University of Alberta

Reading between the lines: The stories of young adults experience with the onset and persistence of self-harm behaviour

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ABSTRACT

Non-suicidal self-injury (NSSI) is a prevalent and serious issue in adolescent populations. There is limited research investigating the phenomenon of NSSI from the individual's perspective. This study explored how young adults began self-harming as adolescents and how the behaviour progressed for them. The aim of the study is to elucidate an understanding of NSSI from the perspective of the self-injurer. Eleven young adults with a history of NSSI were invited to tell their stories. Transcripts were analyzed using a narrative research approach (Emden, 1988b) and a story was re-created for each participant. Transcripts and stories were also analyzed across participants and four major themes were uncovered: adverse circumstances in childhood, emotions, sense of self, and function. Self-harm was used as a form of behaviour management and as a mechanism to reduce or eliminate what was perceived to be a less desirable behaviour. This is one of the first known studies to use narrative research methodology to investigate the origins and progression of self-harm behaviour in adolescents. Implications for addressing NSSI are discussed.

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CHAPTER I: INTRODUCTION

As a clinician prior to entering my doctoral studies, my knowledge of self-injurious behaviours was limited. I had only heard about this behaviour in the media by watching movies such as "Girl Interrupted" and reading magazine articles. When I entered my graduate program at the University of Alberta it seemed an important area on which to focus my research. Although self-cutting and other self-injurious behaviours have been studied over many decades and among various populations such as psychiatric and personality-disordered patients, prisoners, individuals with developmental disabilities, and adolescent inpatients, my literature search revealed that little research had been conducted among normative adolescent populations (Carlson, DeGeer, Deur, & Denton, 2005). This was alarming as statistics suggested it was during adolescence in which the increase of self-harm behaviour was the greatest (Favazza, 1998; Fowler, Hilsenroth, & Nolan, 2000) and when the behaviour typically begins (Favazza & Conterio, 1989). Lifetime prevalence rates of Non-Suicidal Self-Injury (NSSI) in North American adolescents range from 13% to 28% in community samples (Muehlenkamp, Clae, Havertape, & Plener, 2012), compared to a rate of 4 to 6 % in adult populations (Briere & Gil, 1998; Klonsky, 2011).

Boyce and his colleagues (2001) report that the rise of NSSI in adolescents is the result of external influences such as the media, Internet, peers, and subcultures that celebrate self-harm. Welsh (2004) claims that self-harm may be the new "teen disorder." After conducting an extensive search, it was apparent that more research was needed to understand why this behaviour has become so prevalent in North American society. I believed it would be beneficial to listen to individuals' stories of self-harm in order to gain an understanding of this complex behaviour. It was my hope that this knowledge could evoke empathy in those who know or work with individuals who self-injure. This information could also be used to inform public awareness campaigns and prevention and treatment strategies necessary to address this detrimental problem.

Until recently, there has been a lack of consensus in the research community as to which terminology should be used and how self-injurious

behaviour should be defined. The term non-suicidal self-injury (NSSI) has been used most recently (Wilkinson & Goodyer, 2011) and is listed in the DSM-V as a condition for further study. NSSI refers to the deliberate infliction of harm, pain, or both to one's bodily tissues without suicidal intent (Nock & Favazza, 2009). There are various methods of NSSI such as cutting, burning, and scratching (Derouin & Bravender, 2004). Although gender appears to influence preference for method employed (Laye-Gindhu & Schonert-Reichl, 2005), individuals engage in different methods of self-injury over time. Researchers have categorized NSSI into three basic types: major, stereotypic, and superficial or moderate (Favazza, 1996; Favazza & Rosenthal, 1993; McDonald, 2006). Major NSSI involves more extreme forms of tissue damage such as limb amputation but is less frequent. Stereotypic NSSI is a repetitive and monotonous form of self-injury such as head banging that is often seen in individuals with developmental delay and pervasive developmental disorders. Superficial or moderate NSSI is a complex group of behaviours that results in the destruction of body tissue (e.g. cutting) (McDonald). This type of NSSI is most common for adolescents and young adults in the community. Efforts have also been made to differentiate NSSI from suicide. Although there is an association between the two behaviours, researchers suggest that the motivations behind each action are different (e.g. Brown, Comtois, & Linehan, 2002).

Ross and Heath (2002) published a seminal study that brought awareness of the high prevalence rate of NSSI in adolescents. In response, many researchers began to focus their investigations on adolescents in non-clinical settings. They not only discovered comparable prevalence rates to Ross and Heath (e.g. Hilt, Cha, & Nolen-Hoeksma, 2008), but also found evidence to suggest that self-harm was on the rise (Rettner, 2010). Muehlenkamp and his colleagues (2012) claim that although the prevalence of NSSI is still at high levels, the percent of adolescents engaging in self-injury appears to have stabilized.

The age of onset for NSSI is typically between the ages of 14 to 24 (Hodgson, 2004), and self-injurious episodes tend to recur to varying degrees for a period of years (Favazza, 1999). A section on adolescent development will

showcase the many physical, cognitive, emotional, and social changes that adolescents go through that puts them at greater risk of self-harm. The period of young adulthood, coined by Arnett (1999) as "emerging" adulthood will also be described and explored. Arnett indicates that individuals between the ages of 18 to 25 are distinct demographically, subjectively, and in terms of their identity explorations.

During my literature search, I became interested in learning more about the origins of the behaviour such as how an individual develops the idea to injure in the first place. Some research studies cited that participants came across the behaviour through an accidental injury and then discovered the injury produced a positive effect such as a distraction from a stressor they were faced with. Other participants believed that they came up with the idea on their own or had the "urge" to self-injure. The majority of articles referenced external influences as the reason behind why an individual starts to self-injure, such as peer influences, contagion, media exposure, and cultural influences. Another discovery is that there is an association between how an individual starts self-injuring and the severity of the behavior (Nixon, Cloutier, & Aggarwal, 2002).

I was also curious to learn why an individual continues to engage in self-harm and the potential functions it serves. The research literature indicated that factors such as contagion, normalization, and connectedness might influence an individual to engage in the behavior again. As well, individuals engage in self-harm for affect regulation, punishment/control, and as a means of communication (Martinson, 2001). The function of NSSI may vary depending on the severity of the behavior and the gender of the self-injurer.

In my clinical work the issue of NSSI has being encountered more and more frequently. It affirmed my decision to devote my topic research to this area because of the obvious need. I believed it would be valuable to explore the experience of self-harm from the individual's perspective and so I listened to my participants' stories as to how they began engaging in non-suicidal self-injury (NSSI) and how the behaviour became a part of their life. This focus lent itself

well to narrative research, which captures the plot and sequence of events in research data.

A brief background on narrative philosophical tenets and research is provided in the beginning of the Methodology chapter. The recruitment process is explained as well as the inclusion criteria for the 11 participants who were selected. Participants were asked to describe their experience with self-harm in two unstructured interviews that took between a half hour to two hours each.

Emden's (1998b) approach to developing participants' stories was selected. The process of how the interview data were transformed into a core story for each of the participants is explained. An additional analysis was conducted to look at themes across participants' stories. The rigor and soundness of this study ("goodness"; Guba, 1990) is described as well as how an ethical issue was addressed.

There are two chapters that compose the Results section. The first is a narrative analysis and each participant is given a brief introduction followed by a re-creation of their story. The next chapter begins with a description of how the analysis of narrative was conducted. It then leads into an overview and description of themes and sub-themes with examples and quotations for illustration.

The Discussion chapter begins with a summary of the results section. Key themes and sub-themes are then discussed in relation to the current literature. A finding unique to this study is also shared. Strengths and considerations of the study are discussed followed by the application of findings. I conclude this work by providing recommendations for future studies.

CHAPTER II: LITERATURE REVIEW

Background of NSSI

The phenomenon of NSSI was initially addressed by Karl Menniger in a publication dating back to 1935 (Rissanen, Kylma, & Laukkanen, 2008). Despite the identification of its occurrence more than 75 years ago, little research has been done until recent years. Ross and Heath (2002) published the first epidemiological study on adolescents, which demonstrated a high prevalence of self-harm behaviour in a non-clinical population. A large body of research has been growing ever since. Over the past 10 years, investigators have provided information regarding terminology, how to define the behaviour, methods, and different types of NSSI. This information will be discussed in more detail in the following sections.

Terminology. A total of 33 terms have been identified in the literature to describe self-injurious behaviour (Woldorf & Kuntz, 2005). Some of the terminology documented include deliberate self-harm (Gratz, 2001), self-mutilation (Nock & Prinstein, 2005), self-injurious behaviour (Favaro & Santonastaso, 2002), NSSI (Ross, Heath, & Toste, 2009; Wilkinson & Goodyer, 2011), and self-cutting (Rao, 2006). Fortunately, as research on self-injurious thoughts and behaviours has increased, scientists and clinicians have begun to make more careful distinctions and have used clearer and more consistent terms and definitions for these behaviours (Nock, 2010).

