Non-suicidal self-injury in patients with eating disorders: prevalence, forms, functions, and body image correlates

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A B S T R A C T

Introduction: More than one third of patients with eating disorders report NSSI. Moreover, negative attitudes and feelings toward the body, body dissatisfaction, and body image disturbances have been linked to NSSI in community and clinical samples. However, there is a lack of studies exploring NSSI frequency and functions and the specific relationship between multidimensional body image dimensions and NSSI in eating disorder patients.

Objectives: First, we explored the frequency, types, and functions of NSSI in a sample of 226 Spanish female participants with eating disorders (ED). Second, we explored differences in NSSI and body image depending on the ED restrictive-purgative subtype; and third, we explored differences in body dissatisfaction, body image orientation, and body investment in eating disorder patients without NSSI (n = 144), with NSSI in their lifetime (n = 19), and (b) with NSSI in the previous year (n = 63).

Results: Of the overall sample, 37.1% (n = 89) had a history of self-injury during their lifetime, and 27.1% (n = 65) had self-injured in the previous year. Among the types of ongoing NSSI, the most frequent were banging (64.6%) and cutting (56.9%). Restrictive vs purgative patients differed on NSSI lifetime, Appearance Evaluation, Body Areas Satisfaction, Body Protection and Feelings and Attitudes toward the Body. Moreover, significant differences were found on Appearance Evaluation, Body Areas Satisfaction, Positive Feelings and Attitudes towards the Body, Body Protection, and Comfort with physical contact, between participants without a history of self-injury and both NSSI groups.

Discussion: Body dissatisfaction and body investment have been found to be variables related to NSSI. Thus, the present study highlights the importance of working on body image in ED patients to reduce the frequency of NSSI.

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1. Introduction

Non suicidal self-injury (NSSI) is considered any deliberate self-inflicted damage to the surface of the body without suicidal intent, including methods such as skin cutting, burning, stabbing, hitting, scraping, or carving, among others [1]. This phenomenon has been included in the DSM-5 as a condition under study, and its prevalence is rising in adolescent non-clinical [2] and clinical populations, such as participants with eating disorders [3,4]. NSSI rates have been reported between 13.6% and 42.1% for restricting anorexia nervosa (between 27.8% and 68.1% for purging anorexia nervosa), between 26% and 55.2% for bulimia nervosa [4], 26.2% for eating disorders not otherwise specified, and 19.8% for binge eating disorder [5]. In general, studies have found that between 25.4 and 55.2% of eating disorder patients report NSSI [5–7]. Some previous work has found NSSI to be more prevalent in eating disorder patients with binge eating and purging [4,7], whereas others found no differences between restrictive and binge eating/purging patients [6,8]. This distinction, although important in designing psychological interventions, remains unclear.

There is evidence of two main different NSSI functionalities associated with intrapersonal/automatic and interpersonal functions. The first refers to the need to regulate internal states, such as managing distress, anti-dissociation, or anti-suicide, and the second represents social functions such as interpersonal influence and peer bonding [9–10]. Additionally, although different authors have found that eating disorder patients engage in NSSI for both intrapersonal and interpersonal functions, the emotion-regulation and self-punishment (intrapersonal) functions are the most prevalent [6,8,11,12].

Body image refers to the multifaceted psychological experience of embodiment, which includes perceptions and estimations of the individual’s body size and physical appearance, feelings and thoughts associated with the body and physical appearance [13]. Moreover, some authors [14] have pointed out that body image depends on visual,
kinesthetic, and auditory stimuli, inner psychological experiences, satisfaction of main needs, parental reactions to the body, affective education, and parent-child attachment behavior in the early formative years. Additionally, when the child enters adolescence, the affective and cognitive dimensions of body image are already developed. Orbach [15] stated that a central factor in NSSI and suicide attempts is bodily love or body rejection and emotional body investment. Different authors have suggested that negative attitudes and feelings about the body can be predictors of NSSI and suicide attempts, given that a person who develops a disregard for the body produces feelings of detachment, or dissociation [15–17]. This detachment from caring for or protecting the body may lead to physical anhedonia. Thus, a girl or boy who has an experience of the body as an object separate from the self could experience decreased sensitivity to pain and, thus, more easily harm himself/herself as a way of coping with negative moods or emotional deregulation [18]. In the same way, Osman and colleagues [19] pointed out that, theoretically, adolescents with high levels of dysfunctional attitudes and feelings toward the body in family situations have higher probabilities of engaging in self-destructive behaviors.

Based on this theoretical framework, a growing number of studies have linked both body dissatisfaction and body image disturbances to NSSI. For example, Svrko and Hawton [4] highlighted that eating disorders and NSSI share important common factors, such as body dissatisfaction, which is a key etiological variable for both phenomena. Other authors found a relationship between NSSI and negative attitudes towards the body in patients with eating disorders, reflecting increased negative feelings related to the body and self-image. These feelings may underline and motivate self-harming behaviors [20–22] through the view of the body as a depreciated object of contempt, making it easier to harm or destroy its tissues [14].

