other aspects of their lives.

Power (2011) reported that a history of abuse is a risk factor for NSSI but it is not the only historical factor; a history of any trauma, as well as a growing up in a dysfunctional family environment, may increase the risk of NSSI. Depression and anxiety are also related to NSSI; those with depression that engage in NSSI may manifest depression significantly differently than
those who do not engage in NSSI (Power, 2011). Eating disorders, anger, impulsivity, aggression and suicide were also found to correlate with NSSI when present either historically or concurrently (Power, 2011). Power (2011) had participants complete a semi-structured interview in order to assess factors associated with NSSI. Power (2011) found that the women with a history of NSSI were more likely to have a history of childhood sexual and emotional abuse. They also found a correlation between NSSI and impulsivity, aggression, and anger (Power, 2011). Power and Usher (2011) conducted an archival study among federally sentenced women and found that women with a history of NSSI had a higher probability of being diagnosed with a psychological disorder or mental health issues.

Factors associated with the behaviour

There are many factors associated with behaviour that may occur simultaneously with NSSI or precede it. Power and Usher (2010) had 56 women, with a history of NSSI, take part in a semi-structured interview that contained four sections: Mental Health History; History of Abuse; Sexual Orientation; and Suicide Attempts. They found reasons given for engaging in NSSI were: expression of anger; punishing oneself; distraction; and to produce feelings of normalcy (Power & Usher, 2010). Power and Usher (2010) concluded that offenders who engaged in suicidal behaviour reported different histories, had different clinical presentations and provided different reasoning than those engaging in NSSI. Suicidal offenders wanted to relieve others of a burden, whereas offenders engaging in NSSI provided the following reasons for the behaviour: to cope, to communicate, to see blood or feel pain, to feel good, to hurt self instead of others, instrumental reasons, being in prison, to feel in control, friend was self-injuring, to re-enact past trauma, to numb emotions, and to hurt self before others could hurt them (Power & Usher, 2010). These responses are not uncommon in women in the correctional system. The women on parole and living in half-way houses may continue to feel incarcerated and lacking control and turn to NSSI as a way to cope (Power & Usher, 2010). There is an increase in self-harm and suicidal behaviours amongst fellow inmates when a woman in prison or half-way house engages in these behaviours. Witnessing peers engage in self-harm may lead to an elevation in stress or stir up past negative feelings (Power & Usher, 2011). Power and Usher (2010) asked the women to identify emotions they experienced before engaging in NSSI; anger, depression, anxiety, fear, upset and loneliness were emotions listed by participants. They also provided emotions that were experienced after the behaviour occurred: relief, regret, shame, worse, rush, and dissociation were cited (Power & Usher, 2010). They asked the women to identify events that may have precipitated the behaviour; interpersonal conflict, abuse stressful life event, offence, institutional event, death of family member, and seeing someone else do it were found to be precipitating events (Power & Usher, 2010). Given the correlation between substance abuse and NSSI, Power and Usher (2010) asked the women if substance abuse had increased or decreased their NSSI; fifty-nine percent of those asked reported that the use of substances increased the likelihood of engaging in self-harm, while forty-one percent reported a decrease in their NSSI after using substances.

Muehlenkamp (2006) reported that there are many challenges faced when working with an individual who engages in NSSI. One of the challenges faced is that NSSI can lead to severe injuries and accidental death. In addition, those who engage in NSSI are at greater risk for suicide. Usually assistance provided for NSSI is hospitalization but this is an expensive approach that has not been helpful in treating patients with NSSI (Muehlenkamp, 2006). Hospitalization is
not always available for those with NSSI unless they have severe injuries, and they will not be held for long at the hospital due to lack of suicidal ideation (Muehlenkamp, 2006).

Mills and Kroner (2010) identified risk factors associated with NSSI among female offenders as depression, hopelessness, and previous NSSI. Being aware of historical factors can help identify those who may engage in NSSI in the future and identify risk factors in individuals actively engaging in self-harm (Mills & Kroner, 2010).