At the broadest level, all behaviours that are performed intentionally and with the knowledge that they can and will result in some degree of physical or psychological injury to oneself can be conceptualized as self-injurious behaviours. Within this general class, most researchers draw a clear distinction between behaviours in which bodily injury is the intended purpose of one's behaviour (direct, such as cutting) and those in which it is the unintended byproduct (indirect, such as substance use). An important division of direct self-harm is made between behaviours that are suicidal in nature, in that there is some intent to die, and those that are non-suicidal, in which there is no intent to die (Nock, 2010). The term that is preferred in the current literature is NSSI (Nock &

Favazza, 2009). Nock and Favazza believe that terms such as deliberate self-harm and parasuicide are too general in describing the behaviour. The term self-mutilation implies an extreme degree of damage and does not fit with most self-harm behaviour, which tends to be less severe. Although many of the terms used in the literature highlight the deliberate nature of the self-injury, they do not convey the non-suicidal nature of the behaviour. Thus, the term non-suicidal self-injury (NSSI) has been selected for the purpose of this study because it more clearly and accurately defines the behaviour and minimizes the possibility for confusion.

Definition. NSSI is the direct, deliberate destruction of one's own body tissue in the absence of the intent to die. This feature distinguishes it from behaviour in which harmful consequences are unintended (e.g. lung cancer from smoking) and from suicidal behaviour. Culturally sanctioned body modification such as tattooing or body piercing is not classified as this type of behaviour (Nock 2009b; 2010). A similar definition has been provided by Wilkinson and Goodyer (2011), researchers who reviewed the criteria proposed for NSSI Disorder in the DSM-V.

Methods of NSSI. The most commonly used method of NSSI is cutting or carving oneself with a sharp instrument such as a knife or razor (Klonsky & Muehlenkamp, 2007; Whitlock, Muehlenkamp, & Eckenrode, 2008). Laye-Gindhu and Schonert-Reichl (2005) purport that the method of preference may depend on the gender of the self-injurer. The researchers ranked cutting behaviours as the most common type of NSSI for females, whereas cutting was ranked second after self-hitting, punching, and biting to cause harm for males. Klonsky (2009) reported that 92% of his participants performed other self-injurious behaviours in addition to cutting. They included banging body parts against something (51%), severe scratching (46%), burning (38%), inserting sharp objects into skin/embedding (28%), interfering with wound healing (26%), severe skin picking (23%), biting (21%), hitting (13%), and rubbing skin against rough surfaces. The mean number of different methods used to self-injure was 3.9. Embedding is a form of NSSI that has come to more recent attention. It is an

extreme form of self-injury that involves the insertion of inanimate objects under the skin or under the muscle such as safety pins (Bennett, Shiels, Young, & Lofthouse, 2011). In most cases the objects are removed, but in some cases they are left and ultimately may need to be surgically removed (Young, Shiels, Murakami, Coley, & Hogan, 2010). Self-harm is accomplished by using tools such as blades, razors, glass, scissors, pins, cigarettes, lighters, candles, and erasers (Rissanen et al. 2008) and occurs mostly on the arms, legs, and stomach (Nock, 2010). Concealment of the behaviour is often a consideration when selecting a site for NSSI (Klonsky & Muehlenkamp, 2007).

Types of NSSI. Nock and Favazza (2009) report that there are three sub-types of NSSI. Stereotypic NSSI refers to self-injury that is performed at high frequency, and often results in minor injury (e.g. head banging). This type of self-injury occurs almost exclusively among individuals with developmental disabilities or neuropsychiatric disorders such as Tourette's Disorder. Major NSSI, the second sub-type, refers to self-injury that is performed at low frequency (e.g. once in a lifetime), with each episode causing severe physical injury (e.g. limb amputation). This type of self-injury occurs most often among individuals with psychotic disorders or within the context of substance abuse or alcohol intoxication.

NSSI that occurs in non-psychiatric community populations is much more prevalent than stereotypic or major NSSI. Nock and Favazza (2009) refer to this type of self-injury as common NSSI that includes three sub-categories: compulsive, which is repetitive and ritualistic (e.g. hair pulling); episodic, which occurs occasionally and is triggered by an event or stressor (e.g. cutting); and repetitive, when the individual becomes preoccupied with episodic NSSI and has difficulty resisting the urge to self-injure. McDonald (2006) believes that the self-injurer becomes addicted to the behaviour between the fifth and twentieth episode and states that repetitive self-injury should be considered a disorder of impulse control. Researchers and clinicians might wish to use modifiers such as mild (low frequency, low severity), moderate (moderate severity such as requiring medical

treatment), and severe (high frequency and severe injury that causes scarring or permanent disfigurement (Nock & Favazza, 2009).

Differentiating Between NSSI and Suicide

Just as researchers and clinicians have distinguished between different types of self-injurious behaviour, they have also made efforts to differentiate between NSSI and suicide. Although related to suicide they indicate that NSSI, represents a behaviour based on different motivations (Bolognini, Plancherel, Laget, Stephan, & Halfon, 2003; Brown et al., 2002; Crowe & Bunckark, 2000; McDonald, 2006; Motz, 2001). The most notable difference is that when individuals engage in episodes of NSSI, they do not wish to die (Wilkinson, 2011). Although self-injurers may become actively suicidal at times, they cognitively distinguish their self-injurious acts from their suicide attempts. NSSI behaviour is viewed as an alternative to suicide (Nixon et al., 2002); when individuals self-injure, they are focusing on one part of the body instead of the entire body as if to avoid suicide (Zila & Kiselica, 2001). Researchers also distinguish these two acts by claiming that self-injurers seek relief from overwhelming feelings, wheras suicidal individuals seek to end all feelings (Muehlenkamp & Gutierrez; 2004). One individual distinguishes her self-injurious act from suicide by saying, "The objective wasn't to make myself bleed to death, just to let go of the ugly feelings holding me hostage--feelings that would leave at the sight of blood" (Pederson, 1998; p. 64).

Although the motivations behind NSSI and suicide differ, studies suggest that NSSI can be a risk factor for suicide attempts and completions. One study found that 70% of teenagers engaging in NSSI made a least one suicide attempt and 55% had multiple attempts (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). An explanation for the transition is based on the observation that individuals who engage in NSSI have difficulties with verbal and emotional expression (Nock, 2010). Because there are both intra- and interpersonal motivations for both NSSI and suicidal behaviour, Nock purports that if NSSI does not achieve the desired results the individual is looking for, he or she may, in desperation "turn up the volume" and engage in suicidal behaviour. Another

theory posits that NSSI as well as traumatic experiences like childhood sexual abuse desensitize the individual to pain and fear of self-destruction, making suicidal behaviour more likely to occur (Van Orden, Witte, Cukrowicz, Braithwaite, Selby, & Joiner, 2010).

Prevalence of NSSI

Once thought to be a component of psychopathology in psychiatric populations or behaviour in developmentally disabled cohorts, NSSI has emerged as part of a new demographic group. Adolescents and young adults in the community are using self-injury primarily as a coping strategy (Glenn & DeNisco, 2006; Mikolajczak, Petrides, & Hurry, 2009). Estimates of the prevalence of NSSI have varied across studies in large part due to the fact that measures for this behaviour have not been included in large scale epidemiologic surveys that are used to generate prevalence estimates. As a result researchers have had to rely on estimates generated from small, regional studies that vary regarding the definition used for NSSI. Estimate rates are higher when a broader definition is used, when rating scales are utilized rather than interview, and when only a single episode of NSSI is required to be included in the estimate (Nock, 2010). To account for some of these discrepancies, only prevalence and incidence estimates from studies utilizing a similar definition of NSSI will be discussed.

Community samples. As shown in Table 1, the prevalence rate for NSSI in the preadolescent age group falls between 7.5 and 13.9% (Hilt, Nock et al., 2008; Ross & Heath, 2002). Although the rate is much lower in Hilt, Nock et al., it is important to note that participants were asked to report on their self-harm behaviour in the last year, compared to a lifetime incidence rate in Ross and Heath. For adolescents, the range in prevalence rates is much greater--between 7%-46.5% (Laye-Gindhu & Schonert-Reichl, 2005; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Muehlenkamp & Gutierrez, 2007; Nixon, Cloutier & Jansson, 2008 Taliaferro, Muehlenkamp, Borowsky, McMorris, Kugler, 2012). Although Laye-Gindhu and Shonert-Reichl document a lifetime prevalence rate of 15%, they reveal that 26% of this group report participating in the behaviour in the past year or a prevalence rate 3.9%. A comparable rate has been reported by

Taliaferro and his colleagues (2012). Seven percent of participants reported NSSI during the previous year with 3.9% reporting current NSSI without a history of a suicide attempt. This is the largest epidemiological study of adolescents to date in the United States.

