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CHARACTERISTICS OF FAMILIES WITH ADOLESCENTS WHO HAVE ENGAGED IN NON-SUICIDAL SELF-INJURY

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Non-suicidal self-injury (NSSI) in adolescents is a complex phenomenon determined by numerous individual, family and sociocultural factors. The aim of the study was to determine whether families with adolescents who have engaged in NSSI differ in functionality from families with no NNSI adolescents. The study involved 99 adolescents, of both sexes, aged 14-18, divided into two groups: the clinical and the control one. The clinical group included adolescents who had engaged at least once in deliberate self-injury, confirmed by an objective physical examination and anamnestic interview with the respondents. The control group consisted of adolescents with no history of NSSI or another psychiatric disorder. A questionnaire designed for the purpose of this study and FACES III (Family Adaptability and Cohesion Evaluation Scale) were used. Disengaged and separated families (51% and 24.5%, respectively) were dominant in the clinical group, while the dominant ones in the control group were separated (53.1%) and connected families (26.5%). The clinical group was dominated by rigid (51.0%) and chaotic (22.4 %) families, while in the control group they were flexible (42.9%) and structured (36.7%). The results showed a markedly significant difference in the categories of cohesiveness and adaptability between the examined groups. The clinical group had predominantly disengaged/rigid families (36.7%), while the presence of all other levels was less than 10.0%. The control group was dominated by flexible/separated (30.0%) and structured/separated families (20.0%). The study revealed that families with adolecsents who had engaged in NSSI differed from the ones with no NNSI adolescents in terms of functionality on FACES III. These results confirmed the previously obtained results on the connection between family dysfunctionality and engaging in NSSI behavior in adolescents and can have clinical implications in working with the vulnerable group of adolescents and their families.

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Key words: *non-suicidal self-injury, family functionality, FACES III*

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Introduction

Nonsuicidal self-injury (NSSI) refers to the deliberate, self-inflicted destruction of body tissue without suicidal intent, and for purposes not socially sanctioned. It includes behaviour such as cutting, burning, biting and skin scratching (1). NSSI has been shown to be a common phenomenon in adolescents both in clinical and community samples. The incidence and prevalence of self-injury is mainly unreliable due to the fact that self-injury is inflicted in secret or it is not clearly recognizable. In general population, only 10%-15% of adolescents who engage in self-injury seek help in hospitals, which indicates that there is a large number of unrecorded cases of adolescents with mental disorders, including serious psychiatric disorders (2-4). In the clinical population of adolescents, self-injury is more common in comparison with the general population, and is often in comorbidity with borderline personality organization, depressive or anxiety disorders (PTSD), eating disorders, and psychoactive substance abuse (4). Nonsuicidal self-injury may also be present without any psychiatric comorbidities (5).

Motivation for NSSI as well as its function is extremely individual. Adolescents who engage in self-injury can also be classified according to the function of NSSI. These functions can change and

overlap over time, and serve to express different aspects of the same events. Klonsky (6) carried out a comprehensive review of theoretical views on the functions of NSSI and research to date in the field. Seven main categories of NSSI functions were derived from this review: affect regulation, self-punishment, anti-dissociation, interpersonal influence, interpersonal boundaries, sensation-seeking, and anti-suicide (6). The emotional cascade model asserts that NSSI serves as a form of distraction which temporarily reduces negative emotion and increases a perception of relief or even wellbeing. In this way, NSSI represents a negative reinforcer in the emotion-behavior interaction (7).

There are various interpretations as well as numerous prejudices about the causes of non-suicidal self-injury in young people. Its genesis involves a large number of individual, family and sociocultural factors. With regard to family factors, authors differ in stressing the role of families in genesis and maintenance of NSSI in young people. It is stated that dysfunctional families (8), lack of parental support (9, 10), parental criticism (11) and family conflicts (12) increase the risk of non-suicidal self-injury in children.

Within the framework of systemic family therapy, Olson's Circumplex Model of marital and family relationships, reviews family functionality through two basic dimensions: family cohesion and adaptability (13). Cohesion refers to the emotional connections existing among the family elements and describes the way the family understands the balance between union and individuation.There are four levels of cohesion: disengaged, separated, connected, and enmeshed. It is assumed that the central levels of cohesion (separation and connection) are the most desirable for optimal family functioning, since they allow family members to freely experience separation and connection, while being separated and connected to their family at the same time. Extreme leves of cohesiveness (disengaged and enmeshed) are generally seen as a problem in family functioning (13). Adaptability refers to the balance between stability and change. A familial system's adaptability describes its flexibility in changing its structure, roles and relational rules in response to different situations and developmental stress. There are also four levels of adaptability: rigid, structured, flexible, and chaotic. It is believed that the central levels are better for the successful functioning, while the extremes are problematic. According to Olson's theory, in order for a family to be functional, it must be flexible in terms of adaptability and separated in terms of cohesiveness (13).