Wichmann, Serin, and Abracen (2002) suggested that many women who come into contact with the correctional system have been victims of physical and/or sexual abuse. These women may experience feelings of loneliness or isolation, have histories of suicide attempts, and lack of social support, which are all known risk factors for NSSI. Also NSSI is viewed as a coping mechanism among these women in the prisons, a way of coping with past traumas, present stressful situations, and gaining control over their lives.

**Appropriate Alternatives and Approaches to NSSI**

NSSI is used to cope with stressful events in life that may have already happened or are presently occurring. This section will identify different approaches available that can be taught as alternative coping strategies to NSSI. Cognitive behavioural therapy (CBT) has been demonstrated to effectively decrease repetitive self-harming behaviours, suggesting that it can be used to decrease NSSI (Muehlenkamp, 2006). Muehlenkamp (2006) identified two types of CBT therapy that can help to decrease the likelihood of engaging in self-injurious behaviour: Problem-Solving Therapy (PST) and Dialectical behaviour therapy (DBT). These treatments share a common feature in that each is a structured approach which emphasizes on instantly targeting NSSI and skill deficits. The main purpose of the therapies mentioned above are to assist clients in learning healthy coping mechanisms and methods to identify and resolve problems they may be encountering (Muehlenkamp, 2006). Clients are taught the following problem solving steps: problem identification; goal setting; brainstorming; assessing potential solutions; selecting and implementing a solution; evaluating the success of the chosen solution (Muehlenkamp, 2006). Teaching these steps has been found to be important because those who engage in NSSI often lack problem solving skills (Muehlenkamp, 2006). Dialectical behaviour therapy is made up of a combination of Zen Buddhism, skills training, problem solving, and cognitive behavioural interventions (Muehlenkamp, 2006). One of DBT’s primary goals is to reduce NSSI by assisting clients in developing healthy coping skills, addressing motivational obstacles through therapy and teaching to generalize skills (Muehlenkamp, 2006). Muehlenkamp (2006) discussed the importance of focusing on creating a strong collaborative and empathetic alliance with clients if success is ever to be reached. By identifying skill deficits, greater success may be reached because this assists clients in developing an adaptive ability to face the world, bear distress and regulate emotions (Muehlenkamp, 2006).

Power and Usher (2010) identified appropriate ways of releasing emotions for women in the federal prisons: relaxation; distraction; positive self-talk; behaviour substitution; speaking to a psychologist; attending programs. The last two methods require the assistance of a professional but the rest are skills that can be learned independently (Power & Usher, 2010). It is beneficial for individuals to learn more than one of these skills (Power & Usher 2010). These skills for releasing emotions may decrease NSSI but may also help to increase self-esteem in those regularly practising their skills (Power & Usher, 2010). These are skills that they can continue to
use once they have left the prison system (Power & Usher, 2010). Often the struggle faced within
the correctional system is that the women can be provided with a variety of supports and many
people to assist them but they are unable to transfer and generalize what they have learned in
order to face difficult situations when they are back in the community alone (Power & Usher,
2010).

Usher, Power, and Wilton (2010) reported that when working with someone who is
struggling with NSSI, it is important to begin with a risk assessment to determine the amount of
assistance they will require. In order to do so, there are a number of instruments available; two
commonly used scales are the Beck Hopelessness Scale, (BHS) a 20-item, true-false, self-report
questionnaire which looks at pessimism and hopelessness (Beck et al., 1993), and Suicide
Concerns for Offenders in Prison Environment (SCOPE) (Perry et al., 2009), a self-report
questionnaire made up of 27 items which are self-rated from strongly agree to strongly disagree;
this measure is used to identify the risk of self-harm and suicidal behavioural (Usher et al.,
2010).