Lloyd-Richardson and his colleagues report an alarmingly high prevalence rate of 45.6% of NSSI behaviour in the past year with an average of 12.9 incidents in the past 12 months. The authors state that the type of reporting may have impacted the rate obtained. Participants were given a detailed listing of self-harm behaviours, which may have cued the reporting behaviours. As well, reports were provided anonymously. When moderate/severe forms of self-harm were looked at specifically (e.g. cutting, carving, burning of the skin), a lower and more comparable rate to other studies can be noted (28%).

Table 1

Prevalence Statistics of NSSI in North America

Age Range	Sample Size (N)	Area of Study	Time Frame Assessed	Prevalence Rate	Citation
Ages 10-14	508	North Eastern United States	12 months	7.5%	Hilt, Nock et al., 2008
Ages 12-15	444	Eastern Canada	Lifetime	13.9%	Ross & Heath, 2002
Ages 13-18	61,330 students	North-Central United States	12 months	7%	Taliaferro, Muehlenkamp, Borowsky, McMorris, Kugler, 2012
Ages 13-18	633	Mid-Western United States	12 months	46.5%	Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007
Ages 13-18	424	Western Canada	Lifetime	15%	Laye-Gindhu & Schonert-Reichl, 2005
Ages 13-18	540	Mid-Western United	Lifetime	23.2%	Muehlenkamp & Gutierrez, 2007

		States			
Ages 18 years and older	2848	Mid-Western United States	4 weeks	7%	Gollust, Eisenberg, & Golberstein, 2008
Ages 18 years and older	5689	North-Central United States	12 months	14.3%	Serras, Saules, Cranford, & Eisenberg, 2010
Ages 18 years and older	439	United States (all states except Hawaii and Alaska)	Lifetime	5.9%	Klonsky, 2011
Ages 18 years and older	1986 (military recruits)	United States	Lifetime	4%	Klonsky, Oltmanns, & Turkheimer, 2003

Although not reported in Table 1, Muehlenkamp and his colleagues (2012) conducted a systematic review of 52 empirical studies (2005-2011) that investigated the prevalence of NSSI and deliberate self-harm behaviours (including self-damaging acts both with and without suicidal intent) in adolescents around the world. The term deliberate self-harm includes acts with suicidal intent and is used predominantly in European countries and Australia. A lifetime prevalence rate of NSSI in North America was found to be between 13 to 28%. The mean lifetime prevalence rate internationally was 18% (SD = 7.3). The authors reported that assessments using single-item questions led to lower prevalence rates compared to assessment with specific behaviour checklists. They also claim that the mean prevalence rates have not increased in the past five years suggesting stabilization for self-harm behaviour in adolescents and young adults within community populations.

The prevalence rates of NSSI in young adults and adults in a college/university setting have also been investigated. A rate of 7% was found

when inquiring about participation in NSSI in the past month (Gollust, Eisenberg, & Golberstein, 2008) and 14.3% in the past year (Serras, Saules, Cranford, & Eisenberg, 2010). As Table 1 illustrates, NSSI is lowest in adult populations (4-5.9%: Klonsky, 2011; Klonsky, Oltmanns, & Turkheimer, 2003).

As Table 2 illustrates, when participants were asked to report self-harm behaviour in the past year (6-12 months), comparable rates of 41 to 42% of NSSI were found in community samples of adolescents in both Italy and Sweden (Cerutti, Manca, Presaghi & Gratz, 2011; Lundh, Wangby-Lundh, & Bjärehed, 2011). The prevalence rate is lower in Turkey and Germany (21-26%), even when a lifetime time frame was assessed (Plener, Libal, Keller, Fegert, & Muehlenkamp, 2009; Zoroglu et al. 2003). Plener et al. also found no differences in the rates between Germany and the United States. These prevalence statistics suggest that NSSI in community adolescent populations is a widespread phenomenon, as least in Western Cultures.

Table 2

Prevalence Statistics of NSSI in Adolescents in European Countries

Country	Time Frame Assessed	Prevalence Statistic	Citation
Turkey	Lifetime	21.4%	Zoroglu et al. 2003
Italy	12 months	42%	Cerutti, Manca, Presaghi & Gratz, 2011
Sweden	6 months	41.5%	Lundh, Wangby-Lundh, & Bjärehed, 2011
Germany	Lifetime	25.6%	Plener, Libal, Keller, Fegert, & Muehlenkamp, 2009

As noted in Table 3, of adolescents that recount a lifetime history of NSSI, 75% of this group report engaging in the behaviour on more than one occasion, (Whitlock, Eckenrode, Silverman, 2006) and 6 to 7% engaging in repetitive self-harm (Gollust, Eisenberg, & Golberstein, 2008; Jacobson & Gould, 2007; Whitlock, Eckenrode, et al.). With regards to repetitive NSSI, Klonsky (2009)

found of the 39 participants he surveyed, the mean estimate of cutting episodes was 17.2. In another study, Polk and Liss (2009) discovered that of the 154 participants they interviewed, 51.4% self-injured at least once a week, 24.5% once a day, 16.1% once a month and 7.8% once a year.

Table 3

Frequency of NSSI in Adolescents

Frequency	Prevalence	Citation
More than one occasion	75%	Whitlock, Eckenrode, Silverman, 2006
Repetitive behaviour in last year	6-7%	Gollust, Eisenberg, & Golberstein, 2008; Jacobson & Gould, 2007; Whitlock, Eckenrode, et al., 2006

In order to address retrospective reporting biases, researchers have begun to use ecological momentary assessments (EMA; Shiffman, Stone, & Hufford, 2008), which is a method to study NSSI as it occurs in real time outside the research laboratory (Nock, Prinstein, & Sterba, 2009). In a recent EMA study among self-injuring adolescents from the community, participants reported having thoughts of engaging in self-injury approximately five times a week and engaged in the behaviour one to two times per week (Nock et al. 2009). This study also revealed that when present, thoughts of self-injury (85% of the time) lasted less than one hour. These results suggest that although youth engage in self-injurious behaviour on a frequent basis, more than half the time they do not act on their self-injurious thoughts, particularly if they are able to distract themselves within the hour the thoughts are present.

Gender differences. NSSI is typically assumed to be a female phenomenon (Carey, 2004; Woldorf & Kuntz, 2005); however, this assumption has not been fully supported in the literature (Muehlenkamp & Gutierrez, 2004; Nock & Prinstein, 2004). Many of the studies to date have been conducted in clinical settings where women are overrepresented (Whitlock, Eckenrode, et al, 2006). Women with psychological and psychiatric problems are more likely to self-injure than men (Suyemoto, 1998). In these studies, women were found to

self-injure 1.5 to 3 times more often (Favazza, 1999; Suyemoto, 1998; Turp, 1999). Thus, if prevalence rates are solely collected from clinical samples, NSSI will be more pronounced in women. Data that have been obtained from additional samples such as the community reveal a less pronounced or no gender difference (Gollust et al., 2008; Hall & Place, 2010; Heath, Toste, Nedecheva, & Charlebois, 2008; Hilt, Nock et al., 2008; Rodham & Hawton, 2009).

Taylor (2003) provides another rationale for the perceived gender difference of NSSI. He purports that females are more likely to obtain medical attention for their injuries and male injuries are more likely to be diagnosed as accidental. Further, males are more likely to engage in violent and public forms of NSSI (e.g. punching windows), which are more socially acceptable methods of harming in society and tend not to be examined in investigations. Whitlock and his colleagues (2008) discovered a similar finding of men engaging in public NSSI and "self-battery." A recent study also found no gender difference in the prevalence but found a difference in preferred method of self-injuring. They authors state that the most common method of NSSI reported among men was self-hitting. Between genders, men were more likely to report burning and women were significantly more likely to report cutting and scratching (Andover, Primack, Gibb, & Pepper, 2010).

Prevalence in homeless youth. Tyler, Whitbeck, Hoyt, and Johnson (2003) purport that homeless individuals are at risk of engaging in destructive behaviours such as NSSI because they have little control over the stressors associated with their disadvantaged circumstances and likely lack adaptive alternatives. These researchers report an estimate as high as 69% as a prevalence rate for NSSI behaviour in homeless youth that reside in the Mid-Western United States. Tyler, Melander, and Almazan's (2009) sample of homeless young adults included 69 female and 103 males, also from the Mid-Western United States. Thirty-five identified as lesbian, gay, or bisexual. The majority of the sample were white (80%) and almost half (48%) had a high school diploma. Additionally, almost half (47%) experienced sexual abuse, 39% were sexually victimized on the street and 78% experienced neglect. The prevalence rate of NSSI was 63%, which

is comparable to the rate Tyler and his colleagues documented in 2003 (69%). In this group of self-injurers, 77% reported doing so on more than one occasion. Cutting was the most common form of self-harm, followed by scratching (higher in females) and burning (higher in males).

