University of Alberta

Exploration of Self-Mutilation in Young Adults

by

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Abstract

Eight young adults from the community were interviewed in order to gain a greater understanding of their experience of self-mutilation. Of particular interest were the affective, cognitive, and behavioural processes involved in self-mutilation. In addition to participant descriptions and historical antecedents of the behaviour, ten themes that represented participants' experience of self-mutilation were constructed from basic interpretive qualitative data analysis. The findings highlight that self-mutilation is a complex phenomenon. There is a cyclical nature of emotions and cognitions involved in the experience that is more salient to the participants than the behaviour alone. Pain and several dissociative processes were also important aspects of the experience. Implications for the findings include understanding the cycle of self-mutilation and using multimodal treatment to address emotion, cognitions, and behaviour. The findings also present avenues for future research into the addictiveness of the behaviour, pain, dissociation, and improved treatment.

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Chapter I – Introduction

The idea of purposely injuring one's self in order to feel better is, for many of us, hard to fathom. Yet, countless people make the decision to engage in self-mutilation on a regular basis to cope with difficult thoughts, emotions, and circumstances. Self-mutilation appears to quickly relieve a distressing situation for some individuals giving it a potential to be highly addictive and resistant to treatment. Health professionals are typically personally and professionally challenged when faced with a self-mutilating client; often stunned or disgusted by what they see and do not know how to proceed with treatment. The objective of this study is to gain a better understanding of various aspects of self-mutilation.

Definition and Classification of Self-Mutilation

Self-mutilation can be defined as "the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent" (Favazza, 1998, p. 260). In the past, various other terms have been applied to the behaviour: focal suicide, attempted suicide, wrist cutting or slashing, delicate self-cutting syndrome, self-assault, parasuicide, chronic repetitive self-injury, non-fatal self-harm, and deliberate self-harm syndrome (Walsh & Rosen, 1988). The use of a variety of terms has made it difficult to compare results and to conduct consistent research because what is an inclusion criterion in one study may not be included in another study. Presently, Favazza's (1998) definition of self-mutilation is commonly accepted in the field, although some have recently argued that the term self-mutilation is pejorative and should be called self-injury, (Walsh, 2006). I have decided to continue to use the term self-mutilation as people engaging in the behaviour are causing a specific type of self-inflicted damage to part of their body. Furthermore the word mutilate

can be defined as to "excise or damage part of" something (Oxford, 1998). Also, by using the word self-mutilation, the behaviour cannot be confused with other forms of self-injury. Conversely, the term self-injury is a broad term that can be applied to behaviours such as eating disorders, self-poisoning, substance abuse, and risk taking, which are not part of this study.

In terms of the classification of the behaviour, it has several different forms ranging on a continuum from scratching to amputating body parts. Favazza and Rosenthal's (1993) classification is considered the standard. Their classification system is comprised of three typologies: Major, Stereotypic, and Superficial/Moderate mutilation.

Major self-mutilation includes amputation, castration and removal of the eyes. This behaviour is infrequent and is usually executed in those that are in a psychotic state. In contrast, Stereotypic mutilation is performed frequently and takes the form of repetitive behaviours such as hitting, head banging, or biting. This is seen regularly in the mentally disabled, the schizophrenic, and in individuals with certain disorders such as Tourette's and Lesch-Nyhan syndrome. Superficial/Moderate mutilation involves behaviours such as bone breaking, burning, cutting, hair pulling, and wound interference. This is the more common form of self-mutilation. This classification can be sub-divided, based on frequency, into episodic and repetitive self-mutilation (Favazza, 1998). Episodic self-mutilation is likely to co-exist with another psychiatric disorder, whereas with repetitive self-mutilation, the individual becomes preoccupied with the behaviour and it is best thought of as a disorder of impulse-control (Favazza). The focus of this thesis is on superficial/moderate self-mutilation as it is the most common form of the behaviour and is the type often presented within a counselling setting (Alderman, 1997).

Background

The use of self-mutilation can be traced back to biblical times and to many different cultures where it is seen as socially acceptable (Favazza, 1998; Hewitt, 1997). Often it was used as a form of purification or redemption (Babiker & Arnold, 1998). Although the behaviour has been known to exist for many centuries, it has only recently piqued the interests of psychologists. Much of the early work in this area comes from observations and studies of psychiatric in-patients (e.g. Asch, 1971; Pao, 1969). Earlier studies sometimes reported the behaviour as being related to suicide (e.g., Menninger, 1935; Weissman, 1975); however, over the years, researchers came to understand that the behaviour was separate from suicide. The difference being there was a will to end unbearable pain in order to live, as opposed to ending the pain along with one's life (Walsh & Rosen, 1988).

Today there is a more comprehensive understanding of self-mutilation though research is primarily derived from adult and adolescent psychiatric samples as well as some incarcerated males (e.g., Kumar, Pepe, & Steer, 2004; Langbehn & Pfohl, 1993; Shea, 1993). There is general agreement that self-mutilation is used for a variety of functions, often to cope with distressing events and negative affect (Suyemoto, 1998). In Favazza's influential book *Bodies Under Siege* (1996) he concludes that, "Self-mutilation is best regarded as a morbid form of self-help" (p.286).

When the circumstances demand professional intervention for this behaviour, practitioners have found it difficult to treat (Feldman, 1988). This is partially related to factors such as the secrecy of the behaviour, non-compliant attitudes towards treatment, its addictive nature, and the shame associated with the behaviour (Favazza, 1998).

Compounding the difficulty in treatment is the negative reaction that self-mutilators are sometimes faced with when they seek out help (Jeffrey & Warm, 2002).

The fact that much of the research has been derived from psychiatric and institutionalized samples creates a tendency for the behaviour to be linked to a psychiatric disorder. Indeed, Favazza's (1998) description of self-mutilation tends to attribute it to an impulse disorder or a mental illness. Is self-mutilation the same when investigated outside of these types of samples? This is a difficult question to answer as only recently have investigators begun to look at samples derived from the community. Consequently, additional research is needed in order to better understand self-mutilation both in the community and from the perspective of those that engage in the behaviour. Do they view self-mutilation as being a mental illness or is the behaviour conceptualized differently? Few studies have attempted to understand self-mutilation from the injurers' perspective. This is important as self-mutilation is becoming more prominent in the community and the way the behaviour is viewed (i.e. deviant or normal, sick or healthy) could influence whether or not treatment is sought out and if past research is applicable to those in the community.

Statement of the Problem

In general, it is estimated the rates of self-mutilation have increased 150% over the last 20 years (Walsh, 2006). One of the few studies that investigated self-mutilation in the general population reported the prevalence rate to be at 4% (Briere & Gil, 1998). To put this in perspective, depression has a prevalence rate in the general population of 2% to 9% and has been the subject of countless studies compared to those on self-mutilation (DSM-IV-TR, 2000). Ross and Heath (2002) who assessed the frequency of self-

mutilation in a community sample of adolescents surmised that the rates of the behaviour would increase in the future. Consequently, it is imperative that we seek to understand self-mutilation in the community in order to provide prevention and treatment of the behaviour.

Unfortunately, few studies have been done that would help shed light on understanding self-mutilators in the community. The handful of studies that have been conducted consist of adolescent samples (e.g., Ross and Heath, 2002) or samples that combine, adolescents, adults, and older adults (e.g., Favazza & Conterio, 1989). One specific co-hort that has been identified as a high risk for self-mutilation is young adults. Gratz (2001) assessed for the behaviour using an undergraduate sample and found 35% of the sample had engaged in self-mutilation. This is of concern as the behaviour is often associated with pre-existing mental health concerns, high-risk sexual behaviour, physical complaints, depressive symptoms, demoralization, and suicide risk (Favazza, 1996/1998; Favazza & Conterio, 1988; Suyemoto, 1998). Clearly, there is a need to learn more about young adults who self-mutilate as it can be expected that some will seek treatment.

Purpose of the Study

This exploratory study will provide an opportunity to gain an understanding of self-mutilation in young adults. The main research question guiding this exploration is, "What is your experience of self-mutilation?" Research questions will also explore the affective, cognitive, and behavioural processes involved in the before, during, and after stages of self-mutilation, for example, "What emotions were you experiencing prior to/during/after you hurt yourself?" Authors have written about the cyclical nature or a

feedback system (e.g., Alderman, 1997; Turner, 2002) being involved in the behaviour, though this has not been a focus of their research.

A further purpose of the study is to provide detailed information on this phenomenon that may help treatment practices and advance research, for example "What helped you stop self-mutilating?" This research is not constrained by hypotheses, but rather will provide information that future hypotheses can test and the results of which may contribute to theory building. It is also hoped that this research will be of interest to practitioners when they are working with a self-mutilating client. Unfortunately, many therapists are unfamiliar with the behaviour as it is often not discussed in the majority of psychology textbooks (Feldman, 1988). This is problematic as it can be expected that if rates continue to increase it will become common to work with these types of clients and having information about them will be vital for treatment.

Importance of the Study

Although the number of research studies on self-mutilation has been increasing, there still remain unanswered questions about many aspects of the behaviour. As discussed previously, one area that is in desperate need of understanding is the use of self-mutilation in the general population. These individuals may not always fit the typical 'mould' of self-mutilators that has been derived from clinical investigations. A result can be missed diagnosis and ineffective treatment. That said, the goal of this research is to understand the experiences of young adult self-mutilators.

This study may also provide insights into treatment and areas for further research. Additionally, this and subsequent research will hopefully legitimize self-mutilation as a disorder on its own, rather than a by-product of other disorders, for example it is a

diagnostic criteria for the Borderline Personality Disorder in the DSM-IV-TR. There have been pressures in the field to add self-mutilation to the DSM category of Impulse control disorders, however there is no decision on whether or not the DSM-V will include these changes (Favazza & Rosenthal, 1993; Pattison & Kahn, 1983; Yates, 2003). In summary, this research is important in order to advance the overall understanding, treatment, and research of self-mutilation in young adults residing in the general population.

Chapter II – Literature Review

Included in this literature review are a presentation of the theoretical positions of self-mutilation and an overview of the empirical research. Characteristics of self-mutilators, risk factors associated with the behaviour, functions served by self-mutilation, and treatment considerations will also be discussed along with limitations of past research findings and ways the proposed research will increase understanding of self-mutilation.

Theoretical Understandings of Self-Mutilation

Psychoanalytic

According to psychoanalysis, self-mutilation is a method to satisfy innate drives. The conflict between the life and death drives of the id can be mediated through the ego by way of a self-mutilative act. Menninger (1935) used the term focal suicide to describe self-mutilation. Committing suicide would be antithetical as it would not fulfill the need for punishment and atonement, however with focal suicide a portion of the self could be sacrificed and life could continue (Menninger). Sexual drives are also related to self-mutilation. The behaviour serves as an alternative outlet or substitution for the genitals, for example a cut can symbolize the female genitalia (Siomopouls, 1974). Self-mutilation was also viewed as a punishment for masturbation (Menninger).

Karl Menninger (1935) was the first to put forth an in-depth theoretical explanation and classification of self-mutilation. He used a series of case studies to derive six different forms of self-mutilation: Neurotic Self-Mutilation, Religious Self-Mutilation, Puberty Rites, Self-Mutilation in Psychotic Patients, Self-Mutilation in Organic Diseases, and Self-Mutilation in Normal People. Three common themes were found across all forms. The first theme related to the removal or injury of a body part in

an attempt to atone for some wrongdoing. Menninger linked this to castration. He described the case of a woman who after murdering her child with a hammer had the offending arm severed by placing it on train tracks. This was a form of punishment for her actions. According to Menninger's second theme, there is an aggressive drive behind self-mutilation towards the self or another, although outward aggression is directed inward through introjection. The final theme was that self-mutilation provided an alternative outlet for erotic drives other than masturbation, which was seen as an unacceptable act. In support of this, Simopoulous (1974) observed that patients who ended masturbation often began to self-mutilate in order to express erotic drives. In summary, psychoanalytic theory depicts self-mutilation as being an outlet for instinctual drives such as aggression, life, death, eroticism, and a mechanism for punishment.

Psychodynamic

Psychodynamic theory extends upon the psychoanalytic position by placing more emphasis on early attachment relationships and their importance in learning to effectively regulate emotions. Briefly, Bowlby's (1969/1982) attachment theory posits that from birth, all humans have behaviours that orient them to seek out relationships, usually with caregivers that will help them survive and navigate the world around them. For example, if they are in an aroused state caused by fear or anger, they look for someone to help them regulate those emotions and return to a calm baseline level of functioning. The child's success in forging close relationships that will help with stressful situations depends on how their immediate caregivers meet their needs. The caregiver's reactions are internalized by the child and become a template for how they view other people in the world around them. These templates are known as attachment styles and are crucial for

affect regulation (Mikulincer & Florian, 2004; Segal, 1999). Unfortunately not all attachment styles successfully regulate emotion. Individuals with insecure, avoidant, or disorganized attachment styles have difficulty regulating emotions (Segal, 1999; Sroufe, 1996). Furthermore, individuals with disorganized attachment are more likely than others to use dissociation to cope with overwhelming emotions (Liotti, 1992; Segal, 1999).

In relation, self-mutilation is thought to be a mechanism used to help regulate emotions. The behaviour serves as a way to achieve a sense of calmness during an emotionally overwhelmed state and has been reported to symbolize the absent nurturing relationship of a mother as well as a symbolic way to retaliate against an unnurturing caregiver (Graff & Maillin, 1967; Kafka, 1969; Winchel & Stanley, 1991). An inability to regulate emotions by verbally expressing them (i.e. alexithymia) may also contribute to the use of self-mutilation as an alternative way to communicate emotions (Suyemoto, 1998).

Boundaries are another area informed by attachment relationships. Object-relations theory, borne out of psychodynamics, offers the idea that self-mutilation is a way of addressing unclear boundaries between self and others (Yates, 2004). This boundary confusion stems from inadequate caregiving. According to Suyemoto (1998), "...these patients were unable to adequately separate or individuate from their mothers, primarily because the attachment was not secure enough in the first place" (p. 547). Caregiving may have been too distant or too smothering. Grunebaum and Klerman (1967) observed that the self-mutilator's family history was dysfunctional in that the mother was often cold, demanding, and quick to dole out punishment, whereas the father was usually sexually inappropriate or overly aggressive. An ability to sense where one's

boundaries begin and end in a chaotic environment can be difficult to achieve and makes it challenging to establish an independent sense of self separate from the caregiver (Pao, 1969; Suyemoto, 1998) This creates a fear of abandonment, isolation, anger, and depersonalization, which is a feeling of being separated from one's self or not existing (Darche, 1990; Pao, 1969; Simpson & Porter, 1981).

The purpose of self-mutilation can be to physically establish individual boundaries and gain a sense of self, often achieved through seeing the blood flow from the injuries (Simpson & Porter, 1981). Although self-mutilation is viewed by some as being manipulative, it may also prevent perceived or real abandonment from taking place. The injuries typically elicit caring, thus preventing the abandonment and receiving attention (Paris, 2005). This is typically witnessed in individuals with Borderline Personality Disorder who have had disturbed childhoods and poor attachment relationships, fear abandonment, experience dissociation, and identity diffusion (DSM-IV-TR, 2000; Ross & McKay, 1979).

In summary, the psychodynamic theory rests heavily on maladaptive attachment patterns as an explanation for self-mutilation. Self-mutilation serves to regulate aversive emotions and may also symbolize positive or negative aspects of caregiving relationships. It also serves to establish a sense of self and mark boundaries during times of abandonment and experiences of self-fragmentation (i.e., dissociation). The psychodynamic theoretical explanation of self-mutilation has received a great deal of attention in the literature.

Behavioural

In contrast to the elaborate psychoanalytic and psychodynamic understandings of self-mutilation, behavioural theory offers a simple explanation that has been applied to the behaviour in the developmentally disabled (e.g., Murphy & Wilson, 1985). Specifically, self-mutilation can be explained using operant conditioning and social learning.

The basis of operant conditioning is that individuals perform specific behaviours in order to change some aspect of their environment (Gray, 1991). The change in the environment is often reinforcing, thus making it more likely that the behaviour will be repeated in the future under similar circumstances (Gray). The reinforcement of self-mutilation can be positive or negative, though most often it is negative reinforcement that maintains the behaviour (Nock & Prinstein, 2004). With negative reinforcement, the removal or avoidance of negative stimuli is followed by the presence of positive feelings (Baumeister & Rollings, 1985; Nock & Prinstein, 2004), attention from others or to avoid punishment from others (Ross & McKay, 1979), all of which also become positively reinforcing.