To the authors' knowledge, there have been no studies using Olson's Circumplex Model for the assessment of the functionality in families with adolescents who have engaged in NSSI in our surroundings. Hence the idea for precisely examining these dimensions of family functionality, which would contribute to a better understanding of this complex phenomenon from the aspect of family functioning.

Aims

The aim of the study was to determine whether families with adolescents who have engaged in NSSI differ in functionality from families with no NNSI adolescents on FACES III. The hypothesis was that families with NSSI adolescents are generally less functional than families with no NSSI adolescents on FACES III.

Methodology

The study was conducted in the period from December 2017 to December 2018 at the Department of Child and Adolescent Psychiatry, Center for Mental Health Protection, Clinical Center Niš, Serbia.

Sample description

The study included a total of 99 adolescents divided into two groups: the clinical and control one. The clinical group included adolescents who had engaged at least once in deliberate self-injury, confirmed by an objective physical examination and anamnestic interview with the respondents. The control group consisted of adolescents with no history of NSSI or another confirmed psychiatric disorder. The respondents in the groups were of both sexes, aged 14-18, chosen by convenience sampling. The clinical group consisted of respondents who were treated at the Department of Child and Adolescent Psychiatry at the Department of Mental Health Protection at the outpatient clinic or hospital, and were willing to participate in the study, which they confirmed by signing an informed consent. The control group consisted of adolescents from the general population, without the diagnosis of psychiatric disorders.

Instruments

The study used FACES III (Family Adaptability and Cohesion Evaluation Scale), i.e. a questionnaire for assessing family adaptability and cohesion (14). Family cohesion represents the degree of separation or connection among family members and differentiates among four levels of cohesion: disengaged, separated, connected, and enmeshed. There are also four levels of adaptability: rigid, structured, flexible, and chaotic. FACES III consists of 10 cohesion items and 10 adaptability items. The instrument asks the respondents to indicate how frequently the described behavior occurred in his or her family on a Likert scale from 1 (almost never) to 5 (almost always). The total scores of cohesion and adaptability respectively ranged from 10 points to 50 points. Internal consistency was also tested in the sample of adolescents and was deemed acceptable (Cronbach α = 0.76 for family adaptability; α = 0.81 for family cohesion). A general questionnaire designed for the purpose of this study included information regarding the respondents' gender and age, as well as family structure and socio-economic status.

Data processing

The data are presented in the form of an arithmetic mean and a standard deviation, i.e. in the form of absolute and relative numbers. Continuous variables were compared using the t test, while Chi-square test was used to compare the observed and expected frequencies. The hypothesis was tested with a significance threshold of $p < 0.05$. Statistical data processing was performed using the SPSS 16.0 software package.

Results

The study included 49 respondents within the clinical group and 50 respondents in the control group. The groups were age-balanced ($p = 1.000$). There were significantly more female respondents in the clinical group than in the control group (69.4% vs 40.0%, $p = 0.006$) (Table 1). Families with two children were dominant in both groups (63.3%, and 72.0%, $p = 0.416$). There were more families with divorced parents in the clinical group (30.6%), compared to the control group (14.0%), but no statistically significant difference was found ($p = 0.081$). In both groups, the socio-economic status was predominantly average (63.3%, or 70.0%, $p = 0.605$) (Table 2).

Disengaged and separated families (51% and 24.5%, respectively) were dominant in the clinical group, while the dominant ones in the control group were separated (53.1%) and connected families (26.5%). There was a statistically significant difference in cohesion between the two examined groups ($p < 0.001$) (Table 3).

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The clinical group had predominantly disengaged/rigid families (36.7%), while the presence of all other levels was less than 10.0%. The control group was dominated by flexible/separated (30.0%) and structured/separated families (20.0%). All other family types were present in a significantly lower percentage (Table 4).

