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**Functions of Non-Suicidal Self-Injury in Prisoners with Mental Health Diagnoses**

**Abstract**

Non-suicidal self-injury (NSSI) presents a serious concern for prisons, being particularly prevalent in prisoners with mental health difficulties. This study gained accounts of the functions of self-harm in a sample of adult, male prisoners with mental health difficulties and understand what they believe would help them reduce or stop their NSSI. Six semi-structured interviews were carried out and thematic analysis conducted. Four main themes were identified: Affect regulation, affective change following NSSI and mediators of NSSI. All participants cited affect regulation as the function of their NSSI and discussed the impact of the prison environment on the behaviour. Results highlight the importance of interventions targeting emotion identification, regulation and expression and coping skills within prison environments. This study was limited by its small sample size, however, findings indicate this would be a valid area for further research to gain greater understanding of NSSI within the

prison population, providing the opportunity to consolidate themes. This research focussed on the function of NSSI for prisoners as opposed to the nature, prevalence and context of these incidents, which research has traditionally focussed on. This is an important due to increasing rates of NSSI within the prison system in the context of resource pressures.

Key Words: Non-suicidal self injury (NSSI), prisoners, mental health, functions, affect-regulation.

## **Introduction**

In recent years increasing rates of NSSI observed in various populations have highlighted a necessity to further investigate this poorly understood behavioural phenomenon (Klonsky and Glenn, 2008). NSSI is most commonly defined as the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent (Favazza, 1998). The most commonly reported form of NSSI is skin cutting; other examples include ingestion of objects/substances, banging or hitting body parts and interfering with the healing of wounds (Klonsky, 2007).

NSSI is a prevalent issue in prisons. Ministry of Justice statistics for England and Wales identify an increase from 23,139 recorded incidents of self-injury/suicidal behaviour (irrespective of intent) in 2013 to 23,798 in 2014 (Safer in Custody Statistics in England and Wales, 2014). The report highlights a decline in rates of such behaviours in female prisoners as opposed to the increase of the behaviour in their male counterparts. The prison system has been under strain in recent years, with an increasing population and significant reductions in staffing (Hadley, 2014), NSSI places increases pressure. NSSI is detrimental to the safety, physical health and emotional wellbeing of prisoners and places financial strain on limited prison resources, significantly contributing to staff sickness and stress (Gallagher and Sheldon, 2010). Furthermore, longitudinal research has indicated that those who engage in NSSI are at a higher risk of attempting suicide (Cooper *et al.*, 2005; Owens *et al.*, 2002).

Palmer and Connelly (2005) highlight that a disproportionate number of offenders demonstrate characteristics which are known risk factors for NSSI, such as mental health difficulties (Nock, 2010), poor coping skills (Zamble and Porporino, 1990), trauma, family backgrounds characterised by criminality, alcoholism and abuse (Forth, 1995, Sarchiopone *et*

*al.*, 2009; Bennett & Moss, 2013; Smith 2015), poor problem solving and deficits in decision making skills (Jollant *et al.*, 2005, McMurrin *et al.*, 1999). Research has evidenced links between NSSI and major depression, substance abuse, posttraumatic stress disorder and schizophrenia (Klonsky and Glenn, 2008, Ennis *et al.*, 1989 McLaughlin *et al.*, 1996, Klonsky *et al.*, 2003; Wakai *et al.*, 2013; Smith 2015). Birmingham (2003) states that 90% of prisoners have at least one mental health disorder and literature highlights that a mental health diagnosis is a significant risk factor for a prisoner engaging in NSSI (Humber *et al.*, 2013, Applebaum *et al.*, 2011).