Sexual orientation. Studies that investigated the association of sexual orientation and NSSI document that gay, lesbians, bisexuals, or those questioning their sexual orientation are at greater risk of NSSI than their heterosexual counterparts (Skegg, Nada-Raja, Dickson, Paul, & Williams 2003; Whitlock, Eckenrode, et al., 2006) and report higher levels of frequency of NSSI behaviour (Gollust et al., 2008; Whitlock, Eckenrode, et al.). Finnbogason (2010) investigated the phenomenon of NSSI more fully in lesbian, gay, bisexual, transgendered, genderqueer (LGBTQ), and heterosexual individuals. Findings indicate that there was a statistically significant difference in the rate of NSSI in the total LGBTQ sample (47%) compared to the heterosexual sample (28%). The highest rate of self-injury was in the transgendered and genderqueer sub-sample, which had a NSSI rate of 67%. This sub-sample also had the highest severity of self-injury. Finnbogason found that parental reaction to the individuals "coming out" impacted the rates of NSSI, and the individual's own reaction to identifying as LGBT or G/Q contributed to the severity of the self-harm behaviour. Another factor that had an influence on the severity of NSSI was whether the individual was physically attacked or bullied as a result of sexual orientation or gender identity.

NSSI disorder. In a recent study, Zetterqvist and his colleagues (2013) conducted a cross-sectional study of Swedish adolescents in the community. Although they gathered prevalence statistics, they were most interested in determining how many adolescents in their sample met the DSM-5 criteria for NSSI disorder. It was determined that 6.7% met this diagnosis. Interestingly, the NSSI disorder diagnosis was significantly more common in girls (11.1% versus 2.3%). To account for this gender difference, the authors reveal that more girls than boys met Criterion B and C of NSSI Disorder, which consists of the experience of negative feelings such as anxiety and degree of impairment.

Zetterqvist and his colleagues propose that as a group, boys may be less likely to admit their experiences and difficulties with distress. A similar prevalence rate (4-7%) of repetitive NSSI has been found by other researchers (Brunner et al., 2007; Lloyd-Richardson et al. , 2007; Plener et al., 2009; Muehlenkamp et al., 2012).

Age of Onset and Life-Course of the Behaviour

The typical age of onset for NSSI tends to occur at puberty, around 12 to 14 years old (Nock, 2009b; Nock, Teper, & Hollander, 2007; Williams & Bydalek, 2007), often reaching its peak in early adulthood (age 24) (Muehlenkamp & Gutierrez, 2004, 2007). Klonsky (2009) found that the mean age of onset for cutting was 14.1 and the mean duration was 3.5 years. Seventy-two percent of the undergraduate students he surveyed had self-injured within the past year.

Some researchers believe that NSSI behaviour emerges in the course of two distinct pathways: a) A severe pathway begins in childhood and persists throughout adulthood, and b) A less enduring pathway that begins in late adolescence and ameliorates in young adulthood (e.g. Nixon et al, 2002). Yates (2005) found results to support the hypothesis that NSSI follows different developmental patterns as a function of severity. Although most self-injurers commenced NSSI during adolescence, severe injurers were significantly younger when they first engaged in it. Mild self-injurers reported that they first began injuring around the age of 15 or 16 and stopped before the age of 18, and severe injurers began around age 12 and continued for a period of 8 to 9 years. Because NSSI emerges in adolescence and young adulthood, it seems important to look at these developmental stages further.

Adolescent Development

Adolescence is a period involving physical, cognitive, emotional, and social changes. Some adolescents find it stressful and challenging while making these adjustments (Kimball, 2002). According to Jaffe (1998), adolescents have mixed feelings about physical and sexual maturation; those that perceive themselves to be maturing at a different rate than their peers tend to feel stressed, self-conscious, or embarrassed, particularly because this is a period in which

feeling normal is important. However, Jaffe indicates that early maturing boys tend to be more enthusiastic about their changes, likely because they develop at the same rate as average maturing girls, thus avoiding the stigma of being different from classmates. As well, early maturing boys tend to be taller, stronger, better coordinated, and as a result tend to be given more opportunities (Jaffe, 1998). Patton and his colleagues (2007) found an association between early maturation in adolescent girls and a higher risk for NSSI. However, they suggest that this variable may be confounded by other risk factors associated with early menarche and puberty (e.g., childhood sexual abuse and family conflict).

Jaffe (1998) reports that cognitively, adolescents are able to think more abstractly, hypothetically, and flexibly than younger children. Yet, despite improvements in reasoning, adolescents may be self-conscious about their appearance and personal qualities, and overly concerned with how people view them. Jaffe states that risk-taking behaviour is more common during adolescence than in any other life stage, due to feelings of vulnerability, the desire for peer approval, and unrealistic thinking about consequences of actions. Thus, if adolescents are introduced to NSSI they may not consider long-term consequences of the behaviour or the potential for it to become a serious issue.

As well, there are a lot of changes in the structure and function of the brain during adolescence. Brain development occurs in the frontal and parietal cortices, the site of executive functions. A peak in grey matter volume at puberty is followed by a decline as the cortex is fine-tuned through synaptic pruning in areas that play a role in judgment, impulse control, planning, and emotional regulation (Casey, Giedd, & Thomas, 2000; Giedd et al. 1999). These rapid neurobiological changes may predispose adolescents to be uniquely sensitive to the effects of stress (Romeo, 2010).

Kimball (2002) states that on an emotional level, adolescents are impacted by on-going day-to-day stresses and that they are to experience a reaction to a major event (e.g. break-up) because that stressor sets off a chain of events that disrupts the day-to-day conditions of their lives. To cope with stress, adolescents respond through: a) problem solving, which involves trying to change a situation;

and b) managing emotions, which involves handling thoughts and feelings caused by the problem. According to Hjelmeland and Groholt (2005), some adolescents lack cognitive maturity for effective problem-solving. Thus they may perceive problems to be more overwhelming or distressing than other adolescents or adults would. Nock (2010) reports that adolescents are less likely than adults to have the coping skills required to deal effectively with stressful situations. Furthermore, he indicates that teenagers are less skilled at effectively communicating concerns to members of their social network.

Managing emotions is helpful when an adolescent is dealing with an uncontrollable problem (e.g. parental divorce). Hjelmeland and Groholt (2005) indicate that many adolescents lack the life experiences that would otherwise help them to predict outcomes of situations that arise, or the knowledge of how to deal with particular stressors and overwhelming feelings. Kimball (2002) documents that common ways to cope with stress are distraction techniques such as watching television or listening to music. If adolescents lack ways of problem solving and coping abilities, they may be susceptible to developing maladaptive strategies such as self-injurious behaviour as a way to deal with the overwhelming feelings they are experiencing at the time.

Researchers have reported that mental health problems have increased considerably for adolescents over the past 20 to 30 years (Belfer, 2008; Michaud & Fombonne; 2005; Rutter & Smith, 1995). Michaud and Fombonne suggest the rise is related to social change including disruption to family structure and increased educational and vocational pressures. There is also evidence that adolescence is a time of greater mood disruptions (Arnett, 1999). Larson and Richard (1994) document that adolescents report more extremes of emotion than adults (parents) and preadolescents. They state that environmental and cognitive factors influence how an adolescent responds to a stressful event. It is less about the circumstance, than about how they experience and interpret the event that explains the "moodiness" phenomenon. Larson and Richards state that even in response to similar events, adolescents report more extreme and negative moods than adults or preadolescents.

Recent studies suggest that adolescents display increased limbic activity (sensitivity to threat), exaggerated startle reflex (a measure of fear processing), and stronger interference effects form emotional stimuli on task completion during adolescence (Hare et al., 2008; Quevedo, Benning, Gunnar, & Dahl, 2009; Silk et al., 2010; Thomas et al., 2001). These findings lend support to the proposition that the adolescent brain is particularly reactive to emotional information (Blakemore, 2011; Casey, Jones, & Hare, 2008). Scholars in the field do not want to perpetuate the stereotype that the period of adolescence is difficult for all individuals. Instead they want to highlight that adolescents have the tendency to experience mood disruptions more than any other period of life.