Some comprehensive therapies have been put forth; Cognitive behaviour therapy (CBT)
focuses on altering behaviours by cognitive restructuring (Usher et al., 2010). Dialectical
behaviour therapy (DBT) was first developed by Marsha Linehan and is a type of CBT that
focuses on individuals with borderline personality disorder who frequently engage in suicidal
and self-injurious behaviours (Usher et al., 2010). Manual assisted cognitive behaviour therapy
(MACT) is a combination of CBT and DBT used to target suicidal and self-injurious behaviour
(Usher et al., 2010). Acceptance and commitment therapy (ACT) is applicable to many
psychological problems such as depression, anxiety, psychosis and is a therapy that proposes that
people relate emotions, cognitions and behaviours to the context in which they occur (Usher et
al., 2010).

Non-suicidal self-injurious behaviour in prison

In prison, NSSI is an ongoing battle; it is estimated that 2-4% of the prison population
engage in NSSI and 15% of prisoners who receive psychiatric treatment are engaging in NSSI
(Smith & Kaminski, 2010). A correlation between aggressive individuals and engagement in
NSSI among prisoners has been identified (Mangnall & Yurkovich, 2010). Incarcerated women
reported that NSSI can be a form of release and relief when in prison; however, when they
engage in these behaviours staff is reacting with punishment such as solitary confinement
(Mangnall & Yurkovich, 2010). Marzano, Hawton, Rivlin, and Fazel (2011), found that there are
environmental factors related to a female inmate’s likelihood to engage in NSSI. Factors
contributing were: prior incarceration; single cell accommodations; previous sexual assault; past
trauma; previous experiences with prisons that were typically negative; and lack of social
supports. They found that these factors played a larger role in identifying self-harm than criminal
history. All of these factors need to be taken into consideration by the people who work with
these women while in prison. The prison staff require extensive training in order to help these
women manage needs and to reduce future risk (Marzano, Ciclitira, & Adler, 2012). Cutting has
been identified as one of the most common forms of NSSI, in prison, there are many more
dangerous ways that the women have been hurting themselves. Some of these methods include
reopening wounds, inserting items into old wounds and using staples or wires to cut themselves.
The methods used by women in prison may be seen as higher risk because they use items that are
not meant to be weapons but are found in the prison and used as weapons with which to self-
harm (DeHart, Smith, & Kaminiski, 2009). Although there is an increased risk for the women harming themselves, there is also an added stressor on the staff in charge of watching them because they need to be able to identify risks as well as harmful objects in order to keep these women safe (DeHart, Smith, & Kaminiski, 2009).

Depending on life events and the coping skills developed by a person, anyone may be at risk for NSSI. Women entering prison may be at higher risk, particularly if they have been diagnosed with a mental illness (Fazel, 2009). These women, who are vulnerable and entering a stressful environment, need to be placed with staff trained to manage individuals who engage in self-harm (Fazel, 2009).

**Effects on staff of managing chronic self-harm**

Staff who work with clients that engage in self-harming behaviour may react strongly and struggle with how to proceed (Hoffmen & Kress, 2008). Most staff members encounter an inmate or offender who engages in self-harming behaviour whether it is suicide self-injurious behaviour (SIB) or NSSI (Hoffmen & Kress, 2008). Staff should be able to seek help from supervisors in order to effectively manage these situations (Hoffmen & Kress, 2008). It is important for staff members to be able to identify between NSSI and suicidal behaviour because this is an important distinction. Behaviours are determined to be suicide attempts if the client identifies that suicide was the intent (Hoffmen & Kress, 2008). It is important to assess at intake whether suicidal behaviour or self-injurious behaviour is present or if there is a history of same (Hoffmen & Kress, 2008). If either suicidal behaviour or SIB or NSSI is identified, it is important to make note of the frequency, duration, and methods for future reference (Hoffmen & Kress, 2008). One risk associated with NSSI is accidental death therefore staff training is vital in order for them to have the skills and resources necessary when this occurs (Hoffmen & Kress, 2008). If a staff member is over-reactive this could alienate the client and damage the relationship between staff and client (Hoffmen & Kress, 2008). If a staff member is under-reactive, this could increase the risk of suicide. Supervisors need to teach their staff to identify between self-harm and suicidal behaviours and under-/over-reactive responses (Hoffmen & Kress, 2008). The authours reccomend that staff should attend workshops, read relevant literature, and participate in training in order to develop awareness of SIB, NSSI and suicidal behaviour (Hoffmen & Kress, 2008). If at any time a staff member, whether supervisor or not, is feeling hopelessness, anger, sadness, frustration, disgust, or horror towards clients who self-harm, they need to report it and seek help; that is the only way they can provide their clients with proper care (Hoffmen & Kress, 2008).