Research into NSSI has focussed on the nature, prevalence and context of the behaviour. However a growing evidence base provides insight in to the functions underlying NSSI; Klonsky (2007) carried out a systematic review of existing literature, finding evidence for several functions of the behaviour, including affect-regulation, feeling generation, self-punishment, anti-suicide and interpersonal influence. Much evidence investigating the cross-contextual functions of self-harm suggests that individuals use NSSI in an attempt to reduce negative affect and the act subsequently leads to an improvement in affect (Klonsky, 2010, Dixon-Gordon *et al.*, 2012). Such findings have also been evidenced in those with mental health diagnoses (Dierker and Kelley, 2007) and offenders (Sakelliades *et al.*, 2010, as cited in Dixon-Gordon *et al.*, 2012).

Snow (2002) utilised small space analysis to analyse the interviews of 143 prisoners. She found that the reasons prisoners engaged in NSSI was related to the build up of negative emotions leading to emotional overload or numbness. The use of NSSI was explained as being due to anger towards others, to experience physical pain, to relieve stress, tension or anger, the wish to see blood, an alternative to drugs and alcohol and an alternative to the outward expression of emotion. Jeglic *et al.* (2005) outlined the case studies of four prisoners who presented with self-harm, the functions they identified were depression and suicide intent, manipulative acts of self-harm, self-harm and emotional regulation and self-harm and psychosis. They emphasized the importance of functional assessment in understanding a person's self harm which can lead to an appropriate treatment plan. Smith (2015) employed interpretive phenomenological analysis to analyse the data from interviews with 17 male and three female prisoners. He identified themes relating to: Loss of control and negative affect relief, control and mental illness, control and prison, rage and self-directed violence, physiological responses and coping, condemnation of manipulators and others, and scars and survivorship.

Some research has focussed on the functions of NSSI in particular groups, such as these with personality disorders. Klonsky and Glenn (2009) developed the 'Inventory of Statements about Self-Injury (ISAS)' which is a measure of the frequency and range NSSI behaviours over a persons lifetime. Gardener *et al.*, (2016) used this with a group of male prisoners with and without Borderline Personality Disorder (BPD) traits. They found that the five most frequently endorsed reasons for NSSI within this population were self-punishment, anti-dissociation, interpersonal boundaries, affect regulation and interpersonal influence. Those with more BPD traits endorsed a broader range of functions. Bennett and Moss (2013) interviewed four prisoners with diagnosed personality disorders and identified a number of functions of NSSI, these included: Anger expression, revenge seeking, fascination, sensation seeking, self-punishment, affect-regulation, control, interpersonal influence and status seeking. Although this is a very small study, and employs a case study format to it's analysis, the majority of these themes have been identified in previous literature on the topic.

Although some of the studies looking at NSSI within the prison population have recognised the role mental ill-health plays in NSSI (e.g. Jeglic *et al.*, 2005; Smith, 2015), studies to date have tended to focus either on the general prison population or a sub-group of individuals who present with personality disorders. In addition most previous studies have tended to employ either a case study format or more prescriptive content analysis in their analysis of data. This study interviewed prisoners with a diagnosed mental illness and identified common themes across the data. In addition, previous studies have not asked the prisoners views about what they would find helpful in managing their NSSI.

The existing evidence base lacks detailed, self-reported accounts of the functions of NSSI in the specific population in the current study. It is hypothesised that in obtaining such accounts we may develop a deeper understanding of the underlying reasons for the behaviour in prisoners diagnosed with a mental health difficulty, the specific research questions being 'what are the functions of NSSI in a sample of adult male prisoners with a mental health diagnosis?' and 'what are these prisoners views about what may be helpful in reducing or stopping their NSSI?'

## **Method**

Semi-structured interviews were carried out with six adult, male prisoners from a local, category B prison. A category B prison is defined as an establishment housing prisoners who do not require the highest level of security but for whom escape should be made difficult (National Security Framework Categorisation and Re-categorisation of Adult Male Prisoners, NOMS 2011).