Socially, adolescence is described as a period in which independence is achieved (Christie & Viner, 2005). However, it may be more accurate to view independence as a change in the young person's support system such as becoming more reliant on peers than parents (Christie &Viner). Adolescents are likely to place importance in their peer relationships, and thus may be influenced by such friendships and interactions. Researchers report that most risk taking behaviour such as substance use and reckless driving, takes place in the company of peers (Chassin et al., 2004; Simons-Morton, Lerner, & Singer, 2005). Steinberg and Monahan (2007) report that peer influence is stronger in adolescence than adulthood, peaking around 14-years of age. Therefore, if an adolescent has a peer who is engaging in self-harm behaviour, and that peer endorses self-harm and the benefits, there is a strong likelihood that the adolescent will be curious to experiment with the behaviour. This probability would increase if the adolescent is experiencing distress and does not have adaptive coping strategies.

Emerging Adulthood

Arnett (2000) purports that over the past half century in industrialized countries a shift has taken place that has made the late teens and early twenties (ages 18-24) a distinct period of life, which he labels as emerging adulthood. Others have acknowledged a characteristically different phase that occurs during this age period (Cote, 2000; Nelson et al. 2007). Demographically, marriage and parenthood have been delayed until the mid- to late-twenties for most individuals,

so it is no longer normative to settle into long-term roles during this life period (Arnett, 2000). Those in this age category participate in higher education, experience the highest rate of residential change, and have greater freedom to explore possible life directions, although they have less support, and need to rely more on their own resources and agency (Arnett, 2006a).

Arnett (2000) states that emerging adults subjectively, do not view themselves as adolescents but do not feel they are quite adults either. Interestingly, establishing a stable residence, finishing school, settling into a career, and committing to a long-term love relationship are ranked low as markers for attainment of adulthood. Instead, the characteristics most important to emerging adults are accepting responsibility for oneself and making independent decisions.

Arnett (2000) asserts that another key feature of this period is that it offers opportunity for identity explorations in the areas of love, work, and worldviews. Although a common belief is that identity formation occurs in adolescence, Arnett suggests that identity achievement does not occur until emerging adulthood. Love relationships become more intimate and serious, and individuals' work becomes focused on long-term career objectives. Worldviews change as a result of new experiences, education, and other life factors.

Although there is vast literature on adolescent risk behaviour (e.g. DiClemente, Hansen, & Ponton, 1996; Timmermans, van Lier, & Koot, 2008; Wolfe, Jaffe, & Crooks, 2006), Arnett (2000) states that some risk behaviours peak during emerging adulthood. Engaging in these types of behaviours (e.g. substance use) is part of their identity exploration and a desire to obtain a wide range of experiences before settling into adult roles. There is also greater opportunity in this quest as this group is also less likely to be monitored by a parent or partner. Schulenberg and Zarrett (2006) report that although mental health improves overall during emerging adulthood there is also a higher risk period for diagnosis of major psychopathology such as major depression and borderline personality disorder (BPD). Thus, even though emerging adults have more cognitive maturity and life experiences than adolescents, the tendency

towards risky behaviour, high risk of psychopathology, lack or social support and/or coping resources may explain why some emerging adults may be susceptible to engaging in self-injurious behaviours.

Origins of the Behaviour

Due to the high prevalence of NSSI in adolescents and young adults it seems important to consider how an individual starts the behaviour. The research literature suggests possible origins of NSSI to include self- and accidental discovery, peer influence and group influence, and media and cultural influence.

Self- and accidental discovery. Hodgson (2004) completed one of the few studies that looked at how individuals began cutting and what was occurring in their lives at that time. Many participants reported never having heard of cutting before engaging in the behavior, and some thought they had "invented" it. Others recalled their first injury as accidental. For instance, they hit their arm by accident and noticed that the injury made them temporarily feel better. Conterio and Lader (1998a) state that in their clinical experience, self- and accidental discovery have been reported by many of their clients as how they started self-injuring.

Hodgson (2004) purports that another group of participants experienced a "need" to self-injure and decided to act upon this impulse. Nixon and his colleagues (2002) found that many participants believed the initial idea to self-injure was their own and that they engaged in the behaviour intentionally. Although many self-injurers may discover the behaviour accidentally or on their own, there is other research to suggest that some individuals begin to self-injure as the result of social influences (e.g. Zahl and Hawton, 2004).

Peer and group influence.

Peer influence. Hearing about or seeing others who self-injure is another contributing factor for why people decide to participate in NSSI (Hawton, Rodham, Evans, & Weatherall, 2002; Muehlenkamp, Hoff, Licht, Azure, & Hasenzahl, 2008; Prinstein et al., 2010). Deliberto and Nock (2008) conducted a qualitative study investigating adolescents' self-reported reasons for starting and stopping self-injurious behaviour. Sixty-four participants with a history of NSSI

and 30 participants without a history (comparison group) were matched on age, sex, and ethnicity. They found that 38% of self-injurers reported getting the idea to injure themselves from peers, which was greater than any other source.

Prinstein and his colleagues (2010) also discovered that adolescents' friends' self-harm behaviours were associated with self-injury. Results from this study suggests that friends' self-harm was a significant predictor of NSSI above and beyond the effects of depressive symptoms. This study also yields support for gender as a moderator of peer socialization effects, suggesting that friends' behaviours were a significant predictor of NSSI among girls but not among boys. Therefore, adolescent girls are more likely to engage in NSSI if peers or others they know report it has been a valuable coping strategy or option for them.

Additionally, Nock and Prinstein (2005) indicate that some adolescents noticed that peer's NSSI behaviour was effective at eliciting specific social behaviours from others in an interpersonal context and thus, may be another reason to start engaging in the behaviour. A trend that has occurred amongst peer groups are "cutting clubs" where friends get together and cut as a form of ritual and connection (Booth, 2004). Nock and Prinstein concur and found that 82.1% of adolescents in their study (N = 89) had engaged in NSSI in the company of a friend in the past 12 months, with a mean number of incidents of 4.11. It is important to note however, that this study was conducted with participants in a psychiatric unit, so these numbers may be inflated compared to those adolescents in a community setting.

Contagion. NSSI has been described as having a "potentially suggestive effect" (Lieberman, 2004, p. 4), which some researchers refer to as the contagion factor (Taiminen, Kallio-Soukainen, Nokso-Koivisto, H., Kaljonen, & Kelenius, 1998; Walsh & Doerfler, 2009). Taiminen and her colleagues (1998), who examined the contagion of NSSI in a closed adolescent psychiatric unit, defined contagion as two or more acts of NSSI that involved two or more adolescents and occurred on the same day or consecutive days. Contagion incidents were believed to be associated with group dynamics such as engaging in self-harming behaviours to avoid feeling like an "outsider." The authors suggested that NSSI

became an initiation rite that strengthened group cohesion and concluded by stating that psychiatric facilities and treatment programs can be a "breeding ground" for contagion.

Contagion has also been observed in community settings such as schools and universities (Whitlock, Eckenrode, et al., 2006). As consulting psychiatrists, Fennig, Carlson, and Fennig (1995) discuss their observations of an outbreak of contagious NSSI at a junior high school. The authors indicate that the phenomenon of NSSI may be more prevalent in educational systems than is actually reported. They suggest that this underreporting to the public is due to reluctance about dealing with the problem openly. Walsh (2006) asserts that contagion in the schools may be the result of students openly talking about NSSI and even injuring in each other's presence, sharing tools or taking turns injuring the body of the other. Anecdotal reports from staff working with adolescents in school settings report a "fad" quality to their self-harming behaviour (Walsh, 2006).

Virtual subculture (Internet). A relatively recent phenomenon is contagion episodes that involve people who have never met face-to-face. These have become possible because of electronic communications such as websites, chat rooms, and instant messaging (Walsh, 2006). Adolescents use the Internet for the purpose of connecting with others at higher rates than any other groups (Lenhart, Rainie, & Lewis, 2001). The Internet may have particular relevance for adolescents who are socially isolated or marginalized because it provides a vehicle for finding like-minded others and a way to exchange information that may be difficult to convey in person (McKenna & Green, 2002). The Internet may serve as a virtual support group where adolescents can express feelings and exchange information about methods of coping. However, the Internet can maintain or increase emotional distress if the information exchanged reinforces negative views of the self or suggests maladaptive coping strategies (Whitlock, Powers, et al., 2006).

Walsh reports that NSSI is one maladaptive coping strategy that adolescents can learn through the Internet. Hodgson (2004) indicates that

adolescents may surf the Internet and find NSSI message boards and websites introducing them to the idea or providing more information about it. According to Whitlock, Powers, et al. there are 406 message boards related to NSSI, some of which are cross-listed with other disorders co-morbid with NSSI such as depression and eating disorders. Those that are curious about self-harm can be immediately exposed to a world of information on self-injury (Whitlock, Lader, & Conterio, 2007).