**Policies that address this issue**

The first step staff is to take when faced with an inmate who is engaging in self-injurious behaviour is to turn to the Commissioner's Directive 843 also known as a CD (Correctional Service Canada, 2013). In the CD under the annex B it outlines the steps that a staff member is required to take, there is a short-term response outlined as well as a long-term response (Corrections Service of Canada, 2013). The short-term response is made up of critical response and incident management plan (CRIMP) this is an evaluation of the inmate’s behaviour preceding the act of self-injury and should occur within 24 hours of the self-injurious behaviour (Corrections Service of Canada, 2013). The long-term response includes an interdisciplinary management plan; this is an approach developed for inmates who engage in self-injurious
behaviour for long periods of time and whose behaviour poses substantial challenges (Corrections Service of Canada, 2013). It is also outlined in the CD 843 that a comprehensive psychological/psychiatric assessment, a comprehensive suicide/self-injurious assessment, alternatives/avoiding use of restraints, and clinical opinion and behavioural summary are required for those who have engaged in self-injurious behaviour (Corrections Service of Canada, 2013).

Corrections Service Canada (CSC) requires that all staff who are in contact with inmates must receive suicide prevention training; this training is provided for all staff in the Correctional Training Program or in the New Employee Orientation Program (Usher, Power & Wilton 2010). There is also an in-service staff training program which is tailored to those working with more complex cases related to mental health (Usher et al., 2010). The training is made up of topics related to self-injury (assessments and treatment strategies), as well the best way to help other staff members who frequently are confronted with self-injurious behaviour (Usher et al., 2010). CSC has also implemented the Employee Assistance Program, which is a program made up of staff who have volunteered and are there to assist other staff members with work-related problems (Usher et al., 2010). There is also critical incident stress management which is a subset of EAP and is designed for staffs who are involved in more critical incidents in the workplace. CSC has implemented two initiatives to help with suicide and self-injurious behaviour, Dialectical Behaviour Therapy (DBT) and Peer support programs training for this is typically provided for those who work in the women offender sector (Usher et al., 2010).

It is CSC policy that an intake health status assessment is completed on every offender in which information regarding previous suicide attempts, as well as previous self-injury is recorded. In order to complete this CSC uses a computerized mental health intake screening system (CoMHISS), this is offered to all offenders when they arrive at reception (Corrections Service of Canada, 2007). The purpose of CoMHISS is to identify a measure of mental health such as depressions, suicidal ideation, anxiety, obsessive compulsive disorders and psychotic disorders (Corrections Service of Canada, 2007). Once an offender has completed this if they receive a test score that exceeds their pre-determined threshold they will be recommended for further assessment (Corrections Service of Canada, 2007). If the offender reports a history of engaging in either behaviour, the offender is referred for a comprehensive psychological assessment; an alert is placed on file to inform personnel that this person has a history of self-harm (Usher et al., 2010). If an inmate is deemed high risk he/she may be placed on suicide watch under constant observation in a segregation cell (Usher et al., 2010).