### *Participants*

Participants were over 18 years old and had a history of repetitive (defined as upwards of four incidences in the previous 3 months) non-suicidal NSSI during their current prison sentence. Prisoners placed on the Healthcare wing and who were currently experiencing acute mental health symptoms and were excluded as they were considered to be too vulnerable to participate. Participants were white British males, aged between 18 and 60 and all had sentences of 18 months or longer. All had a diagnosis of depression, four had a diagnosis of schizophrenia and one participant had an acquired brain injury. Half of the participants had a history of NSSI prior to their current period of incarceration.

### *Recruitment*

A member of prison staff acted as a gate-keeper and identified potential participants and nine of these men were randomly selected. Participants were deemed by prison staff as being able to provide informed consent. A total of nine prisoners were approached to take part and provided with an information sheet regarding the study; two declined for unknown reasons and seven initially agreed to participate; however one prisoner later declined to be seen by the researcher.

### *Procedure*

In order to maintain confidentiality and for the participants to remain anonymous, written consent was not taken but verbal consent was spoken and recorded at the beginning of each interview. A semi-structured, face-to-face interview comprised of open-ended questions was employed to allow participants to discuss their views, feelings and experiences (Howitt, 2010) and to give a depth of meaning to the data. This method also ensured that the researcher was able to maintain focus and gather data which successfully addressed the research questions. It was hoped that the use of this method would create an informal atmosphere and be less

intimidating to participants who may have literacy issues and no experience of participating in research. All interviews were audio-recorded and carried out by the first author in a private room on each participant's prison wing. The average length of interview was 50 minutes. Participants were provided with the details of a member of prison healthcare staff they could contact following the interview should they require additional support or to discuss any issues raised.

### *Analysis*

Anonymised interview transcripts were analysed using the thematic analytic approach described by Braun and Clarke (2006). The process involved familiarisation with the data, examining transcripts to produce initial codes, organising potential themes and sub-themes, reviewing identified themes, refining and naming each theme and selecting suitable quotations to represent each one. Thematic analysis was employed for data analysis as it allows for exploration of the experiences, meaning and reality of individual's accounts (Braun and Clarke, 2006) and enables exploration of the views, perceptions and experiences of individuals (Caulfield and Hill 2014).

### *Ethical Considerations*

Ethical approval for the research was obtained from the Cardiff Metropolitan University and Group 4 Security who ran the prison.

## **Results**

Through analysis, four main themes and 10 sub-themes were identified: affect-regulation (anger, frustration, depression), affective change following NSSI (relaxation, relief), coping (coping skills, coping with prison environment, coping with past events) and factors mediating NSSI (medication, social support).

### ***Affect Regulation***

Affect-regulation was cited by all participants as the primary function of their NSSI. Participants discussed an internal build up of emotion which they attempted to relieve through somatic expression, which was usually cutting of the arms. Anger, frustration and depression were the emotions they reported prior to NSSI; the source of these feelings included childhood trauma and grief over the death of loved ones, although participants occasionally found it difficult to identify the cause of the feelings.

#### *Anger and Frustration*

Anger was cited as an emotion which would lead to NSSI: *'I start getting agitated and getting angry and then I start thinking to self-harm, that's the trigger'*. One participant talked of the grief he has experienced following his mother's death and childhood abuse; both of which remained a source of much anger for him: *'If my father was still alive I would be doing life now instead of eighteen months, I would have definitely killed him. I would have. That's the feeling I gets in my head see...stuff like that'*.

Two participants reported feeling increasingly frustrated before an episode of NSSI, which would act as a physical release for these feelings: *'it's a lot of frustration, you just don't know what to do with it all'*: *'I still have little moments where I scratch to try and get the pain out, it's frustration like...it's my way of getting those feelings out'*.

#### *Depression*

Participants reported engaging in NSSI when they became increasingly depressed, until they used NSSI to relieve these feelings: *'my mood gets down and down. One specific thing I think leads to it, I think is depression. I get lower and lower moods'*: suggesting that when depression leads to NSSI, the decline is slower and steadier than was reported with feelings of anger or frustration.