Table 1. Demographic characteristics in the clinical and control group

Parameter	Clinical group		Control group		p
Gender	Number	%	Number	%	
Male	15	30.6	30	60.0	0.006[1]
Female	34	69.4	20	40.0	
Age†	15.00 ± 1.22		15.00 ± 1.21		1.000[2]

[1]Chi-square test, [2]t test, †Arithmetic mean±standard deviation

Table 2. Family structure and economic status in the clinical and control group

Parameter	Clinical group		Control group		p[1]
	Number	%	Number	%	
№ of children in the family					
One	6	12.2	7	14.0	0.416
Two	31	63.3	36	72.0	
More	12	24.5	7	14.0	
Divorce					
Yes	15	30.6	7	14.0	0.081
No	34	69.4	43	86.0	
Socio-economic status					
Below average	16	32.7	12	24.0	0.605
Average	31	63.3	35	70.0	
Above average	2	4.1	3	6.0	

[1]Chi-square test

Table 3. Cohesion and adaptability in the examined groups

Parameter	Clinical group		Control group		p[1]
Cohesion	Number	%	Number	%	
Disengaged	25	51.0	5	10.2	< 0.001
Separated	12	24.5	27	53.1	
Connected	5	10.2	13	26.5	
Enmeshed	7	14.3	5	10.2	
Adaptability					
Rigid	25	51.0	5	10.2	< 0.001
Structured	8	16.3	19	36.7	
Flexible	5	10.2	21	42.9	
Chaotic	11	22.4	5	10.2	

[1]Chi-square test

Table 4. Distribution of families according to the dimensions of cohesion and adaptability in the examined sample

Clinical group								
Cohesion	**Disengaged**		**Separated**		**Connected**		**Enmeshed**	
Adaptability	Number	%	Number	%	Number	%	Number	%
Rigid	18	36.7	4	8.2	3	6.1	0	0.0
Structured	2	4.1	3	6.1	1	2.0	1	4.1
Flexible	1	2.0	2	4.1	0	0.0	2	4.1
Chaotic	4	8.2	3	6.1	1	2.0	3	6.1
Control group								
Cohesion	**Disengaged**		**Separated**		**Connected**		**Enmeshed**	
Adaptability	Number	%	Number	%	Number	%	Number	%
Rigid	1	2.0	2	4.0	2	4.0	0	0.0
Structured	2	4.0	10	20.0	5	10.0	2	4.0
Flexible	1	2.0	15	30.0	5	10.0	0	0.0
Chaotic	1	2.0	0	0.0	1	2.0	3	6.0

Discussion

The study found that adolescents who had engaged in NSSI were more likely to have divorced parents in comparison with the control group. While some studies do not find an increased incidence of NSSI in children with divorced parents (15, 16), others confirm this connection (17). One study found a significant increase in the incidence of NSSI in children whose parents remarried (18). It is believed that increased demands in performing parental functions, lack of support from the biological partner, and often low socio-economic family status can lead to an insufficient emotional and physical presence of the parent with whom the child lives. Regardless of age, research shows that 25% of children from incomplete families (compared to 10% of children with both parents) have difficulties in school, behavioral problems (delinquent behavior, emotional outbreaks), mood disorders, low self-esteem and unsuccessful intimate relationships (19). In terms of the socio-economic status, there was no significant difference among the families in the examined groups, which is in accordance with literature data (20).

It is a unified view that families with adolescents are in a very specific life cycle phase that sets new tasks and goals before both the adolescent and their family. The family dynamics significantly changes when a child goes through the period of adolescence. Due to the essential importance for the development of young people, adolescence is a period in which all weaknesses and failures in the family system are revealed. In case a family fails to meet the need for security and love, when there is emotional disengagement of family members or excessively rigid boundaries and the inability to establish new ones and reorganize family rules, the adolescent will show their dissent openly, turbulently or

specifically - through various emotional problems or specific psychopathological symptoms.

One of the most common findings mentioned in the literature on the non-suicidal self-injury in adolescents is that individuals who engage in NSSI come from families which are dysfunctional at multiple levels (21). Dysfunctional families are characterized by disturbed structures, boundaries, roles, leadership, unnatural alliances, and failure to solve problems. Dysfunctional families are inflexible and poorly adaptable, their interactions do not change according to the child's developmental needs and events in the surrounding. The literature seems to confirm associations between family functioning and various forms of dysfunction, especially depression and anxiety symptoms (22) as well as suicidal behavior (23) in adolescents.

The study found that the functionality of families with NSSI adolescents is significantly different from the family functionality in the control group in both examined dimensions on FACES III – cohesiveness and adaptability. The largest number of adolescents in the study group came from disengaged families, i.e.families with extreme low cohesion. Members of such family systems very rarely interact with other family members, and significantly promote separation and independence, at the expense of closeness and togetherness. In disengaged family systems, everyone usually performs their own tasks and prefers to have their own time, interests and space. Family members cannot rely on each other when it comes to support or solving problems (13).

Emotional attachment and family support facilitate psychological development in adolescence. Some authors (24) showed that perception of family cohesion and adaptability were associated with adolescents' ability to express emotions and to manage stressful situations through positive coping skills. In contrast, low cohesion and poor satisfaction with family relationships represent a serious risk for the psychological adjustment of adolescents. Those adolescents who have negative perceptions of family relationships have more psychopathological symptoms when dealing with stressful situations than adolescents with harmonious family relationships (25). Studies confirm that low family cohesion indirectly increases the risk of NSSI in children (through emotional regulation), especially in females (12).