DBT is a type of Cognitive Behavioural Therapy designed by Marsha Linehan in order to treat Borderline Personality Disorder (BPD) (Usher et al., 2010). Self-injurious behaviour is common among individuals with BPD; therefore the use of DBT could also be beneficial in patients who engage in self-injurious behaviour without BPD (Usher et al., 2010). DBT is made up of four skill modules which are mindfulness skills, emotion regulation skills, distress tolerance skills, and interpersonal effectiveness skills (Usher et al., 2010). The four modules are treated combining the following: skills training; problem solving training; exposure and response prevention; contingency management; and cognitive modifications strategies (Usher et al., 2010). DBT although originally created for community-based treatment is proving to be effective in correctional systems (Usher et al., 2010). DBT has been successful in correctional settings due
to inmates experiencing many negative emotions, as well as having to adapt to a constrained environment (Usher et al., 2010).

Peer Support Programs are made up of inmates who have been trained and are overseen and facilitated by a staff psychologist (Usher et al., 2010). The purpose of this program is to provide inmates with crisis-intervention skills as well as peer-delivered short-term counselling (Usher et al., 2010). The inmates receive specific training on suicide and self-injury intervention and prevention (Usher et al., 2010). The peer support program began in 1990 at the Prison for Women, in Kingston, in order to address distress related to isolation in segregation (Usher et al., 2010). Now that Prison for Women is closed, the peer support program is available at each regional prison for women (Usher et al., 2010).
Chapter III: Method

A search was conducted of scholarly peer-reviewed journals, using Corrections Service Canada, Google Scholar, EBSCO Host, St Lawrence College online Library database, and Queens University Library. The search terms used to perform these searches were: Self-harm; self-injurious behaviour; non-suicidal self-injurious behaviour; NSSI; women who self-harm, adult women who self-harm; female inmate self-harm, inmate self-harm and self-harm in prisons. When choosing which articles for the literature review, research in 11 categories were examined: non-suicidal self-injurious behaviour (NSSI); self-harm in adolescents; gender differences; sexual orientation; health care professionals and their roles with NSSI; contributing factors; factors associated with the behaviour; appropriate alternatives and approaches to NSSI; non-suicidal self-injurious behaviour in prison; the effects on staff of managing chronic self-harm; and policies that address self-harm. A total of 54 peer-reviewed articles were reviewed and used to discuss self-injurious behaviour, its prevalence among women in federal custody, and CSC's policies and practices that address this issue.
Chapter IV: Results

Initially, the focus of the literature review was the supports available in the community and Correctional Services Canada for women on parole with NSSI. However, the writer found that literature that focuses on NSSI and female on parole was limited and, therefore, had to broaden the research. The literature review is made up of research on the following: NSSI; adolescents; gender differences; sexual orientation, health care professionals; contributing factors; factors associated with the behaviour; appropriate alternatives and approaches to NSSI; effects on staff managing chronic self-harm; and policies that address this issue within CSC.

Although much of the research was focused on adolescents, the decision was made to include this research. It was felt that understanding NSSI in adolescents could inform on the issue of women engaging in NSSI and these articles still contained valuable information that relates to female adults.

Identifying the difference between genders was examined to clarify issues unique to females. There does not appear to be a definitive answer on the difference between genders on this issue. Different studies draw multiple conclusions on the matter such as self-harm being underreported in men, and self-harm peaking at different ages in either gender; these conclusions would alter data normally shown in studies and can create a stigma that self-harm is most common among women.

While doing the research a few articles brought up sexual orientation as possibly being an important factor among self-harm, therefore sexual orientation was furthered investigated. What was found was that the research on sexual orientation and self-harm was limited and that this is still a recent focus of research. The two articles found that there is a correlation between self-harm and sexual orientation. Skegg (2003) did find that self-harm among men and women with same-sex attractions had higher rates of self-harm.

Health care professionals are often the first people who treat those who self-harm, whether it is in a hospital due to a severe act of self-injurious behaviour or whether individuals who engage in self-harm seek out help. Most people in a community will go to a doctor before going anywhere else. A medical assessment is completed by the health care professional in order to identify if the patient requires further help and in order to identify suicidal intent (Williams & Padmanabhan 2008).