Participants struggled at times to identify specific emotions and difficulties in emotional expression were evident in their dialogue; *'it's a bit of a mixture of feelings...I don't really know'*; *'I don't know, just feel upset, it's just such a mixture of emotions, it's quite hard to explain'*. Many participants could not describe their thoughts; *'I don't know that thing in my head, I got that much going on in my head, I just get caught up'*. Such difficulties may contribute to the internal state leading to NSSI as prisoners were unable to identify or express their feelings. Interestingly one participant reported using NSSI when he felt any degree of

emotion, positive or negative; *'it's when I start feeling any emotions, it can be angry, happy, anything will send me off to do something'*.

### ***Affective change following NSSI***

Participants reported changes in affective intensity and valence following an episode of NSSI. They reported feelings of relief, peacefulness and relaxation, and that the injury was a bodily outlet of emotion. They described how the pain and sight of blood would contribute to feelings of relaxation, seeing the blood as a visual release of tension from the body; *'like watching the problems pour out of you'*. This finding indicates that physical and visual factors such as the sight of lacerated skin and blood-letting may contribute to the down-regulation.

### ***Relief***

Participants reported a significant reduction in negative affect following NSSI. The primary feeling participants reported was of release; *'it's like watching the problems pour out of you, like watching everything disappear'*, indicating that the blood contributed to the feelings of release. One participant reported that the wound was an opening to release the emotional pain felt; *'when I'm cutting I feel better because it gives you that relief... it's like watching it go, it just goes out of you'*.

### ***Relaxation***

Participants commonly reported relaxation and tension reduction following NSSI: *'just feel calm and relaxed like, it's unreal like, it's such a calm feeling, it's just a nice feeling'*. One participant said NSSI had a normalising effect and returned him to a more relaxed baseline, *'I want to do something to myself straight away, as soon as possible, just to get back to normal'*.

Another participant felt euphoric after NSSI, before regretting his actions; *'I was really happy but in a mad way, a maniac type of happy, blasted my music in my cell and started my own rave. Then I started crying, you feel happy but it's not for long, ten minutes later you realise how much of an idiot you've been'*. This participant reported a cycle of anger, frustration and guilt becoming elation or relief after NSSI then returning to anger and guilt for giving into the urge for NSSI.

### ***Coping***

Difficulty coping with internal affective states led participants to use NSSI. Many felt the behaviour was destructive were unable to express themselves or self-soothe. Participants preferred method of NSSI was skin cutting. Some had spent time under close observations due to their NSSI, when they could not access to sharps so would instead burn themselves with lighters. One participant reported that if staff removed the lighter from his possession he would consider using wall sockets to burn/shock himself.

### *Coping Skills*

NSSI helped participants cope with overwhelming emotions, which they were otherwise unable to express. All wanted to stop their NSSI but, they did not know of another way to process their feelings: *'it was the only way to cope with everything that was going on'*; *'I can understand wanting to get it out of me but I think this is the worst way to do it, but how else can you take your anger out'*? Participants talked about using substances to cope when living in the community but would turn to self-harm when in prison: *'On the out if I was angry I'd turn to drink straight away. That didn't really help either but I'd certainly rather have a drink than start hurting myself'*.

Participants wanted to learn different ways to cope with stressors; *'finding other ways to cope with everything [would help], I've done it for five years, it's the only way I know how to cope with everything. It doesn't matter what your problem is, it's there and it helps for that period of time'*. One participant who had recently stopped using NSSI had discovered writing to express himself: *'I've just found ways of coping, different mechanisms'*.

### *Prison Environment*

Prisoners reported difficulties in adjusting to prison and coping with the environment. Half of the participants self-injured prior to prison admission and believed they would stop after release; suggesting that the prison environment may be a sufficient trigger for those with mental health difficulties and coping deficits to initiate NSSI. Some anxiety experienced by participants was directly related to the environment: *'In this place there's always something bad happening'*; *'obviously there's people inside that don't cut themselves up in prison, obviously they know a way to deal with prison'*. One participant who engaged in NSSI prior to imprisonment did so more frequently when in prison: *'it's not a great place to be, it do tend to make you worse, you do it more in here'*. Another said that a lack of social support contributed to the build up of negative emotions. He noted an artificial comradeship between

prisoners: *'everyone seems all friendly in prison but they're not, they're not friends. Most of the people around you aren't really nice people'*. For this participant the restrictions of the prison environment and being surrounded by offenders triggered disturbing memories of childhood trauma: *'I don't like being two-ed up with anyone; was abused when I was a kid so I'm scared just in case, I never know what people are here for'*.