Hodgson (2004) purports that all that is necessary for adolescents to begin self-harming is an introduction to the idea, discussion of how it is done, and the discovery of support that is received by group member for engaging in the act. One study found that of 80 college students who self-injure, 37 had used the internet in connection with their self-injury (Adler & Adler, 2007). However, adolescents or young adults who engage in NSSI after learning about the idea through the Internet are likely those individuals who are in distress, feel isolated, and are searching for ways to cope with their personal circumstances.

Whitlock, Powers, et al. (2006) examined a total of 3, 219 posts from six message boards over a two-month period. The authors found that 6.2% of postings on the message boards examined were related to sharing details about techniques used to self-injure. The exchanges were generally descriptions of specific NSSI techniques or requests for specific technique information. According to Booth (2004), some message boards even contain links to "pro" self-injury websites where Internet users can purchase self-harm paraphernalia such as bracelets or clothing that signify self-harming status.

In Murray and Fox (2006)'s study, participants were close to evenly split between those who had known self-harmers prior to joining an internet-based NSSI discussion group (n = 49) and those who had not (n = 51). Also, most participants did not know other self-harmers prior to beginning self-harming behaviours (n = 79). Therefore, Internet-based resources such as NSSI discussion groups and message boards put individuals in contact with others who are self-harming. Hearing about NSSI in other members may influence adolescents and young adults to start engaging in the behaviour themselves.

In a recent study, Lewis, Heath, St. Denis, and Noble (2011) were the first to investigate the use of NSSI imagery over the Internet, examining the content of videos uploaded onto YouTube, a video sharing website. The authors found that videos with NSSI content received frequent viewership and were often discussed and rated favourably, suggesting they may be accepted by those who view them. Lewis and his colleagues report that most videos were neutral in purpose (neither encouraging nor discouraging), were predominantly factual and educational, and/or had melancholic tones. They indicated that few videos were made for the purpose of discouraging NSSI. The authors also report that 64% of videos had visual depictions of NSSI (e.g. photographs). Overall, cutting was the most depicted method, followed by self-embedding and burning. The images of NSSI occurred most often on the wrist, arms, followed by legs. Additional research examining personal websites about NSSI and online forums in which pictures are posted indicates that some individuals report finding this material upsetting and triggering (Lewis & Baker, unpublished data; cited in Lewis et al. 2011). Therefore, videos on YouTube may also have triggering-like consequences for those individuals that are introduced to self-harm through this medium or for those who are already self-injuring.

Media and cultural influences.

***Media*.** The media can have both a positive and negative influence on self-injurious behaviour. It has been responsible for increasing the public's awareness on NSSI (Conterio & Lader, 1998a) and how to obtain information and resources for this problem (Carlson et al., 2005). Different types of media h have also helped reduce the stigma associated with the behaviour (Conterio & Lader, 1998a). However, Conterio and Lader allege that it has inadvertently given individuals ideas they may not have had before. Although there is great potential for media forums to help, there is also danger for the media to perpetuate the problem through "normalizing" the behaviour and potentially furthering its contagion (Carlson, DeGeer, Deur, & Fenton, 2005).

Hawton, Rodham, and Evans (2006) purport that adolescents are at particular risk of being influenced by the media if they identify with a celebrity or

fictional character and if the adolescent views the role model in high status or high level of attractiveness. For instance, adolescents who admire Angelina Jolie might experiment with NSSI after learning that she used to engage in self-cutting behaviour. A variety of media outlets have introduced the idea of NSSI to adolescents and the public through popular television shows, movies, music lyrics, and videos (Hawton et al., 2006; Purington & Whitlock, 2010; Walsh, 2006). In addition, the media has revealed high profile individuals like Johnny Depp and Princess Diana who have deliberately cut or self-injured (Walsh, 2006). Whitlock, Purington, and Gershkovich, (2009) contend that the apparent increase in self-harm behaviour may be the result of the increase in reference to NSSI in the media and over the Internet in the past decade.

Conterio and Lader (1998a) state that it is not the well adjusted adolescent who will be influenced. Rather, it is the psychologically vulnerable person who may adopt the behaviour to deal with pre-existing struggles. Whitlock, Powers, et al. (2006) compare the current increase of NSSI behaviour in adolescents to the rise of anorexia nervosa in the 1980's. The authors claim that the media was responsible then for introducing the disorder to individuals with receptive predispositions.

North and Hargreaves (2006) looked specifically at music as a media form and how it related to NSSI. They were interested in whether listening to certain genres of music such as hard rock, hip hop/rap, and punk preceded self-injurious thoughts and behaviours in fans. They found that an interest in these genres of music was associated with four of the five self-injurious measures, although listening to the music did not precede self-injurious thoughts. However, the authors suggest that individuals who are experiencing various emotions and engage in NSSI behaviour may identify more with these types of music.

The increased attention and of production of social media pertaining to self-harm (Whitlock et al., 2009), appears to have influenced rates of NSSI within adolescent populations. Although prevalence rates have increased since research initially focused on NSSI, Muelenkamp and his colleagues purport the prevalence

of the behaviour has largely stabilized in the past five years or so (Muehlenkamp et al., 2009; Muehlenkamp et al., 2012).

Culture. Brumberg (2006) suggests that the violent nature of North American culture provides a climate for self-injurious behaviour. She states that studies have shown that children grow up accustomed to violence of all types and that it has desensitizing effects. Children are shaped by cultural scripts formed by violent television shows, descriptive news stories (e.g. war reportage) video games, and movies. Brumberg indicates that by the time children reach adolescence it is not surprising that some are fascinated by violence and even curious about violence towards the self.

Now that NSSI is more openly discussed in the media, on the Internet, and among peers, there is less stigma associated with the behaviour (Hodgson, 2004), and it is not viewed as pathological as it once was (Brumberg, 2006). It is possible that this transformation has removed a barrier that could have previously inhibited some individuals from participating in the act. Another "cultural" variable of North American society that may contribute to NSSI behaviour is the emphasis on competitive performance, such as how much pain or exhaustion an individual can take. For some, it may take the form of testing their physical endurance (e.g. Olympics) or willpower (e.g. diets). Others may inflict pain by intentionally harming themselves (Levenkron, 1998). Thus, individuals may be subtly receiving the cultural message that pain equals achievement.

Kokaliari and Berzoff (2008) believe that there are cultural contexts at play that contribute to why self-harm is higher in Western cultures and in some cases, women. In their study, participants reported that there were expectations within their families to be autonomous and self-reliant, and to deny their feelings. Thus, self-harm became a way for participants to manage social expectations for high productivity. The authors assert that another Western phenomenon that was elicited in this study was the idea of a "quick fix", that NSSI was a way to provide immediate relief of difficult emotions so that the individual could return to the daily activities of their life. Therefore, the authors claim that the essence of Western culture is to find a quick, private way of coping with problems as a way

to function more productively in the world. This suggests that NSSI may not simply reflect an individual problem but a societal problem and may explain why NSSI has manifested at such alarming rates.

Subgroups of self-injurers. Klonsky and Olino (2008) sought to identify distinct subgroups of self-injurers on the basis of method, and descriptive features of NSSI in young adults. The first group, comprising 61% of participants performed relatively few behaviours and had the fewest clinical symptoms. The authors stated that members of this group may be those who experimented on a few occasions, as opposed to those who self-injure more chronically in response to psychiatric distress and may be considered the "experimental group." The second group (17% of the sample) had an earlier onset of NSSI, performed more behaviours, particularly biting, pinching, and banging/hitting, and can be classified as the "mild NSSI" group. The third and forth groups (22%) of the sample exhibited increased clinical symptomatology and required more aggressive treatment.

Other researchers have also looked at the differences between those who self-injure, particularly age of onset and severity. Nixon and his colleagues (2002) propose that individuals that began self-injuring at an early age (e.g. age 10 to 12) are more likely to have discovered the behaviour on their own and to participate in more severe NSSI with greater frequency and severity. This group has also been found to endorse more addictive features, report having more daily urges and daily acts, and engage in this behaviour in private (Nixon et al.). In contrast, individuals who engage in mild forms of NSSI (e.g. scratching) appear more likely to be influenced by external factors such as peers, media, Internet, and music (Yates, 2005). Some researchers believe that these external influences can explain the recent increases in NSSI in adolescents and young adults (Derouin & Bravender, 2004; Fennig et al., 1995; Taiminen et al., 1998), likely because more people are becoming aware of this option as a coping strategy and its other functions such as communication of distress.