Although self-mutilation is maintained through operant conditioning, this does not explain how the behaviour is first learned. Therefore, social learning is often put forth as an explanation for how the behaviour is added to an individual's repertoire (e.g., Alderman, 1997). Individuals learn about self-mutilation through social interactions with other self-mutilators as well as through media such as television (Yates, 2004). A prime example of social learning is the contagion effect that is frequently seen with self-mutilation in prison or hospital wards. A contagion effect occurs when two or more

people engage in behaviour deemed problematic by staff members (Rosen & Walsh, 1989). The behaviour then spreads as other people recognize and experience its consequences (e.g., attention, emotional relief, avoiding responsibilities).

Essentially, self-mutilation can be learned through watching or hearing about someone else who has done the behaviour, it is then maintained through the process of operant conditioning (Yates, 2004). It is important to note that the behaviour may also be acquired by accident. For example, an individual might scratch their skin and find that experience to be pleasurable and therefore reinforcing, thus increasing the likelihood that the behaviour will be repeated.

Biological

Compared to the theories covered thus far, the area of biopsychology is relatively new. Self-mutilation is viewed as a result of dysfunctional serotonin neurotransmitters and the endogenous opioid system, which release pain-suppressing chemicals called endorphins that result in pleasurable feelings (Yates, 2004). Low serotonin has been consistently linked to aggressive behaviour in animals and humans (e.g., Frankle et al., 2005; Oliver, 2005). Low levels of serotonin have also been implicated as a reason why individuals engage in self-mutilation (e.g., Favazza, 1996; Simeon et al., 1992). Serotonin deficiencies have also been implicated in poor impulse control, a trait often displayed in self-mutilators (Herperz, Sass, & Favazza, 1997; Smith, Cox, & Saradijan, 1999).

Additionally, the act of self-mutilation activates the body's opioid system that results in a decrease of pain sensations and an increase in endorphin release (Bohus et al., 2000; Smith, Cox, & Saradijan, 1999). Self-mutilators can become addicted to the endorphin rush that can be achieved with little to no pain (Turner, 2002). In addition to

the opioid system, high levels of cortisol have also been attributed to the instigation of the behaviour (Sachsse, Von Der Heyde, & Huether, 2002). This makes sense considering stressful events tend to trigger self-mutilation (Alderman, 1997).

These neurological events that contribute to self-mutilative behaviour are thought to have their roots in trauma or poor caregiving relationships in early childhood that result in dysregulated internal states (Turner, 2002). Support for this assumption has been found in several studies (e.g., van der Kolk, Perry, & Herman, 1991; van der Kolk, 1996).

Biological explanations of self-mutilation point to ineffective serotonin receptors and dysfunction or dependence on the endogenous opioid system for the origin and maintenance of self-mutilation. These two areas have received more attention than investigations into cortisol. Regardless, the origins of these neurological problems appear to stem from past trauma or from ineffective attachment relationships that leave their mark on the brain and alter development.

Psychoanalytic, Psychodynamic, Behavioural, and Biological theories have all purported explanations of the origins of self-mutilation. Psychodynamic theorists explain the behaviour as a way to mitigate and punish the instinctual drives such as aggression and sexuality. Menninger classified self-mutilation into different categories, thus providing greater understanding and leading the way for future research. Psychodynamic theory identifies attachment and emotional regulation as integral in the understanding of self-mutilation. The behaviour is used to express or avoid emotions. Establishing boundaries and a sense of self in the world are also part of this theory. Self-mutilation can also be understood from a behavioural perspective that emphasizes the powerful effects of reinforcement and observational learning. Finally, recent advances in neurobiology

have implicated the endorphins in the opioid system, serotonin, and to some degree cortisol as playing an important role in the behaviour. A common thread amongst all the theories is that self-mutilation is able to provide relief by appeasing tension-producing id drives, regulating emotions, adding or removing stimuli, and finally, through the release of pleasure-producing neurotransmitters.

Review of the Research

Characteristics of Self-Mutilators

Adult psychiatric samples. Psychiatric patients were the source of early studies on self-mutilation. More severe forms of the behaviour, such as limb amputation or eye inoculation, were seen in patients with schizophrenia or those in psychotic states (Favazza, 1998). There were also reports of patients who cut themselves, though not deep enough to result in mortality. Graff and Mallin (1967) referred to these individuals as "chronic" patients and set out to understand the behaviour by reviewing the files of 21 patients admitted in a six month period who had cut their wrist. They found the average age of a wrist-cutter was 23 years; 95% of them had been hospitalized more than once and 40% of them had a diagnosis of schizophrenia. Graff and Mallin also reported that all the patients had poor interpersonal relationships and were impulsive with substance use and promiscuity. Interestingly, 35% of the patients could not identify the reason for cutting, 25% stated it was for pleasure and relief, 20% cut out of anger, and 20% cited their cutting was due to depression.

In another study, Pattison and Kahan (1983) undertook an extensive case review of 56 self-mutilators and reported several characteristics of the sample. The average onset of the behaviour was in late adolescence with multiple episodes and types of self-

mutilation (e.g., cutting, burning, and scratching). This is in contrast to the Graff and Mallin (1967) study that addressed only wrist cutters. Individuals that self-mutilated also displayed problems with anger, depression, and anxiety. There was also a history of substance abuse, poor social support, and suicidal ideation. Sixty nine percent of cases listed regulating emotion as a reason for engaging in the behaviour, followed by an inability to think (64%), anxiety (55%), and anger (50%). This implies that self-mutilation was used for more than one reason, though no further exploration was done to determine if reasons varied depending on the triggering event.

Similar studies have also found that the self-mutilator in psychiatric care is typically a young adult that engages in various forms of self-injury (i.e., cutting, hitting, burning) with cutting or scratching being the most common form (e.g., Favazza, 1998; Langbehn & Pfohl, 1993; Roy, 1978). Diagnoses of post-traumatic stress disorder, dissociative disorders, anxiety, poor impulse-control, eating disorders, and mood disorders are commonly comorbid with the behaviour (Coons & Milstein, 1990; Turner, 2002). Diagnoses such as Borderline and Antisocial personality disorders are also common in self-mutilators (Andover et al., 2005; Paris, 2005; Turner, 2002). In fact, self-mutilation is a diagnostic criterion of Borderline Personality Disorder (BPD; DSM-IV-TR, 2000), though the behaviour is not seen in everyone diagnosed with BPD and is thought to be more related to high levels of impulsivity, aggression, and anxiety (Simeon et al., 1992).

A synthesis of the findings from the adult clinical literature suggests that a self-mutilator is a young female adult who typically began the behaviour in adolescence. Self-mutilation occurs in multiple episodes and ranges from cuts to more severe forms such as

amputation, usually seen in individuals with a diagnosis of schizophrenia. The self-mutilator frequently has been given a psychiatric diagnosis and has a history of impulsivity, which may include suicide attempts or gestures; there is also a history of poor interpersonal relationships and social support. Finally, there appears to be a variety of reasons for engaging in the behaviour.

Adults in the community. There are a handful of studies that have examined self-mutilation in the adult community. In samples derived from undergraduate populations and community surveys, the self-mutilator tends to be a Caucasian female in her early to late twenties (Favazza & Conterio, 1989; Gratz, 2002). Nevertheless, there are some findings that also suggest the rates between male and female self-mutilators are relatively equal (e.g., Briere & Gil, 1998; Gratz, 2001). The most frequent form of self-mutilative behviour in these adults was cutting followed by burning and scratching (Briere & Gil, 1998; Favazza & Conterio, 1988; Warm & Fox, 2003). Participants in several studies indicated that they started the behaviour during adolescence, usually by accident and have engaged in the behaviour multiple times (e.g., Favazza & Conterio, 1989; Warm & Fox, 2003).

A seminal study that investigated self-mutilation in the general population assessed several variables including family background, history of mental illness, childhood, personality, sexuality, and general information about self-mutilative behaviour (Favazza & Conterio, 1989). Participants reported having a troubled childhood charaterized by a divorce, parental alcoholism and depression, and abuse. Participants also endorsed numerous statements related to their personality. For example, feeling empty inside, having difficulty expressing feelings, and a tendency to have a

dichotomous attitude towards life. Several of the participants also identified difficulties related to sexuality, such as not liking menstruation and being bothered by sexual feelings. Self-mutilation was also impulsive for 78% of the sample. The reasons most frequently stated for engaging in the behaviour were to gain control over thoughts, feel relaxed, and to alleviate feelings of depression. Eating disorders were present at one time in 61% of the sample and substance abuse was identified in less than half of the sample.

Recently, Warm and Fox (2003) conducted a similar study using an internet survey. Similar to Favazza & Conterio (1989) they also reported that participants had a history of eating disorders, sexual or physical abuse, and substance abuse. The focus of their study was more on determining why people self-mutilate. Participants were presented with a list of statements about reasons for engaging in the behaviour. Frequently endorsed reasons for self-mutilation included releasing anger, gaining control, expressing emotional pain, and coping. Overall, participants engaged in the behaviour in order to feel better, which is similar to other findings (e.g., Briere & Gill, 1998; Favazza & Contario, 1989).

In summary, adult self-mutilators in the community are typically Caucasian females in their twenties, though an argument could be made that males are as likely as females to engage in the behaviour. The average person engages more than once in the behaviour, with cutting being the most common form of self-mutilation. The behaviour starts in adolescence and can continue on indefinitely, for example Briere and Gill (1998) had an age range of 18-90 in their sample. Generally, self-mutilation appears to be comorbid with eating disorders and to some extent, substance abuse. The self-mutilator in the community, more likely than not, has been the victim of child abuse. Common

reasons given for the engaging in the behaviour were to feel relief from thoughts, feelings, or sensations (i.e., feeling dead).

There is much overlap between the two streams of research on adult self-mutilators. Both the psychiatric literature and that on the general population present the self-mutilator typically as a young female adult who has engaged in the behaviour since adolescence on several occasions. Both groups also have histories of abuse. The difference between the groups appears to be the severity of psychopathology. Further research in this area should assess for the presence of clinical disorders in community samples.

Inmates. Self-mutilation is a growing epidemic in correctional facilities. Traditionally seen as behaviour used mainly by women, this is reversed in prison populations and provides an opportunity to learn more about the male self-mutilator. Bach-Y-Rita (1974) found the males in his sample (n = 22) to have started injuring themselves, predominantly by cutting, in late adolescence. The men also had a dysfunctional family upbringing characterizied by domestic violence or neglect. A history of depression and suicidal behaviour was also common. Self-mutilation was brought on by feelings of depression, anxiety, agitation, or frustration. Bach-Y-Rita observed that this behaviour was more frequent in solitary confinement situations where acting out (i.e., fighting with others) was constrained. Shea and Shea (1991) had similar findings where inmates self-injured to relieve anger, though some also did it to relieve tension and exert control. Schizophrenic inmates performed the more extreme forms of self-mutilation. The rate of self-mutilation also increased in hotter months, which suggests the behaviour may be a way to cope with anger. As temperature increases, aggression has also been found to

increase (Anderson, 2001). Self-mutilation in penal institutions appears to be "an act of aggression against an oppressive system and its agents" (Shea & Shea, p.66). An inability to have control over the environment, particularly in regard to problem-solving has also been reported in other studies on inmate populations (Haines & Williams, 1997).

Prison populations are also susceptible to contagion effects of self-mutilation (Shea,1993). While the behaviour may be used to relieve aversive emotional states (e.g., anger, depression) it is used as a tool to manipulate the environment in order to receive attention or to have requests fulfilled such as transferring to another location. As other inmates see the benefits associated with the behaviour, its frequency tends to increase (Shea). Contagions can also be brought on by a small group of people that are attracted to the dangerous excitement of the behaviour or as a way to create a pact between a few select individuals (Rosen & Walsh, 1989; Ross & McKay, 1979).

Considering the claims of alarming rates of self-mutilation within prisons, there is a dearth of research in the area. It is not clear if inmates who self-mutilate do so only within the context of incarceration. Furthermore, there is little discussion on how Anti-social Personality Disorder (APD) ties into self-mutilation even though it is known to be a comorbid condition and prisons have staggering numbers of inmates with APD (Favazza, 1996; Rotter et al., 2002).

Taking the research findings into consideration, it appears that self-mutilation in prisons is in a few ways similar to the results from psychiatric populations. The age of onset and repetitive nature of the behaviour is consistent, as is its use to alleviate intolerable emotions. On the same point, the predominant emotions are limited in comparison to psychiatric samples and seem to be anger and frustration that stem from

the confined nature of a prison environment. There is also the strong incentive of using self-mutilation to manipulate one's environment. Though this is seen sometimes in the psychiatric literature, it is a frequent motivation for the behaviour in prisons. Contagion effects are also more common in locked institutional settings (Rosen & Walsh, 1989).

Adolescent psychiatric samples. Adolescents have been the focus of a substantial portion of the self-mutilation research, although much of it has been confounded with suicide attempts. The behaviour typically begins in this developmental stage and the prevalence rate of self-mutilation in adolescents continues to grow to staggering numbers (Favazza & Conterio, 1989; Ross & Heath, 2002). Adolescents have been studied in psychiatric settings and more recently in the general population (e.g., Darche, 1990; Ross & Heath, 2002/2003). The mean age of adolescent inpatients is 15 years old (e.g., Darche, 1990; Kumar, Pepe, & Steer, 2004; Nixon, Cloutier, & Aggarwal, 2003). In general, females are reported to be more likely to self-mutilate than males (Ross & Heath, 2002; Zila & Kiselica, 2001). However, these findings may be skewed by the fact that females are more likely to seek out treatment or internalize their emotions, thus ending up in psychiatric wards where studies are being conducted, whereas males tend to externalize their emotions and are more likely to act out towards others or property, which may result in incarceration.

Studies have mainly consisted of file reviews of hospitalized adolescents. Similar to the adult findings, self-mutilating adolescents have usually been hospitalized several times, have a history of suicidal ideation and behaviour, use drugs and alcohol, and have engaged in several types of self-mutilation on different occasions (Nixon et al., 2002; Simpson & Porter, 1981). Adolescents engage in the behaviour frequently. In one study,

participants reported a range of performing the behaviour from daily to once a week (Nixon et al., 2002). Darche (1990) compared self-mutilating (n = 48) and non-self-mutilating patients (n = 48) on several variables. There were significant differences between the two groups, suggesting that the self-mutilating group was more psychologically distressed than non-self-mutilators, particularly with regard to depressive symptoms, eating disorders, and suicidality. Self-mutilators also reported a history of sexual abuse more often than non-self-mutilators. Simpson and Porter (1981) reported similar findings along with their discovery that self-mutilators planned their behaviour rather than it being an impulsive act.

Although file reviews provide general characteristics associated with self-mutilation, they remove the adolescent participant from the research process and are based on the staff's observations and labelling of the patients rather than the patients' own accounts of their experience. In an attempt to depart from this methodology, Kumar et al. (2004) used self-reports from adolescents (n = 50) to gather descriptive information and to discern their reasons for self-mutilation, specifically cutting. Contrary to Simpson and Porter's (1981) findings, the majority of the sample indicated their behaviour was impulsive; however, 44% stated that the behaviour was planned. The most reported reason for engaging in the behaviour was to feel better (i.e., to feel relief from tension and depression). This was also found in a similar study by Nixon et al. (2002); however, self-mutilation was not restricted to cutting.

Adolescents in the community. Only recently is research beginning to examine self-mutilation in adolescents in the community. Ross and Heath (2002) screened 440 suburban and urban adolescents ranging in grades from 7 to 11 for the presence of self-

mutilative behaviour. After the screening, 13.9% of the sample met the authors' criteria for self-mutilation, which was indicating the use of self-mutilation to deal with stress. Caucasians were more likely to self-mutilate compared to Black, Asian, or Hispanic ethnicities. Fifty nine percent of the post-screened sample also came from homes where both parents were still married. Approximately 19% of the sample indicated that they only engaged in the behaviour one time. More than half of the adolescents reported starting the behaviour in grade 7 or 8, which is roughly around the age of 12 or 13. This is slightly younger than other reports (i.e., Favazza & Conterio, 1989; Zila & Kiselica, 2001). Finally Ross and Heath reported symptoms of depression and anxiety to be greater in the adolescents that self-mutilated. This is consistent with the clinical research. Quite different from the research with psychiatric adolescents is that 64% of the sample indicated they no longer self-mutilated. Ross and Heath concluded that self-mutilation within their community sample appeared to be used as a short-term coping mechanism.

There are similarities and differences between adolescents self-mutilating in psychiatric care and those within the general community. Both tend to start the behaviour in early adolescence. The frequency and forms of self-mutilation are varied in each group. There are also greater numbers of females than males engaging in the behaviour. Depression is a comorbid symptom, though more severe within psychiatric adolescents. Both populations tend to use self-mutilation as a coping mechanism, though the community sample in Ross and Heath's study appeared to use the behaviour only once, thus not becoming dependent on it as others have (e.g., Nixon et al., 2002). A problem in comparing the two populations is the lack of non-clinical data on adolescents. Thus, the general characteristics of psychiatric and community adults or adolescents who self-

mutilate are: (1) onset during adolescence; (2) cutting is the most common form; (3) several occurrences of the behaviour; (4) multiple reasons for engaging in the behaviour (i.e., release of anger, coping, relief from depression, anxiety), (5) a history of substance use and child abuse; and (6) more often than not, a history of mental illness (e.g., eating disorder, depression, suicidality, and personality disorders).