#### *Previous Trauma*

Participants reported that ruminating over childhood trauma increased the urge to use NSSI. Childhood abuse during childhood was mentioned by three of the six participants: *'when I was getting down and that I was thinking about the past and stuff that's happened'*, *'my mum and stuff like that, what my father used to do to us. I was abused when I was a kid, everything like that just gets on top of me'*, *'stuff from when I was a kid, I was abused by my dad when I was a kid and stuff like that, it just starts me off'*.

#### **Mediators of NSSI**

Participants discussed factors that increased or reduced their NSSI.

#### *Effects of medication*

A participant who had recently stopped NSSI attributed it to his antidepressant medication. However two other participants reported an increase in NSSI since taking antidepressant medication. One participant said that the medication had ended a long period of dissociation but he was unable to cope with his emotions, which led to more frequent episodes of NSSI: *'it's only since I've been put on the tablets that I can feel emotions again. I don't know whether that's a good or bad thing'*: another said *'there have been quite a few incidents since I've been on the tablets'*. Another participant had not used NSSI for a long time until taking antidepressant medication: *'I haven't done it too much until recently, I'm not sure why. I've recently started medication; they've said they might make you worse at first'*.

#### *Social Support*

Participants discussed the importance of social support in mediating their NSSI: *"if I could just ring my mate up and speak to him it might be easier. Or if I could speak to my family, 'I'll talk to someone who makes me laugh, that usually snaps it out of me'*. They felt frustrated at not having a confidante inside the prison, as this would be an outlet which may decrease the urge

for NSSI: *“it would be alright if you had a mate you could talk to in here”*. One participant had recently stopped using NSSI with help from the prison inreach mental health team, having had the opportunity to talk: *‘I speak to somebody, that will help me’*. Two participants said that it would be helpful for prisoners to discuss their NSSI with someone who has experienced it, and spent time in the prison environment, rather than staff formally trained to deal with such issues; *‘you could talk to them more because they would know how it feels’*. Of the two participants who had recently stopped NSSI, two said they had done so with the support of others: *‘every time I get thoughts about self-harm, I speak to my cell mate or staff’*.

## **Discussion**

This preliminary research provides insights into the functions of NSSI in adult, male prisoners with mental health difficulties and what they feel would help them reduce or prevent the behaviour. Participants discussed their difficulties expressing and coping with strong emotions, past traumatic events and prison life. These are themes that have been recognised in previous studies within the prison population (Snow, 2002; Bennett & Moss, 2013; Smith, 2015). Interestingly, their reference to prison life related to witnessing negative events and the lack of social support they experienced as opposed to feelings associated with lack of control. Lack of control was not identified by any of the participants in any domain. Smith (2015) discussed the lack of control prisoners felt but also later discusses how isolation can reinforce a sense of loneliness and aggravate pre-existing mental health conditions. It is possible that this a difference in found in prisoners with mental health difficulties.