While some studies show no differences in NSSI risk associated with family adaptability (26), the other results point out that elevated risk for NSSI is associated with greater family rigidity (27). The respondents from the clinical group in our study significantly more often come from families with low adaptability compared to the respondents from the control group, i.e. they come from families with rigid family functioning. Rigid families exhibit excessive rigidity and control, no negotiation, and most decisions are made by the leader. The rules of conduct are therefore strict and limited and there is limited communication among family members (13).

The results of our study on the functioning of families with NSSI adolescents indicate that the examined families are, in most cases, disengaged in terms of cohesion and rigid in terms of adaptability. According to Olson's Circumplex Model, this type of family is considered to be extreme in terms of both dimensions of family functioning (13). The limitation of this study is in its methodology and refers to a small sample of respondents and a method of assessing family functioning. Having in mind that a self-assessment tool was used (which always carries the risk of subjectivity), it is recommended that more family members be included in the following studies on this topic to verify the conformity of their assessment, which would give a more realistic picture of family functionality.

With regard to the implications of the obtained results on the relationship between family functionality measured by FACES III and NSSI in adolescents, we can point out that this simple family self-assessment can be useful in dealing with high risk families. It is also possible to effectively single out the cases of young people where work with the family would be of significant importance, while functional scores for some of the FACES III dimensions could be of benefit to family therapists.

Conclusion

The study revealed that families with adolescents who had engaged in NSSI differed from the ones with no NNSI adolescents in terms of functionality on FACES III. It was shown that families with adolecsents who had engaged in NSSI are more commonly grouped within the zones of low family cohesion and adaptability in comparison to the control group. These results confirmed the previously obtained results on the connection between family dysfunctionality and engaging in NSSI behavior in adolescents and can have clinical implications in working with the vulnerable group of adolescents and their families.

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KARAKTERISTIKE PORODICA ADOLESCENATA SA NESUICIDALNIM SAMOPOVREĐIVANJEM

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Nesuicidalno samopovređivanje (engl. NSSI) među adolescentima je kompleksni fenomen determinisan mnogobrojnim individualnim, porodičnim i sociokulturalnim faktorima.

Cilj istraživanja bio je da se utvrdi da li se porodice adolescenata koji se samopovređuju razlikuju po stepenu funkcionalnosti u odnosu na porodice u kojima nema samopovređivanja adolescenata.

U istraživanju je učestvovalo 99 adolescenata, oba pola, uzrasta od 14 do 18 godina, koji su podeljeni u dve grupe: kliničku i kontrolnu. Kliničku grupu činili su adolescenti koji su načinili najmanje jednu namernu samopovredu, što je potvrđeno objektivnim kliničkim pregledom i anamnestičkim intervjuom ispitanika. Kontrolnu grupu činili su adolescenti koji nemaju istoriju samopovređivanja, niti drugi psihijatrijski poremećaj. U istraživanju je korišćen upitnik sačinjen za potrebe istraživanja i FACES III skala (Family Adaptability and Cohesion Evaluation Scale).

U kliničkoj grupi dominiraju razjedinjene (51,0%) i udaljene (24,5%) porodice, a u kontrolnoj grupi dominiraju udaljene (53,1%) i povezane (26,5%) porodice. U kliničkoj grupi dominiraju rigidne (51,0%) i haotične (22,4%) porodice, a u kontrolnoj grupi fleksibilne (42,9%) i strukturirane (36,7%). Utvrđeno je da postoji statistički značajna razlika u kategorijama kohezivnosti i adaptabilnosti među ispitivanim grupama. U kliničkoj grupi najviše je razjedinjenih/rigidnih porodica (36,7%), a učestalost svih ostalih porodica manja je od 10,0%. U kontrolnoj grupi dominiraju fleksibilne/odvojene porodice (30,0%) i strukturirane/odvojene porodice (20,0%).

Ovim istraživanjem utvrdili smo da se porodice adolescenata, koji se samopovređuju razlikuju po stepenu funkcionalnosti u odnosu na porodice u kojima nema samopovređivanja adolescenata, mereno skalom FACES III. Rezultati su potvrda, na uzorku naše populacije, ranije dobijenih rezultata o vezi između porodične disfunkcionalnosti i samopovređujućeg ponašanja adolescenata i mogu imati kliničke implikacije u radu sa vulnerabilnom grupom adolescenata i njihovim porodicama.

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Ključne reči: *nesuicidalno samopovređivanje, porodična funkcionalnost, FACES III*