The extant descriptive information of self-mutilators is informative though there are limitations to the findings. The larger survey studies (e.g., Favazza & Conterio, 1989; Warm & Fox, 2003) make it difficult to properly screen participants and establish whether or not they fit the criteria. Also, those individuals that choose to complete surveys may be quite different than self-mutilators who choose not to participate. The survey questions are often forced choice, thus placing restrictions on participants' responses. Many of the psychiatric studies are based on file review and it is not always clear if follow up or clarification was done with the participants. A difficulty in comparing the studies done is the lack of consistency between them, for example one study may assess suicidal ideation whereas the other does not. Replications of past findings would be helpful in this regard. Finally further research into behaviour within the prison environment would also be beneficial to the area of self-mutilation, particularly in ascertaining whether or not self-mutilation was done prior to or after incarceration. Overall, much of the research in the area of self-mutilation is general information derived mainly from female participants and lacks the important details necessary to provide a deeper more unified understanding of the behaviour.

Risk Factors Involved in the Development of Self-Mutilative Behaviour

Traumatic experiences such as childhood abuse and a disruptive family environment along with inadequate attachment patterns and clinical disorders (e.g., eating disorders, depression, anxiety, personality disorders) have been found to be strong predictors of self-mutilative behaviour (Alderman, 1997; Briere & Gil, 1998; Carroll, Schaffer, Spensley, & Abramowitz, 1980; Darche, 1990; Gratz, 2002/2003; Low et al., 2000; Turner, 2002; Walsh & Rosen, 1988; Zlotnick et al., 1996). It has been difficult to empirically research risk factors of self-harm due to the retrospective nature of the studies. Furthermore, many of the risk factors can combine or interact with one another making it difficult to determine which factor is most associated with self-mutilation. Although some of these risk factors have been briefly touched upon in past sections, they will now be further expanded upon.

Trauma. By far the role of child abuse, particularly sexual and physical abuse, has received the majority of attention in the literature. Alderman (1997) claims self-mutilation is inextricable from abuse and the empirical literature appears to support much of this claim. The early case studies described patients having histories of abuse, particularly incestuous relationships with fathers (e.g., Grunebaum & Klerman, 1967). Survey research (e.g., Favazza & Conterio, 1989) has also shown that the majority of respondents have a history of abuse, although it could not be concluded from this kind of methodology whether or not the abuse was an antecedent to self-mutilation. Numerous other investigations have found a relationship between a history of sexual or physical abuse and self-mutilation (e.g., Boudewyn & Liem, 1995; Tyler, Whitbeck, Hoyt, & Johnston, 2003; van der Kolk, Perry, & Herman, 1991).

In contrast to the majority of studies finding a link between child abuse and self-mutilation, there are a handful of studies where this relationship is not supported (e.g., Zweig-Frank, Paris, & Guzder, 1994a, 1994b). In the first cited study, it was hypothesized in females that dissociation mediated the relationship between abuse and self-mutilation in borderline personality disorder (BDP), which was not supported. There are several explanations for these findings, first it is possible that child abuse affects the ability to regulate emotion and this becomes the risk factor for self-mutilation. Second, the authors used a sample of nonBDP and BDP males to test the same hypothesis that was also not supported. Research has shown that for males, childhood separation or loss is a strong risk factor for self-mutilation (Gratz, Conrad, & Roemer, 2002). This factor was given little attention in the Zweig-Frank et al. (1994b) study. A final reason for these different findings may be attributed to a lack of statistical power to detect significant findings or it could be an artifact of the samples used. Overall, it can be concluded from the research that child abuse is a risk factor for self-mutilation.

Child abuse is most damaging when it is perpetrated by those in a caregiving role as it violates a sense of trust and security, thus affecting attachment relationships and the developing sense of self (Bradley, 2000). A sense of self and attachment style can also be shaped by the family environment. Families that are characterized by a lack of involvement (i.e., neglect) or over-involvement (i.e., enmeshment) in a child's life have also been identified as risk factors in the development of self-mutilation (Gratz, 2003). Seventy-four participants were involved in a four year longitudinal study assessing childhood antecedents of self-destructive behaviour (van der Kolk, Perry, & Herman, 1991). Participants were assessed at intake and then assessed again at follow-up

interviews every 4 to 6 months. Childhood neglect was found to be associated with and predictive of self-mutilation, particularly cutting. Female participants (n = 76) were asked what they felt led to their self-mutilative behaviour (Babiker & Arnold, 1998). Neglect and emotional abuse were within the top three experiences reported. Clearly, neglectful home environments contribute to the development and maintenance of self-mutilation. Unfortunately, the majority of research tends to focus on sexual or physical abuse or does not define the type of abuse under investigation and may refer to it as maltreatment (e.g., Yates, 2004).

Studies on self-mutilating individuals highlight their dysfunctional family environment. Unclear communications as well as distressing parental relationships defined by frequent arguments are also risks for self-mutilation (Derouin & Bravender, 2004). According to Levenkron (1998), children that struggle over time to meet their parents' expectations are likely to engage in self-blame that is then taken out on the self. The family environment also tends to be one where domestic violence and substance abuse is present (Babiker & Arnold, 1998; Grunebaum & Klerman, 1967). Moreover, Carroll et al. (1980) found that the self-mutilation was more common in families where anger was not allowed to be expressed by the children, though it was frequently observed between the parents.

Attachment. Although abuse and dysfunctional family environments are risk factors, they often lay the foundation for another risk factor, which is the inability to form secure attachments with caregivers and later with intimate partners that provide effective emotion regulation and a positive sense of self. This may come as a result of abusive parents, but can also be borne from the mother and child relationship, for example having

a parent, usually mother, that is not available in times of need or is inconsistent in caregiving. Graff and Mallin (1967) described the mothers and fathers of their sample as emotionally unavailable and detached. Representing an under researched area, a loss or separation from a caregiver (i.e., death or parental abandonment) can also disrupt attachment relationships and possibly create fears around abandonment later in life (Carroll et al., 1980; Gratz, 2003).

In an extensive review of the affect regulation literature, Bradley (2000) reported that problems with emotional regulation include the inability to use adaptive coping strategies, poor impulse control, alexithymia, and being more sensitive to situations that may bring on negative affect. Various studies speak to the use of inadaptive coping strategies used by self-mutilators. They are more likely to engage in alcohol or drug use and experiential avoidance (e.g., Champan, Gratz, & Brown, 2006; Haines & Williams, 1997; Langbehn & Pfohl, 1992). Dissociation is also a coping method used by many to avoid overwhelming emotions that can be unknowingly tied to early trauma and re-enacted through destructive acts such as self-mutilation (Chu, 1991). The role of dissociation in self-mutilators still requires further research. Self-mutilation has been found to end a dissociative state as well as induce the state in order to avoid feelings of pain (Zlotnick et al., 1996). In summary, the area of attachment and its relationship to self-mutilation is important for understanding and subsequent treatment of the behaviour, however it still requires further investigation.

Psychiatric disorders. Another prominent risk factor in the development of self-mutilative behaviour is being diagnosed with personality or mood disorders. Personality disorders, particularly Borderline Personality Disorder, are common diagnoses applied to

those who self-mutilate (Sansone, Gaither, & Songer, 2002; Simeon, et al, 1992). Schizophrenics will engage in more severe, non-repetitive self-mutilation (Favazza, 1996). Other psychopathologies linked to self-mutilation are depression (Derouin & Bravender, 2004), anxiety (Ross & Heath, 2002), impulse control disorder (Herpertz, Sass, & Favazza, 1997), dissociative disorders (Coons & Milstein, 1990), eating disorders (Favazza, DeRosear, & Conterio, 1989), post-traumatic stress disorder (van der Kolk, 2002), and suicide (Alderman, 1997). Often self-mutilation is used as a coping mechanism to deal with the symptoms of these disorders. In the case of suicide, self-mutilation has been described as an alternative to suicide and a way to communicate internal emotional pain (Solomon & Farrand, 1996).

Common risk factors in the development of self-mutilative behaviour include trauma, insecure attachments, and a psychiatric history. Trauma is a frequently cited precipitant to self-mutilation. This includes child abuse and neglect as well as numerous factors within the family home such as domestic violence, substance use, and parental loss or separation. Many of these situations stem from poor attachment relationships between the caregiver and the child. The inability to form secure attachment relationships then affects the ability to effectively regulate emotion and self-mutilation may become a method by which emotions are reined under control. Although many of these risk factors occur during childhood, it is important to note that adult experiences such as sexual assault, domestic violence, loss of a child, and a lack of social support have been linked to self-mutilation (Babiker & Arnold, 1998). Experiencing a trauma may also lead to dissociative states that can be alleviated through self-mutilation. Other risk factors also include the presence of a clinical disorder, though this may be a result of using samples of

psychiatric patients rather than a true risk factor for self-mutilation. In this case, self-mutilation can be a symptom of a disorder or can be a coping mechanism to alleviate symptoms.

The Functions of Self-Mutilation

According to the literature, self-mutilation serves numerous functions. Ross and McKay (1979) provided an extensive list of the reasons for the behaviour. These included proving one is alive, manipulation, risk-taking, retaliation, iatrogenic, frustration, contagion, depression, tension relief, drug-related behaviour, deprivation, body alienation, behavioural conditioning, and low self-esteem. Many of these reasons for self-mutilation have been supported by recent research (e.g., Babiker & Arnold, 1998; Cross, 1993; Favazza, 1996; Levenkron, 1998; Osuch, Noll, & Putnam, 1999; Shea & Shea, 1991; Warm & Fox, 2003).

Dissociation. One clear function of the behaviour is to end dissociation. Dissociation can be defined as a split in the normally integrated stream of consciousness (Spiegal & Vermutten, 1994). It is often linked to a traumatic incident and can be part of one of the symptoms for post-traumatic stress disorder (van der Kolk, 2002). The common forms of dissociation described in the self-mutilation literature are depersonalization and derealization. With depersonalization there is a sense of being separated or detached from one's own body, a sense of numbness or deadness, often due to an inability to experience affect (Steinburg, 1994). Derealization is described as a sense of distorted reality or that the world around the individual is not real or is somehow foreign (Steinburg). Several studies have supported the idea that self-mutilation ends a dissociative state. Many of the reasons reported by a sample of self-mutilators (n=93) in

Briere and Gill's investigation into the functions of the behaviour were suggestive of terminating dissociation. These included: (1) feeling that the body is real, (2) to feel alive; and (3) to feel something. Other findings have also supported this function of self-mutilation (e.g., Babiker & Arnold, 1998; Favazza & Conterio, 1989; Kumar, Pepe, Steer, 1994; Osuch, Noll, & Putnam, 1999),

Emotion regulation. Another frequently cited function of self-mutilation is that it is a mechanism used to regulate distressing emotions such as anger, anxiety, and depression (e.g., Kumar, Pepe, & Steer, 2004). According to Ross and Heath's (2003) review of the hostility model (2003), individuals introject their anger and become hostile towards the self. The hostility continues to build and create an unbearable tension that is relieved by the act of self-mutilation. In the anxiety model, stressful life events bring on mounting tension that becomes increasingly difficult to bear and self-mutilation provides relief. The authors found support for the hostility model in a community sample of adolescent self-mutilators (n = 231), however they also found that anxiety was present in many of the adolescents prior to self-mutilating.

Osuch, Noll, and Putnum (1999) set out to investigate and develop a scale to assess the motivation for self-mutilation in psychiatric patients (n = 99). They found that the self-mutilation was done to regulate feelings associated with anxiety, anger, depression, shame, and guilt. There is also support that the behaviour is a means to distract or avoid distressing emotions (Babiker & Arnold, 1998; Briere & Gil, 1998; Chapman, Gratz, & Brown, 2006). Emotion regulation serves to gain some grasp of control of an uncontrollable emotional state. While many studies have identified self-

mutilation as a method for emotion regulation, few studies have set out to explain its process.

Control. Self-mutilation is also frequently cited as a way to gain a sense of control over the self and the environment. A statement about using self-mutilation as a method to stay in control was endorsed by 87.6% of Warm and Fox's (2003) sample. A similar statement was agreed to by 71% of Briere & Gill's (1998) sample. Control over thoughts as well as having a belief that the action will control other people has been indicated as a function of self-mutilation (Favazza & Conterio, 1989; Osuch, Noll, & Putnam, 1999). Although gaining control appears to be an important function of self-mutilation, this is not a common focus of the research.

Additional functions. In addition to ending dissociation, emotion regulation, and gaining control, there are several other functions of self-behaviour. These include marking personal boundaries, communication, gaining attention, self-nurturing, re-enacting abuse, sexual stimulation, purification, security, relief from loneliness, and boredom (Babiker & Arnold, 1998; Favazza, 1996; Osuch, Noll, Putnam, 1999; Ross & McKay, 1979; Solomon & Farband, 1996; Suyemoto, 1998). A relief model appears to be a suitable way to conceptualize many of these functions (Symons, 2002). All of the cited reasons for self-mutilation are rooted in a state that is uncomfortable for the individual. As a way of coping, self-mutilation provides a quick way to relieve the aversive state. Gaining a greater understanding of this process would be helpful in advancing the research in this area and beneficial for treatment. Unfortunately, little empirical research has focused on this area although it has been presented in secondary sources (e.g., Alderman, 1997; Turner, 2002).

Treatment of Self-Mutilation

Consequently, the use of self-mutilation as a quick and effective coping mechanism for a variety of problems often makes it difficult to treat. Adding to this is the lack of knowledge about the behaviour as well as at times, self-mutilators not wanting to stop the behaviour (Alderman, 1997; Favazza & Conterio, 1998). Furthermore, an additional factor that effects treatment is medical and health workers misunderstanding and negative reactions to the behaviour. Gurlanik and Simeon (2001) suggest that this reaction to the behaviour may in part explain the lack of research in the general area. To investigate the negative view of individuals who purposely harm themselves, Jeffrey and Warm (2002) recruited a sample of individuals in various health professions (e.g., nurses, psychiatrists, psychologists, social workers) and asked them to rate their agreement to twenty statements about self-mutilation. Some of the statements were accurate whereas some were myths, for example, the behaviour is a failed suicide attempt. The results indicated that for this sample, the understanding of self-mutilation was poorer in medical professionals. This has implication for effective treatment as prescribed medications are common forms of treatment though they are possibly being administered by medical doctors and psychiatrists who may not have an accurate understanding of their clients' conditions (Favazza, 1998). Not being able to understand or empathize with clients may negatively effect treatment as the therapeutic relationship has been found to be an integral part to treating self-mutilation (Graff & Mallin, 1967; Huband & Tantam, 2004).

Limitations of the Self-Mutilation Studies

There are several limitations in the self-mutilation research. First, the early studies consisted of case studies (e.g., Kafka, 1969) or file reviews (e.g.,Weissman, 1975). These

methods limit the generalization of the findings. In the case of file reviews, there is the possibility of errors recorded in charts or inconsistent review practices. Furthermore, these methods involve applying labels and defining behaviour based on observations, usually by more than one person and inter-rater reliability is not reported. Other methodological limitations include the use of small samples sizes for quantitative studies and purposeful sampling or convenience sampling as in the large survey studies (e.g., Favazza & Conterio, 1989). Additionally, using retrospective accounts of trauma and self-mutilative behaviour may also be susceptible to memory degradation, thus reducing the accuracy.

Another limitation is the selection criteria used for some studies. In the Weissman (1975) study only wrist cutters were included though self-mutilation is done on other parts of the body. Furthermore, cutting on the wrist could have suicidal intent, which is a different motivation than self-mutilation. This confusion between terms and actions has plagued the literature on self-mutilation and has made interpreting the research difficult, especially when attempting to legitimize the seriousness of the behaviour (Pattison & Kahan, 1983). Finally, many of the studies rely on survey or measures that require forced-choice answers and do not allow for in-depth response, thus limiting the understanding of the behaviour. Warm and Fox (2003) have stated the need for more in-depth qualitative research to promote understanding and some investigators have heeded this call (e.g., Crouch & Wright, 2004).

In addition to methodological issues, the sample characteristics of many studies also limit the exiting literature. Much of the research is derived from female samples although the rates of self-mutilation have been found to be equal between the genders

(Briere & Gill, 1998). That said, it is unclear whether factors involved in female's self-mutilation behaviour are similar in males. Another limitation of the literature is that a large proportion of them use psychiatric samples, which are quite different from populations derived from the general population. The severity of the behaviour along with co-morbid psychiatric conditions are often more severe in these clinical samples. This may influence the function of the behaviour as well as considerations for treatment.