Prisoners in this study reported the release they experienced watching the blood flow, and the use of NSSI as a replacement for substances, these functions have also been found in previous research (Snow, 2002; Bennett & Moss, 2013). Similarly the relationship of NSSI with anger, low mood and the coping are identified within previous work (Snow, 2002; Jeglic *et al.*, 2005; Smith, 2015; Bennett & Moss, 2013). The results of this study contribute to a growing evidence base supporting the affect-regulation function of NSSI in various populations, but particularly in relation to this study, prisoners who present with NSSI (e.g. Dixon-Gordon *et al.*, 2012; Snow, 2002; Jeglic *et al.*, 2005; Bennett & Moss, 2013; Smith, 2015; Gardener *et al.*, 2016) and provide insight into the functions underlying self-harm in male offenders with mental health diagnoses. It is noteworthy that prisoners with mental health difficulties show

similar functions to NSSI in other forensic populations, there is more common ground than difference (Jeglic *et al.*, 2005; Smith, 2015). This may be due to the fact that mental ill-health has been a recognised function of NSSI identified within other studies and therefore this is in fact the same population being studied, that is most prisoners who engage in NSSI have underlying mental health conditions.

When asked what would be helpful in managing their NSSI prisoners reported mixed outcomes in relation to medication. The participant reports of increased NSSI since taking antidepressant medication provides support for previous literature highlighting a link between antidepressants and an increase in NSSI (Waechter, 2003). This relationship is more commonly noted in adolescents and young people (Gunnell and Ashby, 2004); accordingly the participants reporting this in the current study were the youngest of the sample (aged 18 and 20). This association requires further investigation due to the well evidenced link between depression and NSSI (e.g. Klonsky and Glenn, 2008) and therefore higher likelihood of such individuals being prescribed antidepressant medication upon presentation to mental health services.

Participants did however say that the support of others would, or has, reduced the frequency and severity of their NSSI. Gardener *et al.*, (2016) refers to the endorsement of 'interpersonal influence' within her population, in terms of letting others know about ones emotional pain or seeking care and help from others. This clearly has implications for practice. Historically terms such as attention seeking and manipulation have been used to describe NSSI in prisoners (e.g. Jeglic *et al.*, 2005), Smith (2015) has gone to great lengths to explore these beliefs and identifies these views lack an evidence base and are counter-therapeutic, often leading to punitive approaches. Gardener *et al.* (2016) argue that interpersonal reasons offered for NSSI should not reinforce the perceived manipulative function of NSSI but be seen as one of multiple inter and intra personal functions of self harm that highlight the complexity of reasons behaving NSSI. Prisoners in this study are simply asking for someone to talk to when they feel distressed, to help them 'snap out of it', or soothe them.

There are limitations to the current research. As this was a preliminary study, the sample size was small; however, it has been helpful in showing the validity, and importance of further, larger-scale studies of self-harm with male prisoners with mental health difficulties to clarify and consolidate themes related to their experiences. Prisoners housed on the Healthcare wing

were excluded from participating as are considered particularly vulnerable. However, this included those who have recently engaged in NSSI, and inflicted moderate to severe injury on themselves; the exclusion of these people is important to note as they may report issues not discussed by the current participant group. Individuals with active symptoms of mental illness were not approached; it should be noted that different experiences may be reported in such individuals, and similarly, in those detained in forensic inpatient settings with greater psychopathology. Future research may consider qualitative research with such individuals' self-reported accounts of NSSI, with an appropriate follow-up procedure in place. A participant sample for such research may be recruited from a prison healthcare wing or a secure psychiatric facility. Future research could also use more quantitative methods, such as using the 'Inventory of Statements about Self Injury' (Klonsky & Glenn, 2009) with a much larger sample of prisoners with mental health difficulties.

Although participants were willing to openly discuss their NSSI it should be acknowledged that the participants had met with the researcher only once prior to the interview taking place, therefore there was no opportunity to build a relationship over time and participants may have been less inclined to discuss the sensitive issue of NSSI. The absence of a pre-existing relationship with the researcher may have also increased the likelihood of participants' responses being influenced by social desirability bias, particularly if their NSSI was related to their offending history. Participants discussed retrospective incidences of NSSI; such data may be affected by recall issues, particularly as NSSI is often carried out in a state of emotional arousal, which may affect the quality and reliability of the memories. Participants had difficulty identifying and expressing emotions, which may have implications for the validity and reliability of their reporting of these emotions and identifying and articulating the process' influencing NSSI. However, despite this the data was rich enough to conduct a qualitative analysis and provided narratives which had the depth required to offer the detailed insights provided. In future studies the data should be analysed by more than one individual and transcripts checked back with participants to ensure their views are validly represented (Fereday and Muir-Coachrance 2006).