Summary. The research literature on NSSI has documented several possible origins and external influences of the behaviour. The most commonly

discussed are: self- and accidental discovery; peer and group influences; and media and cultural influences. Researchers have suggested that there are different developmental pathways for NSSI behaviour in that those individuals that engage in more frequent and severe forms of self-injurious behaviour began at a younger age than those with occasional use and mild NSSI, and that the behaviour persists for a longer period. It also appears that severe self-injurers report self- and accidental means reinforced by external factors as origins of their behaviour, whereas mild self-injurers appear to respond primarily to external influences.

Perpetuation and Functions of the Behaviour

According to researchers, the majority of adolescents and young adults participate in NSSI on more than one occasion, and most report at least three or more incidents of self-harm (Nixon et al., 2008; Swannell, Martin, Scott, Gibbons, & Gifford, 2008). The literature provides many reasons as to why self-injurious behaviour persists. External influences such as contagion, normalization, and connectedness have been found to impact the development of the behaviour. NSSI may also continue because the self-injurer discovers the various function(s) it can serve for them. The literature cites a variety of reasons that can broadly grouped into four categories: affect regulation, punishment/control, communication, and accessibility/pragmatics.

Contagion. Not only is contagion a reason why someone begins to engage in NSSI behaviour, hearing or reading about the self-injurious behaviour of others can elicit NSSI behaviour in individuals who have previously engaged in the act, sometimes referred to as "triggering" (Purington & Whitlock, 2010). Research suggests that youth who self-harm participate in more online social networking that those who do not (Heath, Baxter, Toste, & McLouth, 2010; Mitchell & Ybarra, 2007). This finding suggests that there is greater likelihood for these youth to be exposed to websites containing photos, videos, and written accounts of NSSI that could have negative consequences for the individual. Murray and Fox (2006) asked participants whether anything posted on one of the largest NSSI discussion group triggered their engagement. Forty-nine percent answered in the affirmative, and 46% of this group said it was the nature of the

posts they found triggering. These included posts that have graphic descriptions, negative responses to respondents' posts, and descriptions of new methods of self-harming. Eleven percent of respondents indicated a negative impact of group membership on their self-injurious behaviour, such as enacting more severe methods and feeling less of a need to stop as a consequence of becoming a group member. The results from this study support the claim that hearing/reading the details about acts of NSSI or knowing someone who self-harms can have a "triggering" effect that perpetuates the use of self-injurious behaviour.

Normalization and connectedness. If individuals who self-injure are in contact with or hear about others who self-injure, there is also the potential that the behaviour will be normalized and viewed as an adaptive coping strategy. For instance, NSSI discussion groups on the Internet can expose vulnerable adolescents to a subculture where the behaviour may be accepted and encouraged, and can lead to the maintenance or even an increase in the behaviour (Adams, Rodham, & Gavin, 2005; Rodham, Gavin, & Miles, 2007; Whitlock, Powers, et al., 2006). Whitlock, Powers, et al. state that the adolescent drive to belong and the satisfaction that comes from associating with a community of similar others may inadvertently feed this self-destructive behaviour for some. The fact that a virtual subculture of like-minded others is so accessible may reinforce the behaviour in a certain portion of adolescents. Some participants in Murray and Fox's (2006) study said they felt less need to stop self-injuring as a consequence of exposure to a NSSI discussion group.

Self-injurers often state that there is a special bond between people who cut or harm themselves. They share a unique experience that is intense and intimate (Walsh, 2006) and may share details of how it feels to lacerate the skin. They believe that no one can understand them like another person who self-injures and who can provide the same empathetic form of support (Walsh, 2006) that can be extremely vital. According to Whitlock, Powers et al. (2006), vulnerable adolescents may find it difficult to end a strategy for coping with emotional distress and leave the support gained from a virtual community. Therefore, they may not feel the urgency to find alternate ways of coping.

Franzén and Gottzén (2011) conducted a study on an on-line community and found that there is a strong taboo against self-injuring for the purposes of attention seeking. Within the normalizing discourse, it is only acceptable for an individual to self-injure if they have "real" problems. Moreover, blood and scars are only beautiful as long as they are expressions of "real" emotions. For the member of the Web community, there is impending risk of being classified as a "poser" if he/she does not succeed in positioning him/herself as an authentic cutter.

Affect Regulation. The affect regulation model of NSSI is the most supported in the literature (Hawton et al, 2006; Klonsky, 2007 Kumar, Pepe, & Steer, 2004; Nixon et al, 2002). This model suggests that NSSI may be used to alleviate negative emotional states (Klonsky, 2009; Nock & Prinstein, 2005), obtain emotional release (Klonsky, 2009), end a period of dissociation, and bring about positive affect. Other researchers have also found that individuals may engage in acts of NSSI as a way to relieve the overwhelming emotions they are experiencing (Gallop, 2002; Gratz, 2003; Laye-Gindhu & Schonert-Reichl, 2005). Klonsky (2009) reports that self-injury is often preceded by affect states such as "anxiety", "hurt/vulnerable", and "being overwhelmed" and is followed by feelings of "calmness" and a sense of "relief." This author also found substantial changes in both affective valence and arousal from before the act of self-injury to after the act was completed. High arousal negative affect-states (e.g. overwhelmed) decreased and low arousal positive affect-states (e.g. calm, relaxed) increased. The findings suggest that self-injury may be primarily motivated by a desire to alleviate high arousal negative affect states such as overwhelmed and anxious, as opposed to lower around negative affect-states such as sad, lonely, and empty inside.

In Ross and Heath's (2002) study, participants reported that they engaged in acts of NSSI because physical pain is more tangible and easier to feel than emotional pain. Therefore, self-injurious behaviour becomes a coping strategy for many as a way to cope and regulate unpleasant emotional states. Martinson (1998) found that 39% of respondents viewed NSSI as a method of coping and that 45%

reported no desire to end self-injuring. The research literature suggests that many self-injurers are deficient in problem solving and coping skills, which leaves them vulnerable to the adoption of NSSI behaviour as a coping strategy (Haines & Williams, 2003). Adolescents are particularly susceptible to adopt maladaptive forms of coping because their cognitive and emotional ability to cope is not fully developed (Derouin & Bravender, 2004). If NSSI is utilized as a consistent way of coping, it will make self-injurers less capable of solving problems in the future, which increases the likelihood of engaging in future acts of NSSI (Hawton et al., 2006).

NSSI serves another affective regulatory function for some individuals. One frequently reported reason is to feel alive and to end a period of dissociation or numbness (Polk & Liss, 2009)--a state of feeling detached from one's body, a floating sensation, or that similar to a hypnotic state (Alderman, 1997). The physical sensation of pain and seeing blood proves that they are human (Conterio & Lader, 1998a). In this circumstance, NSSI is used as a grounding technique that brings the individual back to their conscious awareness. One participant in Polk and Liss said, "Sometimes I need a reminder that I am actually alive. That there is blood pumping through my veins and I can feel things" (p. 236). Therefore, self-injury is this instance is used to "create" rather than release or discharge an emotion. This method of grounding is often used by individuals who have a history of trauma such as sexual assault or abuse. van der Kolk, Perry, and Herman (1991) examined the relationship between trauma and self-injurious behaviour and found that 79% reported histories of significant childhood trauma. Self-cutting was significantly correlated with physical abuse, neglect, chaotic family life, and most strongly correlated with a sexual abuse history.

Glenn and Klonsky (2010) claim that the desire to see blood in skin-cutting is relatively common. The authors report that 51.5% of participants desire to see blood as a way to help them feel real. Another interested finding was that those who thought it was important to see blood, self-injured significantly more than participants who did not view seeing blood as important. The authors account for this difference by stating that the "blood important" group endorsed more

symptoms of Borderline Personality Disorder (BPD) and Bulimia Nervosa, and more intrapersonal reasons for their self-injury.

Additionally, NSSI has been reported to create positive feeling states such as calmness. In Hodgson (2004)'s study participants indicated that before they cut for the first time they did not know how it would impact them. However, they discovered that cutting made them feel better and eventually was associated with emotional relief and comfort. Another study found that the majority of participants (92.9%) reported obtaining a sense of "relief" after engaging in acts of NSSI (Nixon et al., 2002). After continued use, self-injurers start to feel that they have no other outlet for their emotional pain, and thus, will not experience a sense of relief until they engage in the behaviour. Sheel (1999) purported that when levels of tension and negative affect become extremely high other means of tension reduction such as relaxation are no longer effective.

Alderman (1997) stated that the "relief" experienced by self-injurers has been associated with endorphins in the brain that provide pleasure and control pain (Hicks & Hinck, 2009). Research has demonstrated that endorphins are produced before, during, and after acts of NSSI (Alderman, 1997). Due to the relief that is experienced after an episode, individuals may develop a preoccupation with the behaviour and it may even develop into an addiction (Alderman, 1997; Derouin & Bravender, 2004). The physiological explanation for continuing to engage in the behaviour can be understood similarly to how drug or alcohol addictions develop. Engaging in the act helps the individual to temporarily escape their problems and feelings and may even make them feel better ("high"). As a result, the individual needs to repeat the behaviour to maintain the high feeling. It eventually becomes difficult to experience feelings such as being hurt or perceived negative situations without relying on this maladaptive strategy (Machoian, 2001).