Other limitations of the self-mutilation literature stem from the lack of an organizing theory (Gratz, 2003; Suyemoto, 1998). There are still many unanswered questions about the functions and origins of the behaviour. There are some steps towards expanding this area (e.g., Chapman, Gratz, & Brown, 2005) though continued research, especially studies with non-psychiatric samples are needed. This will help to inform theory and treatment of a behaviour that is becoming more prevalent in society and will likely be seen more frequently in counselling settings.

Purpose of the Present Study

This study will attempt to address some of the limitations of the existing research by providing detailed information into the participants' own accounts of their experience of self-mutilation as opposed to using restrictive measures. To broaden the scope of the research in this area, the focus will be on young adults in the community as opposed to young adults in psychiatric facilities. The focus of the proposed research will be on understanding the emotional, cognitive, and behavioural processes of self-mutilation. While all three parts have been determined to be important aspects of self-mutilation, not much is known about how emotions, cognitions, and behaviours may change during, before, and after self-mutilation. A hope for this research will also be to shed more light

onto areas that have previously had mixed findings, such as triggering events and the dissociative process. Overall, the impetus for this project is to provide more information on a behaviour that is increasing in prevalence though is still much a mystery and difficult to treat. It is expected that this research will provide new insights into self-mutilation and will act as a springboard for future research.

Summary

Self-mutilation is not limited to a specific population. The behaviour can be explained through the lenses of several theoretical explanations for the behaviour, although psychodynamic and behavioral explanations appear to be the preferred theories. Early studies focused on psychiatric patients, typically females with a complex psychological and developmental history. The focus of much of the research has continued to be on adult and adolescent psychiatric patients though this is beginning to shift somewhat with more research being done in the general community. A synthesis of the research presents the self-mutilator as typically being a female that started the behaviour in adolescence. Self-mutilation has been done on several occasions in response to a variety of triggers. The self-mutilator typically has experienced a traumatic event or been raised in a non-nurturing or dysfunctional family environment. The literature also suggests the self-mutilation serves a variety of functions, many of which provide a sense of relief that is reinforcing and makes it more likely the behaviour will be repeated, potentially becoming an addictive cycle.

Consequently, treating this behaviour has proven to be difficult and there is no single agreement on the best form of treatment. Treatments run the gamut from inpatient programs to self-help groups. A large obstacle for successful treatment is health care

workers' negative attitudes and misunderstanding of the behaviour. A step in formulating appropriate treatment is to educate health care workers as well as to consult with self-mutilators and determine what they found to be helpful in overcoming the behaviour. Recent studies have begun to focus on these two areas.

Finally, the limitations of the research on self-mutilation have been discussed. These include an over reliance on small female psychiatric samples, confusion on the terms and criteria for self-mutilation, as well as a failure to replicate many of the studies. What results is a hodgepodge of findings that are not tied together by theories or models, making it difficult to have a comprehensive understanding of self-mutilation. While this is slowly beginning to change, there has been a recognized need for qualitative research to help fill the gaps in the literature as well as to expand on past findings. This study responds to this need by inviting participants to describe their experiences of self-mutilation.

Chapter III – Methodology

A Rationalization for Qualitative Inquiry

The focus of the research was to gain a detailed understanding into participants' experiences of self-mutilation. A large part of this experience includes an understanding of the affective, cognitive, and behaviour processes involved in self-mutilative behaviour. Capturing this depth of understanding goes beyond the capabilities of a nomothetic approach used in quantitative research and requires the application of qualitative methodology (Denzin & Lincoln, 2000; Merriam, 1998).

The research question in this study would not be adequately addressed through quantitative methods that are constrained by hypotheses and do not allow for rich, descriptive findings that will increase understanding. Furthermore, qualitative research provides the researcher with a holistic view of each participant's experience that cannot be discerned from using quantitative methods which strive to find specific variables through precise measurement that are considered representative of the population under investigation (Merriam, 1998; Silverman, 2005).

Few studies have examined self-mutilation in young adults and Strauss and Corbin (1990) recommend the use of qualitative inquiry for novel research questions or questions that offer a slightly different perspective on a topic, for example, there are several studies on self-mutilation; however few, if any, have focussed on the experiences of young adults residing in the general community. Finally, the research question was best answered through the use of interviews. In similar studies, other researchers interested in understanding participants' experiences have implemented the use of a qualitative inquiry (e.g., Davidson, Sells, Songster, & O'Connell, 2005; Holtslander,

Duggleby, Williams, & Wright, 2005). In conclusion, the decision to use a qualitative research approach was based on the nature of the research question, novelty of the research question, and that data were being collected from participant interviews.

Qualitative Methodology – A –Basic Interpretive Approach

A basic interpretative approach was employed in order to capture participants' experiences of self-mutilation and elucidate the processes involved in this behaviour. The goal of basic interpretive research is to capture a detailed understanding of participants' experiences and the meaning they attach to the phenomena of interest by identifying patterns and themes in the data (Merriam, 2002). This approach is grounded in the ideas of constructionism, which posits that meaning comes from individuals and their daily social interactions (Crotty, 1998).

A way of capturing participant's meanings and experiences of self-mutilation is by using the Hermeneutic Circle (Ellis, 1998). The circle has a forward and backward arc. In the forward arc the researcher enters into the interpretive process with a research question that is based on some previous knowledge of the topic; whether this was gained from the literature, personal beliefs, or experiences (Ellis). The researcher relies on this pre-existing knowledge to see how the data fits within that framework. Often this involves weaving back and forth between holistic and partial understandings of the phenomenon (McLeod, 2001), for example, trying to understand how a certain emotion experienced by a participant fits into the larger picture of self-mutilation. Ellis explains the backward arc of the circle as a stage of evaluation where the researcher re-examines the data to see what differs or adds further knowledge to what was interpreted from the forward arc. Thematic analysis or the identification of patterns across the data set is also

used during the backward arc (Ellis). The patterns and themes obtained through the interpretive analysis should provide answers to the initial research question as well as meet the standards for determining the trustworthiness of qualitative research (e.g., Lincoln & Guba, 1985). These standards will be expanded on in subsequent sections.

The Role of the Researcher

In qualitative research, the researcher is the primary tool for data collection and analysis. Therefore, it is recommended that the researcher state the reason for the topic of inquiry, as this will likely shape the process of research, including participant and investigator interactions (Caelli, Ray, & Mill, 2003; Finlay, 2002; McLeod, 2001).

I became interested in the topic of self-mutilation after reviewing the suicide literature where some articles likened the two behaviours as being similar to one another whereas other articles claimed they were the antithesis of each another. Much of this confusion arises out of the broad application of the term 'deliberate self-harm' for studies that focus on suicide and self-mutilation despite the different functions each behaviour serves (e.g., Klonsky, Oltmanns, & Turkeimer, 2003; Theodoulou, Harriss, Hawton, & Bass, 2005). I further delved into the area to find out more about why people would want to hurt themselves without the intention of dying, but better yet to live. What I found was an area that required more in-depth studies. I also recognized that many people find the idea of self-mutilation hard to fathom; however, I was more perplexed by it rather than repulsed, which in some respects, I believe made me well suited to research this area and less likely to be biased towards negative interpretations of the data. Furthermore, my interest in this area also helped me establish rapport with the participants. In qualitative research, the investigator plays a large part in data collection and analysis (Merriam,

1998). I was keenly aware of my role in both these areas and the implications it would have on the trustworthiness of my findings.

There were several steps I took to ensure the rigour of my findings. Throughout the interviews, I tried to ensure that my participants did not feel judged or exploited. It was important for me that they experienced a sense of control over how they told their stories, as for many of them; control was something that often was lacking in their lives. During data analysis I was reflexive and continually asked myself if I was capturing the participants' experiences or was I trying to force them into filling the gaps in the literature that I had encountered. I wanted the findings to not only capture my voice but to also capture the voices of my participants. I believe that this goal was achieved by taking my time during the analysis, re-examining my findings, and having the participants provide me with feedback on the results.

Limitations of the Methodology

The qualitative research approach selected for this inquiry has some limitations. The purpose of the research was to examine a small group of young adults' experiences and therefore makes the findings not generalizable. Also, it is not possible to guarantee the truthfulness of participants' reports, though there would seem to be little motivation on the part of the participants to fabricate experiences of self-mutilation.

Procedure

Participant selection. Approval from the Faculties of Education and Extension Research Ethics Board at the University of Alberta was granted prior to recruiting participants. Advertisements requesting volunteers for a research project on self-mutilation were posted in Edmonton newspapers and around the University of Alberta

campus (see Appendix A). It was stated on the posters that participation involved providing an interview about the experience of engaging in self-mutilative behaviour. In order to be eligible to participate in the project participants had to be between the ages of 18 to 29 years old, as the research was aimed at understanding young adults' experiences of self-mutilation. In order to guard against memory decay and to gain as much information as possible during the interviews, participants must have self-mutilated within the past two years. A final inclusion criterion was that the self-mutilation must not have been related to a suicide attempt. This criterion was used to ensure that the intentions for self-mutilating were not confounded with suicidal intentions. All individuals who contacted the researcher were screened to ensure they met the above noted criteria. Individuals that completed the research where provided with a ten dollar honorarium to cover their travel expenses to the interview site at the University of Alberta. Participants were not told over the phone about the honorarium unless they specifically asked about compensation. This was done to reduce the possibility of people volunteering for the purpose of obtaining money.

Participant demographics. Eight young adults agreed to participate in the research project. The age of participants ranged from 18 to 26 years old. The average age was 21.75 years. Two of the participants were male and six were female. In terms of ethnicity, five of individuals were Caucasian, two were Métis, and one was of South Asian descent. The amount of education obtained by the participants ranged from having some high school to being in university. The average age for starting self-mutilative behaviour was 13 years. The types of self-mutilative behaviour used were predominately cutting, then burning, and finally hitting one's self. The length of abstinence from self-mutilation

ranged from three weeks to two years. At the time of the interviews, half of the participants were still actively engaging in periodic self-mutilating behaviour.

Data Generation

Interviews. Upon arriving to the interview, participants were provided with an in-depth information letter that outlined the purpose of the study and how the data would be stored and disseminated (see Appendix B). An attempt to build rapport with each participant was done prior to beginning the interview by engaging in brief conversation about daily activities such as work or school. Establishing rapport was important for several reasons. First, I wanted to get an understanding of who each one of them was as a person in order to help me when it came time to immerse myself in the data during analyses. Second, the participants were sharing personal information. If they did not feel comfortable with me then it would be unlikely that they would feel comfortable answering the research questions and providing a detailed description of their experiences. After attempting to establish initial rapport, informed consent was reviewed with each participant (see Appendix C). With the exception of one participant who was interviewed over the phone, data were generated from audio-taped semi-structured, in person interviews with each participant. All participants were told prior to attending the interview that it would be audio-taped. A semi-structured interview provided the opportunity for specific questions to be asked but also permitted the interviewer to follow-up with probes and other questions that flowed from the participants' responses (Berg, 2001). Open questions were used in order to gather as much information as possible (see Appendix D). Some additional questions were added, as previous interviews would inform the next interview, especially during the beginning stages of interviewing.

The researcher stressed that it was important that participants felt their experiences were accurately captured in the analysis and were told that they would be contacted in the future to review the findings. Participants were debriefed and thanked for their involvement at the end of the interview and were given the honorarium. A list of counselling referrals was also provided in case there was any distress that was caused by participating.

Other data sources. Field notes were used to record observations during the interviews as well as to record notes about the recruiting process. Another source of data was the demographics and background sheet that each participant completed (see Appendix E). The existing literature also served as a secondary source of data to compare the findings that were derived from this study.

Data Analysis

The nature of qualitative research requires data analysis to be ongoing throughout the research process as opposed to beginning once all the data has been collected. An attempt was made to transcribe each interview before starting the next interview. The rationale for this was that as data analysis occurs with each interview, it often informs the direction that the research will take, for example, the change or addition of research questions (Strauss & Corbin, 1990). Immediate transcription was able to be done for five of the eight interviews, though the researcher made notes of any important details that came from each of the last three interviews in order to maintain the informative process of the interviews. All eight interviews were transcribed and then checked for accuracy.

Strauss and Corbin's (1990) open coding procedure and a thematic analysis (Aronson, 1994) was used in conjunction with a computer assisted qualitative data

analysis (CAQDA) program, ATLAS.ti. Using CAQDA improves the rigour of the analysis as well as helps organize all of the data (Silverman, 2005). The use of CAQDA allowed for the easy comparison of codes, categories, and themes across interviews and was helpful in the detection of negative cases that appeared to differ from the general findings.

Briefly, Strauss and Corbin's (1990) open coding involves logically breaking the data down into manageable units and segments such as phrases, sentences, or paragraphs. For example, a response could be considered a unit or segment of data. Each segment was analyzed for a conceptual meaning or what some researchers call a code. The concept labelled what that segment implicitly or explicitly described. Each concept was given a definition. After open coding the document, the process of categorizing the data began by grouping concepts together that seemed to be describing similar experiences. This often required re-analysis of the data. A category can be thought of as over-arching term with related concepts below. Each category was defined and given a name that captured the phenomena identified by the concepts. This definition also included how the concepts logically fit within the category. Following Strauss and Corbin's recommendations, after the categories were identified questions were asked about each category in order to identify their properties (i.e., characteristics) and their dimensions (i.e., the frequency of occurrence: never to always) and to get a sense of its overall importance. This questioning helped me to elucidate the themes that represented the processes involved in self-mutilation in as much detail as the data would allow. Thematic analyses involved grouping related categories together and describing their relationship (Aronson, 1994). Data analysis was complete once no further information could be derived from the data

and the research questions were answered (Berg, 2001; Ellis, 1998). The results of the data analysis were shared with each participant to ensure the findings accurately captured their experiences.

Ensuring the Quality of the Research

Trustworthiness encompasses a set of criteria used in qualitative research to establish the rigour and believability of the findings and essentially answers the question: "Do the findings accurately represent the participants' experiences?" The trustworthiness of the present research was demonstrated through the use of four criteria, as described in detail by Lincoln and Guba (1985). These criteria are credibility, transferability, dependability, and confirmability.

Credibility. The credibility of the findings was established through several different procedures. Immersing myself within the self-mutilation literature and the data I collected over a long period of time allowed me to become familiar with the data and to guard against inaccurate interpretations of the participants' experiences. This process is referred to by Lincoln and Guba (1985) as prolonged engagement and persistent observation. In keeping with Lincoln and Guba's recommendations, I also implemented triangulation as a technique to enhance the trustworthiness of the research. Triangulation involved comparing the results to those found within the existing quantitative and qualitative literature on self-mutilation, as well as gathering multiple interviews. Member checks, that is having the participants review the findings, was also employed as a method to assess the credibility of the findings. A final technique for enhancing credibility was that I was reflexive and continued to be aware of how my subjectivity may have affected the findings and recorded these as memos during data analysis.

Transferability. A detailed description of the research methodology with particular emphasis on the participant characteristics was provided so that another researcher would be able to carry out a similar study.

Dependability. Steps were taken in order to ensure the rigour of the research process. In addition to establishing credibility, Lincoln and Guba (1985) suggest that an audit of the research can be a technique used for demonstrating dependability. All audio taped interviews, transcriptions, and detailed method and data analysis sections comprise materials that could be used as an audit trail (Merriam, 1998).

Confirmability. Confirmability techniques assess whether the findings are consistent with the participants' experiences and not based solely on the researcher's subjectivity. One suggested technique for confirmability is a researcher's journal (Lincoln & Guba, 1985). Memoing was used to record reflexive thoughts about the process of research, particularly data collection and analysis. Finlay (2002) defines reflexivity as "thoughtful, conscious self-awareness" (p. 532). Reflexivity aids in establishing confirmability by allowing researchers to ascertain how their role impacts the research process, including interactions with participants (Finlay). Confirmability can also be established through the use of an audit trail (Lincoln & Guba). As stated in the dependability section, this study has an audit trail.

Ethical Considerations

Confidentiality and anonymity. All enquiries about participation in the project were kept confidential. Participants were asked to provide a pseudonym that could be used during the interview and in the write-up of the results. All audio tapes, demographics, background information were coded with numbers instead of names and data kept in

secure storage. While the primary researcher did most of the transcribing, some interviews were contracted out for transcribing and a signed confidentiality form was obtained. Finally, taped interviews and documents pertaining to the study (i.e., transcribed interviews, demographic information) will be destroyed after five years.

Potential harm. There was a possibility that a participant could become psychologically distressed about discussing self-mutilation. Therefore, I debriefed with all of my participants and provided them with contact information for psychological and crisis support services should they be required (see Appendix F).