There are some practical implications for mental health staff working within a prison context. Training should be offered to enable staff to understand the origins, antecedents and functions of NSSI, as well as helpful interventions. The aim would be to promote empathy and understanding within staff with the hope of promoting supportive and enabling approaches

as opposed to punitive and isolating ones. Bennett and Dyson (2014) identified that knowledge, staff skills, environment and treatment resistance act as barriers to the implementation of NSSI reduction policies in prisons. Accordingly, Marzarno *et al.* (2012) reported that prison staff (including doctors and nurses) do not feel equipped to deal with NSSI, which leads to them responding to such incidents with hostility. Punitive responses just serve to replicate prisoner's primary abusive experiences leading to feelings of rejection and isolation (Smith, 2015). It is concerning that half of this sample had not engaged in such behaviours prior to being in prison so it should be recognised there are aspects of the prison environment that trigger or increase the risk of NSSI, and additional specialised support should be provided to those who are thought to be at risk of engaging in NSSI. To reduce NSSI in the prison population the attitudes, skills and training issues with prison staff should be addressed. In recent years prisons have introduced measures in an attempt to reduce NSSI. The Assessment and Care in Custody and Teamwork (ACCT) procedure ensures that those believed to be at risk of harm to themselves receive additional staff support (Management of prisoners at risk of harm to self, to others and from others: Safer Custody, NOMS, 2013). Those implementing ACCT often lack the knowledge and training required to offer appropriate psychological support to individuals presenting with NSSI, training and access to appropriately trained professionals may be helpful. Given the importance participants placed on having access to social support in prison, the facilitation of support networks and peer mentoring may be beneficial in reducing NSSI, particularly when prisoners initially admitted, which is a time of heightened risk.

Multidisciplinary and multiagency collaboration and information sharing should be encouraged to ensure that staff have sufficient information to work with individuals presenting with NSSI. The causes and functions of NSSI for individuals should be explored with the aim of providing appropriate interventions to address the underlying causes. In responding to an incident of NSSI the priorities should be initial treatment of physical injuries and then efforts made to stabilise any underlying mental health issue. Issues should be discussed in a private and respectful manner with prisoners (Smith, 2015).

In terms of social support, many prisons have implemented a Listener Scheme, which trains volunteer prisoners to provide confidential support to distressed peers (Dhaliwal and Harrower, 2009). Improvement in affect following NSSI may positively reinforce the behaviour and the probability of resorting to NSSI to self-soothe (Smith, 2015). The references to relief

and relaxation following NSSI contribute to an extensive evidence base in various populations experiencing these feelings following an episode of NSSI (e.g. Harris 2000, Muehlenkamp, 2005). This study illustrates the need for interventions targeting emotional regulation and coping skills in this population, to reduce the use of NSSI to regulate emotions (such as Dialectical Behaviour Therapy (Linehan, 1993). This supports findings in other populations that suggest that NSSI interventions should focus on improving emotion-regulation skills (Walsh, 2007; Linehan *et al.*, 2006; Low *et al.*, 2001). Bennett and Moss (2013) noted that there was an evolution of the functions of NSSI and that level of insight into these functions improved in relation to the amount of treatment completed. The current results suggest that those prisoners who experience trauma or have mental health difficulties may benefit from such interventions.

In conclusion, this preliminary and exploratory study has highlighted the need for further research in this area with a larger participant group. Within this study, prisoners with mental health difficulties described NSSI as serving the function of affect regulation, affective change and coping. These findings are consistent with research on the functions of NSSI within other populations. Current results identified the mediators of NSSI as social support and medication. The clinical implications of these findings have been outlined. Limitations and suggestions for further research have also been identified.

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