Many contributing factors were found for NSSI. Many offenders who self-harm may also have a mental health history related to the behaviour. Past abuse, alcohol abuse, addictions and traumas were also found to have a relationship with NSSI. Although not all the women in all the studies shared the same history; however, there are factors that may trigger these behaviours and, if identified early, may assist in identifying women who may engage in self-harm.

In the literature review, findings found in the section of Factors Associated with the behaviour had similar results with those found in the section of Contributing factors.

Women in prison may resort to these behaviours not only because of their histories but also because of lack of support while in prison. Also having feelings and reminders of being victims of sexual or physical abuse come up while in prison (Wichmann et al., 2002).
CBT, PST, and DBT are all therapies that have proven to be helpful with treating self-injurious behaviour both in the community and in the prison system (Muehlenkamp, 2006).

Although the focus of this study was the women who engage in NSSI, those working with them are greatly affected and it was necessary to identify what supports are in place for them. CSC recognizes the importance of supporting staff and the potential for burnout among those who work with people who engage in NSSI. As such, CSC has provided workshops on suicide, self-harm, sensitivity training as well as a staff member that is available to talk to when feeling overwhelmed (Hoffman & Kress, 2008).
Chapter V: Discussion

During the literature review it was discussed that there are many factors that increase the risk for engaging in self-injurious behaviour. Some of these risks are external hazards such as maturational or situational hazards. The number of hazards faced by an individual as well as the coping mechanisms the individual has developed can increase the risk of engaging in NSSI. If hazards are identified early, support can be provided to assist the individual through skills training for stress management, or removal of the individual from the situation. By identifying or decreasing these hazards, the likelihood of self-harm may also be reduced. Kokaliari and Berzoff (2008) found that self-harm does not take an overt negative toll in all who engage in it. They interviewed 10 women in college who described their experience with self-harm; these women functioned well in their lives but chose to self-harm as a means to feel in control of their lives (Kokaliari et al., 2008). This demonstrates that self-harm serves many different purposes for different people. Using self-harm as a form of control in their lives was a common theme among women in prisons. There are many factors that contribute to the use of self-harm in prisons prior incarceration: single cell accommodations; previous sexual assault; past trauma; previous experiences with prisons that were typically negative; and lack of social supports (Marzano et al., 2011). These factors have a higher probability of leading to self-harm than a more extensive criminal history alone (Marzano et al., 2011). The women who self-harm in prisons are at an increased risk for accidental suicide because they do not have access to clean sterilized items to harm themselves. Therefore they are using miscellaneous objects for their self-harm, which increases the risk of infection. For these reasons staff is required to monitor items women have access too. These precautions are added stressors for the staffs and may cause them to take an inappropriate approach to deal with these actions; for example, the imprisoned women may sometimes be placed into segregation.

Much of the research on self-harm is based on adolescents and this was used in the literature review for two reasons. First, much of the findings are similar to the limited research on adults or women who self-harm; and research is important because it shows that teens have little to no understanding on the effect of self-harm. The research on adolescents and adults had many similarities such as self-harm being used as a coping mechanism, a poor support system in their lives, as well as a history of sexual abuse, and substance abuse. Findings indicate that many adolescents had little insight into their self-harming behaviour. This demonstrates that in order to reduce the prevalence of self-harm in prison environments it is important to educate adolescents and preteens on self-harm, the consequences of self-harm, and reasons for engaging in self-harm and healthy alternatives for coping.

Although the main focus of this literature review was on females who self-harm it was still necessary to identify if there are any gender differences. Results were inconclusive with respect to prevalence rates in each gender. Given the perception that self-harm is more often found in women, men may be more reluctant to report incidents of self-harm. Gender differences at certain ages may be related to the fact that women typically reach puberty before men.