Chapter IV- Findings

Introduction

This chapter presents descriptions and demographic information pertaining to the eight research participants. Following the descriptive information are the themes that were derived from the interviews as an attempt to gain an in-depth understanding into participants' experiences of self-mutilation, particularly the behavioural, cognitive, and affective processes. The themes that became apparent from the data were Cycle of Emotions, Circularity of Thoughts: "You Always Return to the Same Spot in Your Head that Leads You Down that Same Path", Going Through the Motions, Shutting Down, The Power of Pain, Feeding the Addiction, The Colour of Red, If Scars Could Talk, Ascending the Addiction and Conquering the Cycle: Steps Toward A New Beginning, and Healing Experiences: Helped or Hindered?

Participant Descriptions

Eight young adults aged 18-26 agreed to participate in the study and were provided with pseudonyms in order to maintain anonymity. What follows is a brief portrait of each participant at the time of the interview, as well as historical life events that laid the foundation for the development of self-mutilating behaviour.

Ken

Ken is a 23-year-old male of South Asian decent. He identified himself as being single and in the final stages of completing a post-secondary degree at the time of the interview. Ken recalled starting his self-injurious behaviour accidentally at the age of ten:

> It must have been by accident cause no one told me about that kind of stuff. What really happened was I think I just had an infection or something, like a topical

> infection of the skin and I began scratching and the pain...I just kept scratching and scratching and the deeper I scratched the more pain I would feel and that pain felt good to me.

Ken's primary method for injuring himself was to burn his hand. The frequency of his behaviour ranged from every night for a two-year period to more sporadic episodes. Treatment was required for some of his injuries. He also reported that he did try to hide his burns and behaviour from other people by making up stories as to how he injured himself. Ken's longest period of abstinence from self-injury has been for two years though he stated he engaged in the behaviour once in that time span, which to him was "just stupidness". Ken has received counselling for sexual abuse and for career issues.

Jack

Jack is a 23-year-old female of Métis descent. She identified herself at the time of the interview as being single, though she had recently ended a long-term relationship. She works full-time and has completed some high school. Jack's self-injurious behaviour started at the age of seven. She was unsure of the frequency of the behaviour as it was never planned. Jack learned about self-mutilation by accident:

> Like with the paper clips I was just playing one day and I just went (scratches skin) cause I had an itch on my hand and I was like 'ooooh'. And then so I just played with it just out of curiosity. I put the paper clip aside and just made a mental note 'that feels neat' and then it was just sort of something that I fell into, like it was in my mind 'that feels neat' hold on to that, you know.

Jack's form of self-mutilation is cutting. She knows other people who cut and they all identify themselves as 'cutters'. Jack no longer hides her scars and had no discomfort in

showing them to me during the interview. Her longest time without cutting had been three months. As for counselling experiences, Jack was mandated to attend sessions by her stepmother.

Katie

Katie is a 21-year-old female of Caucasian descent. She reported being single and employed part-time. She has completed some high school. Katie began to self-injure approximately once a month when she was 19. Katie first heard about self-mutilation and decided to try it after listening to other people's experiences with it while she was answering crisis calls. Her mode of injury is either by cutting or burning, "I cut myself more than I burn myself I find. I find burning myself more of a challenge." Katie has been hospitalized once as a result of her injurious behaviour. She does try to hide her behaviour from others although friends and family became aware of what she was doing. The longest Katie had gone without cutting or burning was a month and a half. Katie has attended counselling in order to appease her friends and family who were concerned about her behaviour. She also mentioned attending counselling in order to learn more about herself.

Jazz

Jazz is also a 21-year-old female of Caucasian descent. At the time of the interview, she was single and a post-secondary student. Jazz cuts, burns, and hits herself. She first cut herself with a group of friends who were imitating a witchcraft movie and putting together a spell. Jazz then started to self-mutilate by way of cutting when she was depressed at the age of 14:

> I remember in junior high I felt really depressed and I was like well, depressed people cut themselves. Sometimes when you read stuff in magazines, you read about people who do certain things and then you're like, I feel bad I guess I'll do that.

Jazz injured herself anywhere from one to three times a week. She reported that she does not try to hide her behaviour from others. The longest period of abstinence for Jazz had been one year and eight months. Jazz received counselling for her behaviour.

Carl

Carl is a 26-year-old male of Caucasian descent who is in a co-habitating relationship. He completed high school and at the time of the interview he was unemployed. Carl first started injuring himself at the age of 16 by way of burning and self-hitting. His choice to engage in self-mutilation appeared to be influenced by his religious up bringing, "I suppose growing up in sort of a Christian-Protestant household, the whole idea of salvation is based on pain and suffering, I probably made that connection somehow." Carl engages in this behavior approximately two to three times a year. He does not try to hide it from anyone, though he admitted to feeling embarrassed when people have noticed his burns. Carl had abstained from self-mutilation for months, though he could not recall the exact number. He has attended counselling in the past for depression.

Carrie

Carrie is a 22 year-old Métis female. She reported being single and working part-time as well as attending university. Carrie first started to cut when she was 13. She learned of the behaviour by reading a magazine article about it and she thought that the

idea of using cutting as a way to release pain, "sounded like a good idea." She reported that the frequency of her behaviour goes in phases. At times she has cut everyday for several weeks. Carrie tries to hide her behaviour from other people. She has also had to seek medical treatment as a result of her injuries. The longest period of abstinence from self-injury has been one and half years. Carrie attended counselling for depression, cutting, suicidal thoughts and behaviour. Carrie mentioned after the interview that she preferred the term self-injury to self-mutilation, the former sounding less stigmatizing.

Sheila

Sheila is a 20-year-old female of Caucasian origin. She reported being single and employed part-time while attending university. Since the age of 14, Sheila has engaged in self-mutilation approximately once a month. She tried burning but prefers to cut herself. Sheila learned about self-mutilation through literature that was distributed at school:

> In junior high they give you tons of literature on it just because they know there's always going to be some body in at least one school, or one class, that's going to do it. So they always teach you how to recognize it and so it was just an idea that had been there since you started junior high. And when things started to get really sucky it was ok, maybe this will work. And when you realize what it can do for you it's really hard to get out of that rut.

Sheila hides her behaviour from other people. She reported that she has had medical treatment that stemmed from her injuries. Her longest period of abstinence from the behaviour has been less than two years, though she was not sure of the exact date. She has attended counselling for this behaviour.

Cindy

Cindy was the youngest participant. She is 18-years-old and single. At the time of the interview she was working part-time, as well as attending university. Cindy started injuring herself when she was 12-years-old. She first learned about self-mutilation by accident. "I had begun actually taking rocks and scratching myself until I bled. And then I started cutting with exacto knives and it went on from there." When asked why she picked up the rock, Cindy stated:

> I don't even know to be perfectly honest. I've thought about that a lot of times, about exactly what gave me the idea. Usually things like that come from media or something. But I don't even know. It just occurred to me one day that it might help. I guess I sort of wanted out of my skin and that gave me the idea.

Cindy engaged in self-mutilation by cutting herself approximately every day. She hid her behaviour from other people though they found out and forced her to stop. Three weeks was the longest period of time where she has not injured herself. Cindy has gone for counselling with regards to depression and anxiety.

Historical Life Events: Precursors to Self-Mutilative Behaviour

Many of the participants recounted historical incidents that they felt contributed to the development of self-mutilative behaviours. Some of the participants recounted experiences that are indicative of poor attachment relationships in early childhood. For example, Jazz spoke about missing out on feeling close to her family, "I think I felt like that, yes, for most of my life because for whatever reason I just didn't feel very nurtured when I grew up... since I was child, I remember feeling just really separated from everyone." Related to the concept of attachment was the experience of abandonment from

loved ones, either a romantic partner or family, "It always seemed like they wanted kids but they didn't really at the same time. Maybe it was too early, because it was just like we were always some grand inconvenience to them" (Sheila). These experiences left participants with a feeling of not being wanted.

The majority of participants reported various forms of abuse (i.e., sexual, physical, emotional, and neglect). The perpetrators of abuse were family members and friends. Abuse appeared to tie into feelings of self-hate and feeling different from other people.

Bullying by peers and severe family problems were also incidents experienced by some participants. Family problems included situations such as parental arguments, an unexpected drop in living conditions (i.e., change in socioeconomic status), an important member leaving the family, or an addition to the family. Jack recounted how the birth of a half-sister was a precipitating factor for her self-mutilation:

> Things were different now that they had their own child. I started becoming really angry. It was very overwhelming and pretty intense already, so it was sort of like I would grab paper clips and open them up and cut myself like that. And just scratch it 'till it would bleed and then I guess that's how it started.

Another historical antecedent that was mentioned in some of the interviews was a negative body image that attributed to feeling awkward or out of place. This also tied into hating the body and unhealthy eating behaviours (e.g., bulimia). Having a negative body image appeared to make it easier to injure oneself:

> It was more like, the kind of thing, like my body doesn't matter. Like it doesn't have worth because I'm not, you know the stereotypical beauty. I can do whatever

I want to hurt my body because nobody will think my body is beautiful anyway. (Jazz)

Depression was also seen as a fertile soil in which the seeds of self-mutilation could take root. Several of the participants recalled that they were depressed at the time they first experimented with self-mutilation. Injuring themselves helped to validate their feelings and to release emotional pain.

Themes

Careful analysis of the data resulted in the construction of ten themes that represented participants' experiences of self-mutilation. Vignettes from the actual interviews were used as often as possible to preserve the participants' voices and add to the trustworthiness of the findings.

The Cycle of Emotions

Participants were asked to describe their emotions leading up to, during, and after self-mutilation. As such, the theme is described in three stages, which also helps to draw attention to its cyclical nature. Emotions experienced prior to injury were often of a negative valence and of high intensity. This elevated emotional intensity continued during the act; however, the valence of the act became positive. This continued for a short-time after, but then diminished in favour of a more negative valance due to discomforting affect.

Before. There was a range of feelings experienced by the participants leading up to self-mutilation. All of the participants experienced a sense of not being in control of internal (i.e., emotions) and external (i.e., relationships, the future) situations. Several emotions were identified as belonging with this general sense of not being in control.

These were feeling trapped, powerless, vulnerable, anxious, frustrated, and angry. Carl described his emotional reaction to being in a situation that left him feeling powerless to change things, "It was as though there was no option which often kind of sent me to an angry sort of state."

There was also a general feeling among the participants of being overwhelmed prior to self-mutilating. This tied somewhat into feelings of not being in control but there was more of a feeling of being weighed down by all this emotion and feeling confused as to what the next step should be. Jazz described this feeling of being overwhelmed as "Just a feeling of being bombarded, just kind of being swamped by feelings." Sheila also provided an example of this busy whirl of emotion:

> There was anger against people, there was frustration, there was the feeling of being overwhelmed. There's just a feeling of depression that nothing is going right. What is going on here? A little bit of plain being upset, like, why did this happen today?

Participants also spoke of feeling like an outsider. This encompassed feelings of being different, alone, and not being able to relate well with other people. Interestingly, many of the participants expressed that they had friends but still felt somehow different and set apart. For some of the participants, this appeared to stem from knowing that others are not engaging in self-mutilation. Feeling estranged from others was also tied to traumatic experiences:

> I'm not saying that I was a loner as a kid. I never really was. I was always the funny kid and I was always surrounded by good friends, always. In university I didn't really hang out with so many people in school, but I had a lot of friends

> outside of class. And just everywhere you go though you know you still feel by yourself. You're so different. That's what sexual abuse would do to you. It separates you from everyone else almost permanently. (Ken)

This vignette and those from other interviews indicated that feelings of shame were present for some individuals before they harmed themselves.

A general sense of sadness was also present. Katie spoke of the inability to express the sadness that she felt:

> Katie: Sometimes I feel for no reason just really sad and part of me just really wanted to cry, but then I couldn't.
>
> Sandra: You couldn't cry? And would that then trigger you to want to hurt yourself?
>
> Katie: Yeah. I'd just be frustrated like I really just wanted to cry and let everything out but I couldn't.

More specifically, feelings of sadness, worthlessness, and disappointment directed at the self were funneled into hatred towards the self. This self-hatred could be rooted in present events (e.g., not living up to your expectations) or historical events (e.g., abuse, neglect). Ken spoke of the effect of sexual abuse, "But a lot of stuff that was done to me would cause me to hate myself cause it would feel like it was my fault". A portion of Jazz's interview depicted how severe this self-hate could be, "I wanted that destruction you know. I wanted to be able to see myself being destroyed."

During. The feelings experienced during self-mutilation are in vast opposition to those feelings experienced prior to the act. All of the feelings experienced during self-mutilation were positive. A sense of power and control were coded in the interviews most

often during data analysis. During the act there was a feeling of having control, and for some this was the only time they experienced such a feeling. "Because it's like, in a way you kind of do have control over your body, you know. And in some ways that's the only thing you have control over in life" (Jazz). Sheila described the quick effectiveness of self-mutilation at making her feel in control:

> You couldn't control it five minutes ago, ten minutes ago, and now suddenly you are in control of the situation. You can choose to tell people, you can choose to show people, you can choose to take care of it or not. It's all yours from thereon in. Whereas nothing else that hits you, you could have that kind of control over. This one you did, it was totally yours" (Sheila).

This quotation indicates a reason why self-mutilation may be used repeatedly as a way to gain that sense of mastery over the self and the environment. It also highlights the importance of having control over one's behaviour.

The sensation of pain was also an integral part to the emotions that were experienced during self-mutilation. This pain was described at times as being comforting and tied to a sense of strength and power, "It's very warm for me. Like for me it's just really strong" (Jack). A segment from Carl's interview also describes how pain had the ability to make him go from feeling powerless to feeling powerful:

> It's just additional pain and this feeling of being able to actually somehow manifest myself in the physical universe. So instead of just feeling totally powerless and feeling almost spectral or nothing, I could affect anything you know, it's like I can actually have a physical effect.

Pain provided a way to demonstrate that one is present in the world and that one's actions had tangible consequences.

Related to the sensation of pain was feeling alive or real. It has a comforting property to it, mostly because it appeared to end a dissociative state that is still partially present during the act of self-mutilation. Ken described the feeling of being alive and its ability to reintegrate a fragmented sense of self, "I would feel every part of my body being unified". Feeling alive also helped achieve a sense of grounding:

> That driving sense of pain just kind of released me from that. I mean all those things were still there, it didn't clarify anything but it just kind of put me back into my body and gave me once again the ability to act. (Carl)

Feeling alive was also about ending a state of emotional numbness, "I really got a lot out of it and I enjoyed it even if it was painful, because I was like, 'I'm feeling something' and that's better than feeling nothing" (Jazz). For participants that used cutting, seeing blood was an important part of feeling alive, "If I can physically feel something, I'm ok. You know, I am bleeding, I am actually human" (Jack). Participants reported feeling dead inside prior to self-mutilating and the sight of blood signified being alive.

Participants also reported a rush of positive feelings during self-mutilation (e.g., happiness, accomplishment, pride). The rush was pleasing and allowed participants to give in to the moment, taking it all in. There was an excitement that went along with self-mutilating that was all consuming. It replaced the negativity that was there prior to self-injuring and enabled life to continue. "It was just the restlessness and boredom that didn't

feel very good, but then I cut myself and it kind of turned those feelings into a better feeling" (Katie).

Many of the participants reported having difficulty expressing anger or hurt in their interpersonal relationships and self-mutilation was a way they could express such feelings. Jack provided a powerful example of using one of her mother's dresses in order to express her anger and hurt towards her mother who abandoned her when she was young:

> ...that was what I put on my lap [her mother's dress] when I cut. That's what soaked up the blood. Ok, so this whole thing would be soaked in blood. Like I would seriously go wring it out, bring it back and then put on something else so that my actual clothes wouldn't get bloody and then put this over top and I'm just like 'fuck you', like it's the hugest fuck you I guess, basically like when I think about it when I'm not in the moment.

The last portion of Jack's story suggests that while she was cutting she many not have even been consciously aware that it is was an expression of anger but it still was a cathartic act.

After. Many of the feelings experienced immediately after self-mutilation were similar to those felt during the act. There was still a feeling of control and power as well as positive feelings, particularly relief, comfort, and that sense of being alive. An analogy provided by Jack depicts the sense of relief felt after cutting:

> You know how sometimes you'll jump off a diving board and you'll get to the bottom and you're like coming back up and you don't think you'll ever make it to

the top and you're running out of breath and your swallowing water and then you're there and your like (inhales deeply), it's that same way.

Participants reported feeling unlocked from the negative state that they were in prior to harming. Self-mutilation offered an escape from that negativity.