In this regard, a number of studies have compared the body image in non-clinical samples with and without non-suicidal self-injury. In a community sample of adolescents, Ross et al. [23] found that adolescents who rated themselves as less attractive, showed higher body dissatisfaction, and demonstrated affect regulation problems were more likely to get involved in NSSI than their non-self-injuring peers. The authors concluded that, although emotion deregulation is a risk factor for NSSI, this variable is not a sufficient explanation to engage in NSSI. Thus, additional risk factors, such as body image disturbances, appear to contribute to the tendency to engage in NSSI. Similarly, Brausch and Gutierrez [24] compared adolescents with and without self-harm behaviors (NSSI and NSSI with suicide attempts and a control group), finding that body areas dissatisfaction was significantly higher and self-esteem was significantly lower in both NSSI groups than in the comparison group. Muehlenkamp and Brausch [18] found that body image feelings played a mediating role between negative affect and NSSI in a non-clinical sample of adolescents.

In this direction, Duggan et al. [16] tested a mediation model in 101 adults who had engaged in NSSI, based on the hypothesis that emotional deregulation mediates the relationship between body image and NSSI. The authors found partial support for the proposed model, indicating that negative affect related to body image and suicide thoughts related to body appearance predicted NSSI mediated by emotional deregulation. Finally, Duggan, Heath, and Hu [25] found that children from 11 to 13 years old who engaged in NSSI showed greater body shame, body surveillance, and emotional deregulation than non-NSSI groups. Consequently, body dissatisfaction and body image orientation should be represented in etiological models of NSSI.

Extending this line of inquiry to clinical populations, higher rates of body dissatisfaction have been found in self-injurers [23,26], even after controlling for depression [24,27], and in patients with eating disorders, who, in general and independently of NSSI, showed body disgust [8,11]. A pioneer study by Walsh and Rosen [28] examined the relationship between body image and self-harm behaviors and found that body alienation was a strong predictor of NSSI in adolescents and young people in residential treatment. More recently, other studies have found body image feelings to be associated with NSSI in clinical samples [11]. Claes et al. [12] examined body experience in eating disorder patients with and without NSSI, finding that NSSI patients showed a higher negative appreciation of body size. In addition, Solano and her colleagues [29] found higher body image dissatisfaction in eating disorder patients with NSSI than in those without self-injurious behaviors. Except for the aforementioned studies, to our knowledge, there is a lack of studies exploring the specific relationship between multidimensional body image dimensions and NSSI in eating disorder patients, and no studies have examined this relationship in Spanish participants with eating disorders.

Therefore, the objectives of this research were threefold: first, to explore the frequency, types, number of different types, and functions of NSSI in a sample of Spanish female participants with eating disorders (ED); two, to explore the differences in NSSI frequency and body image depending on the ED subtype (restrictive -ANR- vs binge eating/purging patients -AN-BP, BN, BED, EDNOS), following the subtype categorization proposed by Claes et al. [6]; three, to explore the relationship between body dissatisfaction, body image orientation, and body investment, on the one hand, and NSSI, on the other, in eating disorder patients. Thus, we aimed to compare ED patients with and without NNSI (a) in their lifetime and (b) in the previous year, exploring specific emotional and behavioral dimensions of body image related to NSSI. We hypothesized that body image (BI) dissatisfaction -body areas satisfaction and appearance evaluation (affective dimensions) and BI orientation (behavioral dimension)-, would be higher in patients with NSSI, whereas positive body investment (affective and behavioral dimensions) would be lower. Finally, we aimed to explore the association between NSSI functions and body image.

2. Materials and methods

2.1. Participants

In the context of voluntary participation, 245 participants were initially approached at the outpatient units of two public mental health services, located in different cities in Spain, that provide multidisciplinary short- and long-term treatment for psychiatric disorders, primarily eating disorders. Five patients refused to participate because they did not want to fill out additional questionnaires. Finally, 240 patients completed the study, but we eliminated men (n = 14) due to their small representation in the total sample. Thus, the final sample was composed of 226 women diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5 [27]) criteria for eating disorders (ED), using the Structured clinical interview for DSM-5 disorders –Clinician version (SCID-5-CV) [30]. Of them, 23.5% (n = 53) matched bulimia nervosa -BN- criteria; 29.2% (n = 66) restricting anorexia nervosa -ANR; 10.2% (n = 23) purging AN –AN-BP; 12.4% (n = 28) binge-eating disorder –BED; 24.8% (n = 56) eating disorders not otherwise specified, EDNOS), with a mean age of 24.86 (SD = 11.8; range 12–60), and 24.3% (n = 55) met criteria for borderline personality disorder (BPD). The exclusion criterion was moderate or severe intellectual disability.

The majority of the participants had secondary education (51.3%, n = 116), followed by primary education (25.2%, n = 57), and higher education (23.5%, n = 53). Participants were European Whites, and 51.4% were single (n = 116), 4% were separated, divorced, or widowed (n = 9), and 44.7% were married or living with a partner (n = 101).

The sample was divided into three subgroups according to the presence or absence of non-suicidal self-injury (NSSI). Participants without NSSI made up the first group (G1: no NSSI, n = 144, 63.7%); those with lifetime self-injuries but not in the previous year made up the second group (G2: lifetime NSSI, n = 19, 8.4%); and those who had self-injured in the previous year made up the third group (G3: previous year NSSI, n = 63, 27.9%). In G2, the frequency of self-harm ranged from 1 to 1000, and in G3 it ranged between 1 and >500. Despite the
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