The relationship between sexual orientation and self-harm was examined in a few studies. Results indicate that self-harm was more common among people attracted to the same-sex than among those attracted to the opposite sex. The research is still limited and it is recommended that more research is done in this area.
Individuals who engage in self-injurious behaviour may be taken to the hospital, depending on the severity of their injuries. In a hospital the patient may receive a mental status assessment which is typically made up of an observational period, as well as a screening questionnaire in order to identify the patient’s history of self-harm (Butler & Longhitano, 2008). As noted in the literature review, this is an extensive procedure and the health care professional is required to obtain a lot of information from the client therefore they require proper training as well as sensitivity training. If a person who is seeking help encounters professionals who react with shock, fear, horror, guilt, anger, sadness and even disgust this may reinforce the person's low self-esteem and reinforce their belief that professionals are unsympathetic and unhelpful (Macdonald, 2009).

Some factors that were identified as contributing factors were, borderline personality disorder, post-traumatic stress disorder, childhood abuse, substance abuse, history of trauma and a dysfunctional family environment. Although not always present, these factors are often found among women who self-harm (Power & Usher, 2010).

Depression, hopelessness, and a lack of coping mechanisms are factors that attribute to NSSI but may also be antecedents or consequences the behaviour of NSSI. Self-harm is used as a means to gain control for an individual who, otherwise, may have little control over their situation.

Once there has been a determination of risk, the appropriate treatment must be identified. A tool which was found to be the best for this behaviour was the Beck Hopelessness Scale (BHS). The following therapies have proven to be useful when working with a client who self-harms: cognitive behavioural therapy (CBT), problem-solving therapy (PST), dialectical behaviour therapy (DBT), and manual assisted cognitive behaviour therapy (MACT--this is a combination of CBT and DBT), and acceptance commitment therapy (ACT).

Within CSC, a common problem is not only the offenders who self-harm but also how this affects the staff. Many staff at CSC face this problem on a daily basis and it is important that, just like health care professionals, they approach the problem of self-harm with sensitivity. Differentiating between NSSI and suicidal behaviour is vital when determining treatment options.

CSC has taken this problem seriously, and put training in place for the staff. All staff who are in contact with inmates are required to receive suicide prevention training. There is also an in-service staff training program which is tailored to those working with more complex cases related to mental health. There is also an Employee Assistance Program, which is a program made up of staff who have volunteered and are there to assist other staff members with work-related problems. CSC has implemented two initiatives to help with suicide and self-injurious behaviour; Dialectical Behaviour Therapy (DBT) and Peer support programs (Usher et al., 2010). The main purpose of these trainings and programs are to protect both the staff and the offenders.

Throughout this literature review there were many limitations such as most of the research completed by CSC is done by the same authors, this makes the research available biased because by not having a variety of authors completing research they may have preconceived notions on the topic and may not question their own work. Outside of CSC, the research on
female offenders who self-harm is limited; as previously mentioned, most of the research is on adolescents. Therefore, it is recommended that more research be done on adults with NSSI and, in particular, women.

By reviewing the literature available the writer was able to identify gaps in the research and what further academics can focus on in order to contribute what is required to the field of psychology. The gaps found was a lack of literature about adult females who engage in self-harm. By doing studies directed to adult females in prison environments, on parole, hospitals, and colleges/universities. This would allow us to see in which environment self-harm is higher, by doing so specific stressors maybe identified and more assistance can be provided for these women. Furthermore future researchers should also look more in depth as to how working with individuals who engage in self-harm affects staff members directly. There was some literature available as to what treatments or workshops are being offered but it was limited and for the benefit of staff members it may be helpful to further identify psychological risks.

In conclusion, CSC has a lot of support in place for staff and inmates in the prisons. Although they have a lot of support available none of the research done by CSC or outside authors mentioned anything regarding offenders on parole therefore it is recommended that future research focus on what resources are available either through the community or through CSC for offenders on parole.
References


Craigen, L. M. (2009). "It was like a partnership of the two of us against the cutting" investigation the counselling experiences of young adult women who self-injure. *Journal of Mental Health Counseling*. 31(1), 76-94.


*Psychosocial Nursing & Mental Health Services,* 41(11), 10.