Participants reported that positive feelings were short-lived and replaced by negative feelings as time moved forward. For example, there was regret, "Just when you feel the pain afterwards you really try to see how you really don't want to do this" (Ken). There was also worry, " I think a lot of the reason I don't do it so much anymore is that I know when it's over, oh shit now what am I going to do? I just don't know what to do." This vignette from Carrie's interview demonstrated how thoughts could cycle one back to the point of not feeling in control of the situation. This was further elucidated with a comment from Cindy, "But then after [cutting] that it's usually the harassment of having to deal with it. But then sometimes that just makes me want to cut again." There was also the feeling of disappointment in knowing that this way of coping was only a temporary solution. "Honestly that's what hurt the most was just knowing that it was short term" (Jazz). Shame was also an emotion that many participants had to deal with after "Yes, it's short lasting. Like any relief doesn't last long. And there's the anxiety of having to do something about it, the shame, fear, depression, like it all comes right back." (Carrie)

Circularity of Thoughts: "You Always Return to the Same Spot in Your Head that Leads You Down that Same Path"

The second theme, describes the thoughts that were experienced by participants prior to, during, and after self-mutilation. The theme is circular, much like the Cycle of Emotions. Negative thoughts predominated prior to injuring but were replaced by

positive thoughts and subsequently overtaken by negative thoughts afterwards, thus setting the stage for the repetition of the cycle.

A common experience for participants was a difficulty in recalling thoughts that were present during self-mutilation. This was a phase associated with more emotional content and illustrates how the behaviour is an effective distracter from such burdensome cognitions. This theme also depicts how thoughts are inextricably tied to emotion and as such, cannot always be held in isolation from one another.

Before. Participants experienced a number of self-deprecating thoughts prior to engaging in self-mutilation. These thoughts were often set in motion by some trigger such as stress or interpersonal issues. Participants used several types of cognitive distortions. These included obsessive thinking or rumination, catastrophizing, and pessimistic thinking about not being able to cope with their present situation. Such cognitive distortions were burdensome and prevented one from thinking about anything else. Carl described this obsessive thinking about a romantic breakup that preceded his self-injurious behaviour:

> I become so filled with regret, anger, and powerlessness and you know usually there's--I have justified it away somehow. I could stare at a wall for hours obsessing over it....it's this obsessive thinking that ultimately ends in just brain fog. Not thinking anything anymore.

Other thoughts that were present prior to self-mutilation were ones of failure and not living up to self and others' expectations. Carrie, a self-admitted perfectionist, indicated that not living up to her expectations would send her on the path to cutting. "It's

definitely perfectionism. When you get a 96 you wonder...why didn't I get the other four percent, what's wrong with me?"

Participants spoke of an internal argument that occurred prior to self-mutilation. "It's kind of like back and forth. Like I have an excuse, I don't have to do this now. But at the same time it's like this isn't an excuse. It's kind of like strong and weak. Arguing back and forth" (Katie). It was almost as if part of the mind tried to prevent the self-mutilation from occurring. This internal argument could also be seen as two different parts of the self: emotional vs. logical:

> ...feeling very authentic in my emotions and then coming up to the stonewalling [part of me] who is completely logical you know. Or suddenly what you feel to be like very natural and a very honest expression of yourself is, just you know, negated by logic and trying to communicate between someone who is like, very emotive to someone who is very logical. (Carl)

Part of this internal argument appeared to have a self-preservation element to it as if the mind believed it was wrong to hurt the body:

> Just because before I would hear that voice that was saying you know this isn't right. You know and I would feel ashamed that I was somebody who would harm myself and then also just your instinct of like, you know you should take care of yourself, why would you do this. (Jazz)

Many of the participants acknowledged that they thought about harming themselves in order to get another person's attention, either as a cry for help or to get back at them for a perceived wrongdoing. This was often a more secondary reason for self-injuring. In Sheila's interview, she walked me through her thought process about how

self-harming may be able to get her attention. She realized that with a few scratches on her arm, most people would think it was her cat and not offer her the help she was too afraid to ask for:

> But then you started figuring ok maybe...but how many can they possibly attribute to a cat? Maybe then if there's several, they'll start realizing that maybe something is wrong and then someone will ask some serious questions. It's always easier to open up if someone comes up to you and asks you then to just walk up to someone and say I'm in trouble. So that was pretty much how I started going at it because it was like one isn't going to do it because everyone just thinks I have a cat or I ride horses. Maybe I fell off my horse.

Thoughts of escaping from the current intolerable situation were also present prior to self-mutilation. Participants were aware that making the decision to harm themselves would be an opportunity to escape. "It's as if your skin is crawling and you just want to be out of there and out of the situation. Somewhere else" (Cindy). Ken provided another example of the idea of escape, "I would want to escape. I wouldn't want stress because that stress would lead to other stress and it would just be a chain reaction like a big ball of stress."

During. Participants found it especially difficult to recall the thoughts they were experiencing during self-mutilation. Many recounted that at that time it was mainly the emotions they were feeling. Some of the thoughts identified in the data were about control. Rather than self-deprecating thoughts there were more self-appreciating thoughts around being able to take the pain. This was their time to take care of themselves. The

time taken to self-mutilate was all about the self-injurer and was often one of the rare times they put themselves first:

> While I'm cutting? Just the control thing. That there's a good emphasis on that. Even though, like I said, afterwards it puts me in the mood like I can fake control, during the time it's where I can cut, I get to choose that. It's all things that have to do with me without anyone else's opinions or anyone else's expectations (Cindy).

After. Immediately after self-mutilating, thoughts become clearer and participants stated they were often able to move forward with their life by discharging all of the negativity that was there prior to the act. "I felt it was a huge release and it gave me that ability to say ok, now I can go on. I can do this now" (Sheila). Similar to Sheila's comment, Cindy describes the process of going from being overwhelmed by negative thoughts, to being able to think after harming herself:

> It makes me feel like I can think clear and focus more on that one difficulty or the two difficulties that I'm having and separate them. Because often times beforehand, I start to think that everything's going wrong, there's nothing I can do, it just becomes a big snowball and everything is going down from here. But afterwards I feel like I can think more rationally about it and pick each situation apart and try and fix it. Or at least pretend that I can deal with it.

While there was some clarity of thought after self-mutilation, there was also a realization that the behaviour does not solve problems. Jazz recounted her divided thoughts about self-mutilation:

> Just as it was very worthwhile to do it for me and I got a lot out of it, I remember every time I would do it, I knew it would not change anything. I knew that I

> would still have to go to my job tomorrow and I knew that I would still feel weird around people. And that was the most pain really. That's why I wanted to get to a point where I could attempt to hurt myself really badly because I wanted my harming to change my life.

This quotation also highlights the potential for the behaviour to become more severe and possibly life threatening. Carrie spoke of her changing view of self-injury:

> It's not coping. It's total avoidance. It's just a way to fuck myself up. Usually when I start cutting again in those episodes, I'm just in total self-destruction. Like I don't care what's happening to me, drink at nine o'clock in the morning and get high on coke, then sleep with whoever whenever. Now it's just different. Before it actually—I guess it had a more positive function. I mean positive is not the right word, but it's the opposite of negative. Now it's just a way to destroy myself pretty much.

Going Through the Motions

Participants were asked to describe any behaviours that they engage in prior to, during, and after self-harm. As with thoughts, participants had difficulty recalling specific behaviours.

Before. Behaviours described in the interview ranged from triggers for engaging in self-harm to ritualistic behaviour before self-harm. Triggers can be thought of as conditioned stimuli that, in conjunction with thoughts and feelings, set the cycle of self-mutilation in motion. Triggers were events identified by the participants as happening shortly before self-mutilation occurred. Triggers identified by participants included engaging in interpersonal discord, losing control of situations, not performing to one's

expected standards, alcohol or drug consumption, emotional pain, physical pain (i.e., chronic pain), and engaging in self-stimulatory sexual behaviour. Cindy identified interpersonal interactions and the pressures of having to complete schoolwork as some of her triggers, "It just has to deal with work and school. Having both pressures. And having to go to work and interact with people and pretend to be all nice and happy all day"

Some participants also spoke of engaging in ritualistic behaviour before self-mutilating. This included using a kit, which usually contained the tools needed for self-mutilation (i.e., blades, wipes), cutting in a specific location and/or at a specific time, such as the evening or right before bed:

> It was always at night. It was late at night usually after everyone went to bed. Like it progressed over the years but I always was laying out everything you needed. I started with scissors but I quickly moved onto razor blades. I always had to lay everything out first and then for some reason I always faced the wall. I'm not sure why. (Carrie)

Other rituals included listening to specific types of music and engaging in behaviours such as muscle clenching that would in effect, 'pump up' the person for engaging in self-mutilation.

During. Behaviours exhibited during self-mutilation were varied. For some of the participants, the act of self-mutilation was planned as well as at times impulsive, "The cutting is not something that I ever plan. It just happens" (Jack). The behavior was one that was done in the moment. Engaging in self-mutilation was viewed as coping behaviour that could distract from upsetting thoughts and feelings. It required complete focus and left no room for distressing thoughts and feelings. The concept of control was

also is part of this category. Rarely did participants harm themselves in a haphazard way; instead their behaviour was one of control and precision. At the time of the act, the behaviour could serve as a reward or a punishment, thus making it likely to be repeated in the future.

All the participants who used cutting as a form of self-mutilation indicated that it was important to draw blood. Blood often served as a signal that the cut was deep enough. "Once I started to do the blood stuff I was pretty much good at stopping. Instead of going deeper I would just do it repeatedly in different places (Cindy). Jack described the tactile importance of the blood, "I like to see the blood you know. I like how it drips down. I prefer it to be dark. I want it to be messy. I want to smear it down my arm." Other behaviours that occurred during self-mutilation included clenching teeth, holding the breath, looking at the injury, or looking away.

After. The common types of behaviours reported after self-mutilating were caring for the injuries and taking steps to cover and hide them. Cleaning and bandaging of the wound(s) was important in order to reduce the likelihood of infection. Some participants spoke of wanting to reduce the possibility of scarring. One participant stated that taking care of her cuts was a sign of her independence and ability to take control and look after herself, "In a way I was like, I hurt myself but it felt good that I was the person to take care of myself. It felt like I was still being able to exercise control over my body" (Jazz).

Shutting Down

The theme of Shutting Down was salient across the data. Shutting Down can be described as a narrowing of or change in physical, perceptual, and or physiological processes. This experience occurred in some form or another prior to and during self-

mutilation. Prior to self-mutilation, there was a sense of being separated or detached from one's own body, "I often felt like I was floating, my body would tingle you know, like all sorts of emotions, but more so before I'd do it. I would often feel like I was floating away" (Jazz).

For some there was a sense of a distorted reality or that the world around them was not real. There was also a feeling of numbness both physically and emotionally that created a sense of emptiness or deadness within the individual. The sense of being separated and feeling numb continued for part of the act of self-mutilation. The quality of numbness shifted slightly and for some it was more about not being able to feel much of the pain, whereas for others they were numb to everything but the pain. In these individuals, pain helped to reverse the shutting down process whereas in others it was the sight of blood. Shutting Down during self-mutilation also contributed to changes in vision, hearing, and time. Vision was reported to change; either becoming extraordinarily clearer and more detailed or it would become foggy. Background noise such as music was reported to fade away and time also felt slowed or stopped. Carrie described the changes in vision and hearing she experienced during self-mutilation, "It's definitely tunnel vision like that's the only thing you focus on. The only thing you see is what you're doing, really. In terms of sound, I just don't really hear other things. I just don't hear it"

The Power of Pain

Although briefly touched upon in the theme of emotions, the experience of pain deserves further elaboration. There were more positive elements attributed to pain than negative ones. Overall, pain provided good feelings such as comfort, pride, strength,

control, accomplishment, feeling alive, and feeling reintegrated. Carl provided a description of how pain ends his sense of fragmentation:

> There's a practice in Zen or actually probably most forms of meditation where they hit a gong and you focus on that sound and it's supposed to bring you back into yourself. That's the same sort of association I have with that feeling of pain which is you have the instant pain and you can just feel yourself coming back into yourself until the pain itself kind of like dissolves. Because there's the initial shock of what's happening and then like the slow feeling of your body adjusting.

Pain was used to distract oneself from distressing thoughts and feelings. Essentially emotional pain was replaced or validated by physical pain. Many of the participants also spoke of the importance in controlling the pain, particularly with regards to ending the sensation of pain. Whereas emotional pain may not be so controllable, physical pain can be controlled. "Because that pain of being alienated and not belonging and feeling judged really, really hurt. That was a pain I could never escape and cutting or burning is a pain that is there but it ends" (Jazz).

Feeding the Addiction

Feeding the Addiction is about the addictive nature of self-mutilation. Seven out of the eight participants stated that self-mutilation could be considered an addiction. Participants stated that they became dependent on the behaviour to make them feel better, "You get cravings for it. Like but the cravings aren't for any one thing. The craving is probably escape. Like your mind wants escape from the shitty reality it feels." (Ken). As Cindy stated, "Yes, it works really well and it feels good." The pain and its ability to provide release from the aversive state appeared to be what was addicting, "you almost

relied on it to get through a bad week. Like you needed to do it just to release and feel that it would go away. It was really like an addiction, you had to do it" (Sheila).

Tolerance to the effects of the behaviour was also frequently described. For example, this vignette describes Jack's tolerance, "I can ideally feel the pain and the longer I've been doing it, the less and less I feel". Tolerance leads to engaging in longer periods of self-mutilation, increased frequency and or intensity, such as cutting deeper. One participant stated that she found cutting to be more powerful than drugs, in particular cocaine.

The Colour of Red

The Colour of Red signifies how important it was for the participants who engaged in cutting to draw blood during the act. Participants spoke of being able to see or rub their fingers in their blood. Blood indicated that one was alive or real, "Like being able to see what's underneath your skin basically" (Carrie). There was proof that there was a living person under the skin and not an empty vessel. Participants also reported that the blood was tied to experiencing positive feelings such as comfort, relaxation, and a sense of accomplishment. There was a potential for serious harm with the drawing blood, for example excessive blood loss from deep cuts. Jack provided a graphic description of how deep she cuts, "I cut really deep right away now so it takes a while [to bleed] because I cut into the fat of the skin and so you're kind of passing the part that would make you bleed."

If Scars Could Talk

This category groups together the characteristics of the responses of participants who were asked the question, "If your scars could talk what would they say"? Some

descriptions were slightly negative, whereas other felt their scars would say something more positive. The more negative responses described the scars as being reminders of failures and things that went wrong:

> I didn't want to see them. Scars really bothered me. Doing it didn't so much but the scars still really bother me because I know it's there. At times when I'm not in that place, I knew it would constantly remind me and I wanted to eventually stop and get it out of my life and pretend like it wasn't there. I didn't want to have the scars to remind me. (Sheila)

Positive responses described the scars as a symbol of overcoming something, being courageous and surviving. "Yeah it's like you know that bullet wound from some battle or confrontation. It's more like a souvenir of this terrible thing that I somehow survived." (Carl)

Ascending the Addiction and Conquering the Cycle: Steps Toward A New Beginning

Participants spoke of permanently or temporarily ending the use of self-mutilation as a way to help cope with their problems. Taking the time to identify other ways to cope was one of the concepts that was derived from the interviews. Some of these ways of coping were healthy, such as finding ways to release frustration. Sheila spoke about the therapeutic benefits she received from replacing rotten wood on a cabin every September when the stress of school starts:

> It's like this is the greatest thing ever. And then you put it back together again and you get a feeling of accomplishment because you're like wow, it's done. It's safe. And at the same time you've also vented a lot of anger because you're not going

> to keep that wood anyways, it's rotten. You can just go at it. We have to get the nails out and stuff so there's all kinds of places to vent a lot of stress.

Some of the participants also identified other ways to cope but these alternatives had the potential for creating further problems. These included drug or alcohol use, unhealthy eating, excessive exercising, and promiscuous behaviour.

Participants also spoke about the importance of learning what triggers their self-mutilation. Ken mentioned the hard work involved in being able to stop himself from burning his hand:

> It took work and practice. It even took practice to stop doing it. You really got to practice to resist it. But not only resist it, at the same time you have to analyze it. You can't just resist it. You gotta know what it is that's eating you up.

Journaling was one way that participants learned more about themselves, for example noting triggers, as well as expressing how they were feeling. Talking to others (friends, mental health professionals, support groups) as well as writing poetry and stories was also found to be helpful. Being in relationships was also identified as a way to stop self-injury, perhaps temporarily, as it is difficult to explain the behaviour to a partner as described by Carrie, "I'm not doing it right now and actually being in relationships helps me not do it because it's a lot easier to explain scars than it is to explain stitches." Recognizing that relationships were more important than self-injuring was also a turning point for Sheila, "I realized after one time of him getting really mad at me for doing it I realized that I wanted him more than I wanted this."

Learning self-acceptance was also part of the process in ending the behaviour, "I learned to just really kind of enjoy my physical sensations that come naturally because of

being a very emotional person. If I would get those feelings where I was floating away I would just lie back and enjoy it." For Jazz, rather then using self-mutilation to end her dissociation, she accepted it and let it end on its own. Learning how to express emotions verbally rather than physically was also found to be helpful.

Re-defining the self was another step in ending self-mutilation. Participants spoke of living their life according to their dreams or values rather than someone else's, essentially taking control and responsibility of their future. Another step was of re-defining the self by learning new ways to describe oneself. Ken provided an example of how the people in his support group helped him and encouraged him to learn to define himself differently:

> Ken: They gave me good thoughts. Like I'm courageous for going to a group or you know for talking about it. Real supportive and giving me, I like to call them weapons cause your internal dialogue uses certain words without you knowing your self when you try to explain yourself to yourself. And these people gave me great weapons to use to explain myself to myself. So instead of explaining myself as out of control and just being defined by pain all the time, these people gave me words like courageous and you know smart guy and keep doing what your doing you know, all the positive things. They gave me great weapons.
>
> Sandra: Yeah they gave you a new vocabulary.
>
> Ken: A new vocabulary for my internal dialogue.

Overall, the interviews revealed that finding a different way to express and accept oneself is an important step in ending self-mutilation. The findings also highlight that

ending self-mutilation was not simple. Many of the participants could not say for certain that they would never engage in that behaviour again.

Healing Experiences: Helped or Hindered?

Healing Experiences is a category derived from pieces of interview text that identified issues important for the treatment of self-mutilation. These include clinical considerations as well as the attitudes of healthcare professionals. Issues to consider in therapy are the difficulties that the self-mutilators have in explaining the reasons for their behaviour. In the same vein, alexithymia may also be a barrier to treatment, especially if therapy is emotion-focused. The need for the client to have control over the therapeutic process may also pose difficulties as described by Cindy: "I spend a lot of time trying to take control of situations, which in therapy you really can't. They need to be the ones in control and directing you..." Developing a trusting relationship is also important, especially with adolescent clients who know their parents may be notified if they divulge their behaviours. One participant spoke of the need for helpers to be persistent in trying to get clients to talk about their self-mutilation, "The first time somebody asks you [about self-mutilation] it's like 'No, what are you talking about.' But if they're persistent and they keep asking you and you really start to feel like they care, you might open up to them" (Sheila). The participants attested to the addictive properties of self-mutilation, which therapists must also recognize and address during treatment.

The interviews also highlighted important considerations for group treatment of self-mutilation. Group therapists must have some control over what is and what is not discussed in and out of group. One participant spoke of the underlying current of

competition between cutters where individuals who had stitches were more of a cutter than those without stitches.

The second part of this category relates to the attitudes of helpers when they are faced with someone who self-mutilates. Carrie recounted her negative experience of seeking out medical treatment for her injuries, "...the nurses were really critical. They never specifically said anything to me but like a nurse setting up stuff for stitches, it just...they look at you and you just knew what they were thinking." In contrast, at times helpers may even ignore the behaviour or misconstrue it as something else:

> I told them about my self-mutilation, the therapists there. But I think that they thought it was just me trying to work myself up to kill myself which I explained that they're two different things. Because they really are in my mind. I've never attempted suicide. And if I did it probably wouldn't be by slitting my wrists or anything. I tried to explain that to them but they...I don't know. It's almost as if they ignored that. (Cindy)

Chapter V - Discussion

The findings of this study present an in-depth account of the participants' experiences of self-mutilation. Many of the conceptual themes can be grouped together to highlight commonalities. The Cycle of Emotions and Circularity of Thoughts both describe important cyclical processes that are also tied to the themes of behaviour, blood, and the meaning of the scars that are formed by self-mutilation. Shutting Down, stands alone, yet is still an important part in the understanding of self-mutilation and is related to The Power of Pain. The experience of pain is also linked to the addictive nature of self-mutilation as described by participants. The findings also have important implications for counselling and offer exciting avenues for future research.

The Cyclical Processes

The interviews with the participants provided detail into the cyclical nature of emotions and cognitions involved in self-mutilation. Self-mutilation was used by participants to cope with distressing emotions and thoughts, particularly when they experienced feelings of not being in control of one's self or their situation. Similar to previous findings, a myriad of other negative emotions were also present, such as frustration, feeling overwhelmed, sadness, alienation, and self-hate (Crouch & Wright, 2004; Favazza & Conterio, 1988). They spoke of feeling shame, both prior to and after self-mutilating. It is possible that feeling alienated and being an outsider were somehow related to shame about either self-mutilating or the stigmatizing effects of abuse they experienced. Shame can have devastating consequences on the ability to maintain interpersonal relationships and has been tied to self-blame, anger, and withdrawal

(Tangney & Dearing, 2002). Many of these consequences were triggers for self-mutilation and it would appear that shame helps perpetuate the cycle.

In contrast, feelings during self-mutilation were positive suggesting the behaviour is effective at providing a quick sense of relief (Favazza, 1998). Feeling in control was a predominant emotion. This was tied to feeling powerful and having a sense of mastery over one's self and the immediate situation. Interestingly, the sensation of pain was generally attributed to positive feelings such as comfort, feeling alive, and re-affirming beliefs that one was human. Although this finding appears to be paradoxical, the positive feelings derived from pain may relate back to trauma (e.g., childhood abuse and neglect) or severe childhood illnesses. In these situations, pain becomes linked to a feeling of being nurtured (Yates, 2004). Self-mutilation also served as a way to express displaced feelings, such as anger towards others. In the period after self-mutilation, feelings continued to be positive but then shifted back to negative affect such as regret, shame, sadness, worry, and feeling out of control. This demonstrates how the behaviour's effectiveness is limited, as it only provided short-term coping and created additional stressors such as worrying about hiding injuries (Alderman, 1997).

The cyclical nature of thoughts is revealing and highlights a parallel process with the cycle of emotions. Cognitive distortions such as catastrophizing and pessimistic thinking also helped maintain the cycle by exacerbating stressful situations. Self-mutilation was used to unlock obsessive thinking that became almost incapacitating. Interestingly, having perfectionistic beliefs were tied to a need for control or an attempt to bolster a low self-worth. Participants also reported a conflicting internal dialogue about self-mutilation. This internal argument has been observed previously (e.g., Pao, 1969) but

it has not been directly explored as to how it may be related to self-criticism and depression in self-mutilators. Depression has been reported to be higher in self-mutilators than non-self mutilators and perhaps perfectionisim and self-criticism are important factors in this difference (Darche, 1990).

Participants explained that sometimes their thoughts about engaging in self-mutilation were to elicit attention from others. Often this was secondary to goals such as relieving negative affect. The idea that self-mutilation is done for attention has been an issue of contention in the literature and is often downplayed in practice (Warm & Fox, 2003). Unfortunately, this creates an inaccurate description of self-mutilation and could result in the dismissal of a legitimate reason for the behaviour. The possibility of wanting attention could be conceived of as a cry for help in a behavioural way.

Behavioural aspects involved in self-mutilation are also important in understanding the cyclical process of thoughts and emotions. Specific events such as interpersonal discord or experiencing a situation that lacks control trigger these two processes. Many of the participants also discussed the importance of caring for injuries, which seemed to be tied to positive thoughts and feelings. Self-mutilating may be the only time when self-nurturing occurs (Alderman, 1997). Another interesting finding in those who cut is that the sight of blood was a signal to stop. It also symbolized being alive, which was comforting and calming for the participants. This corresponds with Kafka's (1969) supposition that blood acts as a transitional object, providing the means for a person to pass from the state of feeling dead to feeling alive.

The cyclical nature of thoughts, emotions, and behaviours are presented in some of the literature (e.g. Alderman, 1997), yet much of the empirical research tends to focus

on before and immediately after self-mutilation, thus not capturing the negative states that begin to re-emerge and set the cycle back in motion. The result is an incomplete understanding of the processes involved in the behaviour. This study has attempted to capture these processes in order to provide a holistic understanding of self-mutilation.

The Role of Dissociation

The theme of Shutting Down shed further light on the role of dissociation in self-mutilation. Participants experienced physical, perceptual, and physiological changes both before and during self-mutilation. The relation of dissociation to self-mutilation is not one that can be easily explained, as there appears to be more than one process that occurs (Zlotnick et al., 1996). The participants' descriptions were that the behaviour is used to end a dissociative state, usually one where the individual feels numb or separated from one's self. During self-mutilation, the type of dissociation tends to shift. Rather than feeling dead or separated from the self, there were more perceptual changes reported (i.e., changes in vision, hearing, and time). It is possible that self-mutilating and the presence of pain contributed to a dissociated state that dulled the initial pain. This has been described as an automatic trance state that reduces pain sensitivity (Beahrs, 1982). Additionally, if the individual views the behaviour as wrong or unacceptable, they may dissociate in order to separate that action from their identity (Spiegal & Cardeña, 1990). In fact many of the participants described how they sometimes argued with themselves about self-mutilating, knowing it was wrong. Most of the participants also indicated that feeling pain is what ended the dissociated state (i.e., made them feel real and re-integrated); however for some, the pain was often dull, thus allowing them to continue to harm themselves. This indicates that a dissociated state was still being experienced and

perhaps in these situations, instead of pain, the sight of blood brought on a sense of integration and ended the dissociated state (Suyemoto, 1998).

A tentative explanation of the findings is that the initial dissociative state is brought on by some precipitating factor, perhaps by a trigger of past trauma or intolerable emotions. The act of self-mutilation activates another dissociative process that may or may not be under the individual's control, which allows one to be distant from the pain, either physical or emotional, and possibly from the actions that do not correspond with their self-identity. This purposeful distancing from pain is frequently used in hypnosis and is not regarded as pathological (e.g., Hilgard & Hilgard, 1994). The separating of the self from something that does not fit with the identity is common in the trauma literature but has not been explored in relation to self-mutilation. Dissociation may also provide self-mutilators with the ability to focus all their attention on their action at that moment, thus blocking out distressing feelings and thoughts (Speigal & Vermutten, 1994). Overall, the dissociative process is complex and it would be incorrect to suggest that it occurs only before or during self-mutilation; rather there appears to be variability in its temporal order that may be attributed to individual differences such as having a dissociation-prone personality or a trauma background.

Physical Pain and Addiction

The physical pain inflicted by self-mutilation plays a powerful role as described in the Power of Pain category. It is surprisingly tied to positive feelings such as re-affirming the existence of one's self, control, strength, and accomplishment. Pain also served as an effective distracter and seemed to be a way to represent and validate emotional pain (Suyemoto, 1998). Although this aspect of self-mutilation is important in the current

study, there are scarcely any studies that focus on the meaning of pain. The few studies on pain involve cold-pressor pain sensitivity tasks with Borderline Personality Disorder (BPD) patients who have shown they have a reduced sensitivity to pain (e.g., Bohus et al., 2000; Kemperman, Russ, & Shearnin, 1997). A limitation of these types of studies is that not all self-mutilators are given the diagnostic label of BPD and the similarity between cold-pressor tasks and self-mutilation is very different. Other studies have examined the pain caused by self-mutilation and the release of pleasure producing brain chemicals that become addicting (e.g., Sandman & Hetrick, 1995). Unfortunately these studies tend to focus on self-mutilation only in the developmentally disabled.

A lack of understanding about the meaning and function of pain is surprising considering the addictive nature of self-mutilation, specifically the release of endogenous opioids that are triggered by pain and provide pleasant feelings. Experiencing pain and having it quickly end a distressing state by inducing pleasant feelings may be what participants in this study found addicting. Pain may also be used to access a dissociated state, thus providing a temporary escape from the emotional pain and cognitive blockage. If pain is at the crux of self-mutilative behaviour and its continued use, then it is important to gain a better understanding of this area, specifically with regards to its addictive nature as addictions are commonly used as a way to cope with pain (Dayton, 2000; Ziegler, 2005).

Ending the Cycle of Self-Mutilation

Many of the participants described alternatives to self-mutilation and their experiences of seeking help. Similar to what has been reported by others (e.g., Smith, Cox, & Sarajian, 1999), a clear theme from the interviews is that ending self-mutilation

involves a commitment to identifying triggers to the cycle, learning about oneself, and wanting to change. For many, this was done on their own and rarely with the aid of counsellors. Participants reported that counsellors and medical professionals misinterpreted their behaviour or were not able to be trusted. Some of the participants' experiences of ending self-mutilation seemed to describe a period of inner growth that allowed them to see how their behaviour was only temporarily alleviating their difficulties and did not fit with their new image of the self. In addition to this growth, participants also described creative outlets that were alternatives to self-mutilation. Being accountable to others about explaining scars or marks (e.g., boyfriend) were also reasons to end the behaviour. Participants were not confident in stating they would never use self-mutilation in the future, suggesting there is a dependency on the behaviour, or at the very least a reassurance that if other ways of coping fail, self-mutilation will always be an option.

Implications for Counselling

A novel finding from the present study is that living an authentic life according to one's own values and desires as opposed to someone else's, is helpful in ending self-mutilation. In support of this finding Nicholson (2004) described self-mutilation as "an attempt at recreating the self" (p.31) by working through past abuse. He suggests part of this involves working in a therapeutic relationship, which is understanding and is sensitive to this recreation process and does not intervene prematurely by trying to stop the behaviour. While this could possibly present some ethical dilemmas, other modes of treatment such as learning assertion skills or not being in enmeshed relationships would be avenues to explore in counselling.

Some of the participants also spoke about what they perceived as negative or unhelpful practices of care providers. Counsellors and other mental health workers need to be aware of their attitudes or assumptions about self-mutilators as this can affect treatment or compound one's sense of shame, which could further inhibit seeking out help. Hopefully, learning about self-mutilation will help reduce negative attitudes as most often they are rooted in fear and a lack of understanding. A message taken from the interviews is that professionals working with these individuals must not shy away from enquiring about engaging in self-mutilation. Often trust is an issue for many of these clients and this needs to be established before harming is revealed. Issues around control are also not commonly mentioned in the literature regarding treatment, though they were discussed by some the participants of this study. Finding ways for the client to feel empowered and have some control over the course of therapy is important, while at the same time finding a balance that will still allow the therapist to work. Also learned from some of the participants is that they can be in competition with themselves and others around their harming behaviour. This should be a consideration for therapy, especially group therapy, in order to reduce the likelihood of a contagion effect or an increase in the frequency or severity of the behaviour (Crouch & Wright, 2004).

The participants state there are multiple ways to help break the cycle of self-mutilation. Being creative (i.e., journaling, story writing) is a way to help end the behaviour. This has not been explored to its potential; for example, art therapy may prove to be beneficial, especially for individuals who have trouble expressing their feelings. An important goal for treatment would be to find alternative transitional objects other than

blood that could establish a sense of grounding and prevent the client from self-mutilating.

Counsellors should also be cognizant that some of their self-mutilating clients have a history of trauma that needs to be addressed during treatment. Additionally, it is important to take the time to build a strong working relationship and be sensitive to the client's need for control, perhaps using that as a way to create empowering opportunities (Huband & Tantam, 2004). The therapist must also learn the client's emotional and cognitive cycles, as well as the triggers that maintain self-mutilation. A multi-modal treatment approach can used in order to address emotions, cognitions, and behaviours; however, keep in mind the challenge of working with emotions if the client is alexithymic or when working with traumatic issues. In the former, it may be difficult to identify and work with emotions whereas with the latter, the client could become overwhelmed with emotions, thus increasing the risk of early termination. Finally, the client needs to learn how to better regulate emotions, reduce the level of stress in their lives, and learn adaptive coping strategies (Suyemoto, 1998; Zila & Kiselica, 2001).

In general, there appears to be confusion in the literature about how to treat people who self-mutilate (Alderman, 1997; Jeffery & Warm, 2002; Zila & Kiselica, 2001). Aside from the use of medication and therapeutic relationship factors, there are several other modes of treatment many of which stress the use of creative approaches to form alternative responses to self-mutilation as well as approaches that blend behavioural, cognitive, psychoeducation, and emotional regulation techniques (Muehlenkamp, 2006; Wester & Trepal, 2005). Often, a goal of treatment is to teach clients to verbalize or express their feelings through writing or drawing as opposed to harming (Alderman,

1997; Favazza, 1998; Graff & Mallin, 1967; Smith, Cox, & Saradjian, 1999; Suyemoto, 1998). Behavioural treatment such as examining precipitating factors, relaxation, response prevention, behavioural substitutions, or behavioural contracts have been commonly used (Alderman, 1987; Favazza, 1988; Suyemoto, 1998; Winchel & Stanley, 1991). Interestingly, there is some debate over the effectiveness of contracts, relaxation, and family therapy (Zila & Kiselica, 2001). Effectiveness may depend on the several factors (i.e., severity, age, comorbidity) and asking what clients find helpful is becoming more frequent (e.g., Huband & Tantum, 2004; Lindgren, Wilstrand, Gilje, & Olofsson, 2004).

Limitations of the Study

A limitation of this study is the use of convenience sampling. Individuals that chose to be a part of the research may be quite different in several areas (i.e., maturity, cessation of self-mutilation, verbalization skills, less shame) from those who did not want to participate. The possibility that some participants may have fabricated, omitted, or embellished their narratives must also be considered. The length of time between the interview and last engaging in self-mutilation may have also been a factor in the amount of detail that could be remembered. While every attempt was used to maintain consistency across the interviews, it was not always possible to ask the exact same questions, as not every person's story was the same. Additionally, an attempt to establish rapport was done with each participant; however, participants still many not have felt entirely comfortable sharing personal information. There was also the possibility of researcher bias entering into the data analysis. Member checks were originally scheduled to take place as a way to guard against this, however, only some of the participants could

be contacted after analysis was complete. A research team collaborating together on data analysis would have been another way to manage researcher bias.

Implications for Research

The findings provide several avenues for future research. Qualitative research would be especially helpful in furthering the understanding of self-mutilation, as many of the meanings derived from the data are difficult, and in some cases impossible to assess quantitatively. One exciting area for future research is to understand more about the acquisition of the behaviour. In this study, some of the participants' initial experience of self-mutilation was not planned but instead occurred often by accident. There seemed to be a propensity for curiosity in these individuals, for example, finding out what would happen if an open paper clip was scratched on the arm or what would it feel like to cut or burn the skin. It is possible that certain personality traits such as being open to new experiences may partially account for the first experience of self-mutilative behaviour. An interesting question that remains is why did the behaviour continue to be used after the initial experience? Perhaps one explanation is that pain was paired with a positive feeling and potentially increased the chances of the behaviour being repeated at a later date. This tentative explanation appears to be too simple and further research into the acquisition and maintance of this complex behaviour is warranted, especially with regards to its possible connections to early abuse or traumatic incidents. If the behaviour is tied to trauma as some have suggested (e.g., Chu, 1991) it would be fascinating to understand if the choice to hurt one's self is conscious or a somatic way of somehow reenacting the trauma in an attempt to resolve or provide something that was not there

when it originally happened, for example having control or being comforted (Ogden, Pain, Minton, & Fisher, 2005).

Other possibilities for future research are the role of emotions and cognitions. Particularly how they interact with each other to maintain self-mutilation requires further investigation. The feeling of power that was described by participants has been over-looked by investigators, though it was important to their participants. For example, during the development of a scale to assess the motivations for self-mutilation, the participants in Osuch, Noll, and Putnam's (1999) added statements to the scale that represented feeling powerful and strong, which were then included in the revised scale. If a person is able to feel in control of something, it would seem logical that there would also be a feeling of power involved as well. It would be interesting to focus further research into self-mutilators' internal or external locus of control and to understand how their perception of control may change depending on the situation.

Feeling alienated and like an outsider were also predominant feelings for participants, though these feelings have not been adequately explored. Another important finding taken from the interviews was that participants had trouble expressing their feelings verbally. Only one previous study has focused on this area and found a positive relationship between self-mutilation and alexithymia (Zlotnick et al., 1996). The possible presence of alexithymia has important implications for the techniques and type of therapy used with self-mutilators. Additionally, further research is needed in order to clarify if the inability to talk about feelings is actually due to alexithymia or if it can be attributed to avoiding the experience of distressing feelings that Champan, Gratz, and Brown (2006) term experiential avoidance.

Another area for future exploration is the possible role of perfectionism and self-criticism in self-mutilation. Research has shown that perfectionism and self-criticism have been associated with depression and suicidal ideation (Abramson, Alloy, & Hogan, 1997; Hewitt, Flett, & Weber, 1994; Lynd-Stevenson & Hearne, 1999). Depression has also been associated with self-mutilation and while the behaviour is not done with suicidal intent, over time, it has been found to increase the risk of suicide, possibly due to its limitation of only being a short-term coping mechanism (Favazza, 1996). Perhaps perfectionistic and self-critical beliefs may be contributing factors to creating or compounding stress, while at the same time the individual is not able to effectively employ long-term coping strategies to deal with such stressors.

The obsessiveness and rumination involved in self-mutilation would also be an interesting vein to investigate. While the obsessive component involved in the behaviour has been acknowledged, it has not been a focus of most investigations (Favazza & Rosenthal, 1993). Overall, more understanding, particularly the interplay between emotions and cognitions is required of this area and would be best met through both qualitative and quantitative studies.

According to the interviews, self-mutilation can be impulsive or planned. This requires further investigation, as the majority of research tends to describe self-mutilation as an impulsive act (e.g., Herpertz, Sass, & Favazza, 1997). What would be helpful to know is why the behaviour is sometimes planned and at other times impulsive. This could be related to personality differences or dependent on the type or severity of the trigger experienced. Also related to the behavioural aspect of self-mutilation were the steps taken to prevent infection of wounds. Alderman (1997) has discussed this self-

nurturing, though there are few accounts of it elsewhere. Future research could focus on the importance of this behaviour, particularly its possible symbolic nature to early attachment relationships. Additionally, another aim of research could be to find other more adaptive ways to self-nurture.

The findings also indicate the role of dissociation is not clear and would benefit from future research. Several dissociative processes appear to be involved in self-mutilation and it is not only present prior to self-mutilating. There are individual differences in when and what type of dissociation is experienced and this may be related to pain tolerance, personality, or trauma background. At this point, it is not clear whether or not existing theories of dissociation can adequately explain how it is used in self-mutilation. Further research would help elucidate its role and if necessary, begin to formulate theories that fit with the dissociative experiences of self-mutilators. Researching alternatives to blood in helping prevent a dissociative state or quickly ending one would also be useful for counsellors.

As an additional note, while recounting their experiences during self-mutilation, some of the participants spoke in the second person (e.g., using you instead of I or me) or tended to have long pauses or ask for questions to be repeated, as if they had been daydreaming. It is possible that a small amount of dissociation occurred for some during the interview. This would be interesting to investigate as treatment could be affected if the client is not fully present in the session. Huband and Tantam (2004) have also reported that dissociation could occur during treatment with self-mutilating clients and it needed to be addressed in order for therapy to progress.

The role of pain, particularly in relation to addiction and dissociation is an avenue for further exploration. The area of pain research has burgeoned over the last decade and it would be expected that the knowledge gained would be helpful in understanding how pain operates in self-mutilation. Areas of investigation could be to understand the use of self-mutilation to control chronic pain but more so, emotional pain. It would also be interesting to determine if some individuals who are chronically under-stimulated (i.e., bored and prone to thrill-seeking behaviours) use self-mutilation in order to experience stimulation through physical pain.

The addictive aspect of self-mutilation and its relation to pleasure-producing brain chemicals requires further investigation. It would also be helpful to understand the role of other addictive behaviours (i.e., substance abuse, eating disorders) that are often seen in conjunction with self-mutilation. Finally, the participants viewed their scars as either good or bad. It is interesting to see such a dichotomous split and further research may help identify why some feel shameful whereas other self-mutilators feel pride in their actions.

Considering the estimated increased number of people self-mutilating, future research should focus on prevention and treatment. This could be achieved through interviews with individuals that have ended their self-mutilation and finding out what helped them break the cycle, as well as what they think could have prevented them from beginning the behaviour. As was discussed in one interview with a participant, sometimes providing information about self-mutilation in places such as schools, may actually introduce the idea of using that behaviour in times of stress. This presents a possible problem for prevention. How do counsellors and public health educators introduce an

important topic but not introduce it as a possible coping mechanism? Focus group research would be beneficial to answer such questions.

Other areas of future research should be directed at understanding self-mutilation within the individuals residing in community, as much of the existing research is done with mainly female psychiatric patients who are different than individuals in the community. Research that involves males is also desperately needed. Several of the participants spoke of likely never stopping their behaviour, suggesting that self-mutilation is not a behaviour that is only a phenomenon seen in young people. Unfortunately, the behaviour has not been studied in older adults. It would be interesting to understand the behaviour in older adults, especially how it is incorporated into their identity and how they cope with feelings such as shame and alienation for many years without it progressing to more severe problems, such as depression or suicide.

Finally, research needs to be conducted into how self-mutilators view their behaviour as this will be an integral factor in their willingness to seek treatment. Do they view their behaviour as deviant or odd or do they take the position that it is their body and they can do as they please. Tattooing and piercing were once looked down upon in society but both are now a commonly accepted form of body decoration. Is it possible that purposely hurting oneself in order to feel better will also one day become acceptable?

Summary

In summary, these findings present detailed information on the cyclical processes of thoughts and emotions as well as the behaviours engaged in prior to, during, and after self-mutilation. The interviews also highlight the complex nature of dissociative processes and describe the experiences of pain and addiction as well as ways some of the

participants tried to end the behaviour and seek out professional help. There are also several points to consider for counselling clients that self-mutilate. These include being aware of negative attitudes towards self-mutilators and taking the time to build a strong therapeutic relationship and understand the client's cycle of emotions and thoughts. Moreover, a flexible approach is needed in order to address behaviour, cognition, and emotion. The findings also provide avenues for further research that will hopefully culminate in a greater understanding of self-mutilation.

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Appendix A

Recruitment Poster

HAVE YOU EVER INTENTIONALLY HARMED YOURSELF?

Would you be willing to share your experience of self-harm in an informal interview? I am a Masters student at the University of Alberta conducting research on deliberate self-harm, specifically, self-mutilation. I am looking for participants between 18 and 29 years old and who have self-harmed within the past 2 years.

- 18 to 29 years of age
- Self-harmed within the past 2 years
- Intentional self-harm must **NOT** have been related to a suicide attempt

Participation and email enquiries are strictly confidential. Please email Sandra at
or phone: xxx-xxxx

Appendix B

Information Letter

Exploration of Self-Mutilation in Young Adults - Information Letter

The purpose of this research project is to gain a greater understanding into the experience of deliberate self-harm, specifically, the act of self-mutilation in adults aged 18 to 29 years old. Self-mutilation has been described as a coping mechanism to reduce negative feelings such as anger, tension, and anxiety. It is hoped that this research project will contribute an increase in knowledge about reasons for engaging in self-mutilation as a coping mechanism as well as the reasons for its continued use.

Individuals that are interested in participating in this study must have engaged in self-mutilation within the past 1 – 2 years. Each participant will be invited to attend an open-ended audio taped interview (approximately 90 minutes in length) at the University of Alberta where he or she will be asked questions that relate to their experience of self-mutilation. Participants will also be asked to complete demographic and background information. A follow-up interview will be conducted within one to two months after the initial interview. It is sometimes the case that talking about distressing events may cause individuals to feel upset. Therefore, along with debriefing after each interview, a list of support groups and the referral number for finding a psychologist will be given to each participant.

Participation in the research project is voluntary. Individuals have the right to withdraw from the project at any time without any negative effects. All information collected for this study will be kept confidential and in a locked cabinet that will be accessed only by the researchers. All interviews will be transcribed by the primary researcher. During this process, any identifying information will be changed in order to protect the anonymity of the participants.

This research is being conducted for a requirement for the researcher's Masters Thesis in Counselling Psychology at the University of Alberta under the supervision of Dr. Barbara Paulson. Findings may also be published in professional journals and/or presented at psychological conferences. Participants are entitled to receive a copy of the findings upon completion of the study.

If you have any further questions about your participation in the study at any time, please discuss them with the researcher, Sandra Hall
695-9169.

Appendix C

Informed Consent

Research Project:	Exploration of Self-Mutilation in Young Adults Department of Educational Psychology 6 – 102 Education North University of Alberta
Principal Researcher:	Sandra Hall Phone: 695-6196
Research Supervisor:	Dr. Barbara Paulson Phone: 492-5298 Email: barb.paulson@ualberta.ca
Department Chair:	Dr. Linda McDonald, Department Chair – Educational Psychology Phone: 492-2389 Email: linda.mcdonald@ualberta.ca

The purpose of this research project is to gain a greater understanding into the experience of self-mutilation in young adults in order to gain an increase in knowledge about reasons for engaging in self-mutilation as a coping mechanism as well as the reasons for its continued use. Each participant will attend an audio taped interview at the University of Alberta where he or she will be asked questions that relate to their experience of self-mutilation. Participants will also complete demographic and background information. A follow-up interview will be conducted within one to two months after the initial interview. There is a potential risk for psychological distress or discomfort. Therefore, along with debriefing after each interview, a list of support agencies and the referral number for finding a psychologist will be given to each participant. Participation in the research project is voluntary. Individuals have the right to withdraw from the project at any time without any negative effects. All information collected for this study will be kept confidential. Any identifying information will be changed in order to protect the anonymity of the participant. Participants are entitled to receive a copy of the findings upon completion of the study. The researcher, research supervisor, or department chair can be contacted if you have any questions or concerns about this project.

I give my informed consent to participate in the project.

_____ _____

Printed Name of Participant Date

_____ _____

Signature of Participant Date

This study has been reviewed and approved by the Faculties of Education and Extension Research Ethics Board (EE REB) at the University of Alberta. For questions regarding rights and ethical conduct of research, contact the Chair of the EE REB at (780) 492-3751.

Appendix D

Interview Protocol

1. When did you start to self-mutilate?
2. How did you start to self mutilate? (e.g., Did you see someone else do it, or did you hear about it?)
3. Why did you start to self-mutilate? Did you use any other ways to cope?
4. Could you describe your feelings and thoughts leading up to an episode of self-mutilation? (e.g. tension, anger, anxiety)
5. What are you experiencing when you self-mutilate? Your thoughts? Feelings? Perceptions?
6. What are you experiencing after you self-mutilate?
7. Why do you continue to self-mutilate? What factors influence this behaviour?
8. Have you ever tried to stop self-mutilating?
9. If injuries could talk, what would they say?
10. Are there feelings of integration afterwards? Do you feel you have a better grip on things/reality?
11. Do you self-mutilate in order to escape?
12. How did Self-Mutilation help you cope? Did it make sense of what was going on? Clarify things?
13. What about an addiction to self-mutilation?
14. Is there any fantasy involved (active fantasy world)?
15. Does religion play a role?
16. Is it about control?
17. Is it planned or impulsive?

Appendix E

Demographics and Background Information

I. Demographics

Age: _____ **Gender:** _____ **Ethnicity:** _____

Marital Status: Married _____ Common Law/Co-habitating _____

Single _____ Divorced/Separated _____

Employment Status: (check all that apply) Full-time _____ Part-time _____

Unemployed _____ Student _____

Education: Some High School _____ High School Completion/GED _____

College Diploma/Technical Training _____

University Degree _____

Graduate Degree _____

Household Income: 0 - $15,000 _____
16,000 – 30,000 _____
31,000 – 60,000 _____
61,000 or more _____

II. Background Information

Do you presently self-mutilate? Yes _____ No _____

What type of self-mutilation do you engage in? (e.g., burning, cutting, scratching, hitting). List all that apply.

_____

Have you ever had to be hospitalized or receive medical treatment as a result of your injuries? Yes _____ No_____

How old were you when you first started harming yourself? _____

How often do you self-mutilate? (e.g., 1-2 times a week, once a month)

_____

How long have you gone without self-harming? (e.g., days, weeks, years)

_____

Do you try to hide your self-harm behaviour (e.g., not telling anyone, or hiding cuts and scars)? Yes _____ No _____

Do you have a ritual you follow before self-harming? Yes _____ No _____

Have you ever self-mutilated with the intent to kill yourself? Yes _____ No _____

Have you ever had any psychological counselling? Yes_____ No_____

If yes, what was the reason for seeking counselling:

_____

Have you ever been diagnosed with a psychiatric disorder? Yes _____ No _____

If yes, what was your diagnosis: _____

Appendix F

Contact Information

- The Support Network Distress Line: 482-HELP (4357) 24 hours a day, 7 days a week

- The Support Network Walk-in counselling: 482-0198
  Free-counselling on a walk-in basis (1 hour session)
  301 – 11456 Jasper Avenue
  Hours: Monday – Tuesday – Wednesday 1pm – 8pm
  Thursday – 9am – 4pm
  Friday – 9am – noon

- www.YouthOne.com
  On-line peer support

- SAFE in Canada (Self Abuse Finally Ends) http://www.safeincanada.ca/

- Information on referrals and community agencies: Dial 2-1-1

- Psychologists' Association of Alberta
  Will provide a referral to a licensed psychologist: 428-TALK (8255)

- Catholic Social Services – Counselling Service
  Edmonton locations:
  SOUTH OFFICE
  8815 - 99 Street
  Phone: 432-1137

  CENTRAL OFFICE
  10709-105 Street
  Phone: 424-3545

  EAST OFFICE
  8212-118 Avenue
  Phone: 471-1122

- University of Alberta – Counselling Centre
  Counselling is available from September to April
  492-3746

- Your family Physician can also assist you in finding help