Nixon and his colleagues (2002) indicate that some self-injurers experience mounting tension and a "need" for NSSI because it is the only way they can obtain relief. Increased frequency and severity of their behaviour is required to achieve the same effect, for instance, making deeper cuts over more

extensive areas of the body. Some studies support the emotion regulation model and how the behaviour persists. Gordon and his colleagues (2010) found that individuals with a history of repetitive or habitual NSSI were likely to feel relieved, soothed, and less afraid following their most recent episode of NSSI. Klonsky (2009) also found that participants who engaged in NSSI on a frequent basis were the ones to experience the greatest affective benefits. These findings are concerning given the apparent ease of becoming addicted to NSSI or the difficulty stopping the behaviour.

Punishment/Control. Another function of self-injurious behaviour is punishment and control. Individuals report that they might engage in acts of NSSI as the result of anger they are feeling towards themselves or others. To cope, they inflict harm or "punishment" on themselves (Klonsky, 2009; Nock & Prinstein, 2004). For instance, Klonsky (2009) reported that 69% of participants endorsed "to express anger at myself" (pg. 263), although this was often a secondary function. Nock and colleagues (2009) discovered that "self-hatred" and "anger at self" were precipitating thoughts and feelings for nearly half of self-injury episodes reported. Individuals with an abuse history may incorrectly blame themselves for the abuse or feel that they "deserved it." Some may be overly critical of themselves, which leads to feelings of shame and blame (Nock, 2009b), potentially leading to self-harm behaviour as a form of self-punishment for the negative feelings towards the self (Ferentz, 2001). Recent research supports this hypothesis by showing that the relationship between childhood abuse and deliberate self-harm is mediated by adolescent self-criticism (Glassman, Weierich, Hooley, Deliberto, & Nock, 2007). When NSSI is employed for the purpose of guilt or perceived transgressions, physical pain may be part and parcel of the "discipline" believed to be deserved by the self-injurer (Conterio & Lader, 1998a).

Harm towards the self may also serve as a substitute for anger toward another, and potentially the unconscious desire to inflict pain on that person. The self-injurer may feel that actually inflicting pain, either physical or emotional, on another person is unacceptable for a number of reasons. The self-injurer may

believe that if they express their emotions toward another it may result in the loss of love or care from that person (Johnson, 2006; Levenkron, 1998). Conterio and Lader (1998a) report that self-injurers live with the myth that when someone gets angry, someone has to get hurt. NSSI behaviour provides a way for the self-injurer to rectify a grievance they have towards the person who has angered or hurt them, even if it is fallacious and temporary (Levenkron, 1998), and hurting themselves is seen as a safer alternative than hurting others (Conterio & Lader, 1998a).

Individuals with an abuse history may engage in NSSI as a form of abuse re-enactment because they associate pain with love (Martinson, 2001) and attachment (Levenkron, 1998). When they feel lonely, they may engage in acts of NSSI as a way to recreate the pain that is familiar to them. Levenkron reports that the act of NSSI may also make the self-injurer feel more connected and closer to their abuser. Thus, the behaviour is a way to gain comfort and security when feeling alone or alienated (Martinson, 2001). Levenkron states that these acts provide only short-term superficial relief and that they do not resolve the self-injurer's desire for attachment. If feelings resulting from the abuse are not worked through, the self-injurer may feel the need to repeat the behaviour again and again as a way to fend off the feelings that emerge.

Individuals report that another common reason they injure themselves is to feel in control of their emotions (Klonsky, 2007). Alderman (1997) states that episodes of NSSI are triggered by emotions such as loneliness and alienation that are perceived to be out of the realm of the self-injurers' control. Emotional pain may also seem as if it has an "infinite life" (Levenkron, 1998, p. 105). By planning acts of self-harm, they get to choose when they hurt and how they hurt (Alderman, 1997; Levenkron, 1998). Also, when the self-injurer controls the pain, he/she may not feel as overwhelmed as if it came from outside sources (Conterio & Lader, 1998a).

Communication. Another important function for individuals who participate in self-injurious behaviour is communication. Machoian (2001) found that cutting gained a response when voices failed. People may escalate to the use

of self-injury as a means of communication when less intense strategies have failed due to poor expression quality or clarity, or when such strategies have not produced a desired effect due to an invalidating environment (Nock, 2008).

Some self-injurers cannot communicate their feelings. Alexithymia is a psychological construct used to describe the inability to recognize, differentiate, identify, and name internal affective states (Krystal & Krystal, 1988). Emotions are experienced as undifferentiated because of the inability to identify, verbalize, or describe what they are feeling. If an individual lacks an emotional vocabulary to describe their negative affect, they may turn to NSSI as some form of expression. Polk and Liss (2009) find support for this hypothesis. They state that participants in their study engaged in NSSI to express some sort of emotion. Zlotnick and his colleagues (1996; 2001) found that measures of alexithymia were positively correlated with NSSI behaviour in participants. The authors report that this is congruent with the fact that participants were also not able to identify any particular feeling present before engaging in acts of NSSI.

If feelings begin to amplify for individuals, they may use injurious behaviour as a way to demonstrate the extent of their pain and to elicit help from others. For example, participants in Machoian (2001)'s study felt they had to engage in acts of NSSI in order for people to understand the seriousness of how they were feeling or hurt; in other words, they had to hurt themselves in order to help themselves. Thus, acts of NSSI represented a "cry for help" because they are a way to express feelings tangibly (Derouin & Bravender, 2004). Other researchers concur that NSSI is a symbolic way to communicate inner pain (Crowe & Bunclark, 2000; Milia, 2000), and a means to elicit a caring response from others (Favazza, 1996).

Machoian (2001) comments that if adolescents feel that they are only listened to and responded to when they use violence and harm themselves, this may have damaging repercussions. For example, it may lead to an exacerbation and increase in self-harming behaviours. Thus, when NSSI is used as a means of symbolism and communication, it can evolve into more chronic behaviour such as a function of affect regulation (Machoian, 2001). Self-injurious behaviour that

begins as a signal of distress but becomes chronic can be counterproductive because it tends to alienate people.

There is the risk of self-injurious behaviour to be construed as manipulative to others since it is an indirect way for the individual to have his/her emotional needs met (Martinson, 2001). The author claims that although it is valuable for individuals who self-injure to know how their behaviour is understood, the negative connotation associated with this label may impact how they are perceived by service providers and may also interfere with treatment. Individuals who self-injure for this purpose tend to feel guilty for how their behaviour is being interpreted, which is another way the cycle of using violence towards the self is perpetuated (Machoian, 2001).

Accessibility/Pragmatics. Another parsimonious explanation for why some people use and continue NSSI is that it is a relatively fast and easily accessible method of serving a myriad of functions (Nock, 2009b). Individuals who self-injure likely appreciate that NSSI can be performed quickly and privately in virtually any context and that it does not require the time and materials involved in other behaviours that serve a similar function. This makes it an attractive behaviour for adolescents and young adults who lack the executive control to regulate their emotions and behaviours and who may not have ready access to other maladaptive methods of coping such as alcohol and drugs (Nock, 2010).

Functions of NSSI for subgroups. Similar to how differences have been observed between mild and severe self-injurers in regards to the origins of their NSSI behaviour, Yates (2005) has discovered differences between these two groups in the functions the behaviour serves. He found that severe self-injurers use the behaviour for an intrapersonal regulatory function such as alleviating emotional distress, whereas mild-self-injurers engage in NSSI for an interpersonal regulatory function such as communicating distress. This hypothesis was also supported in Klonsky and Olino (2008)'s classification of self-injurer subgroups. The subgroup that had the highest report of clinical symptomatology was the most likely to endorse intrapersonal functions for the self-injurious behaviour. This

subgroup was also exclusively comprised of those who cut themselves in private and were also likely to have attempted suicide and to have required medical treatment for a suicide attempt. The other subgroups were less severe in their clinical presentation and likely to endorse interpersonal and some intrapersonal functions for their behaviour.

Differences in the reasons for NSSI behaviour have also been found between males and females (Laye-Gindhu and Schonert-Reichl, 2005). Laye-Gindhu and Schonert-Reichl state that in most cases males self-injure to communicate with or influence others, or out of boredom. Females, on the other hand, reported despair and emotional distress as a motivating factor for NSSI (e.g. depression, loneliness, and self-punishment). The authors suggest that these gender differences may be related to socialization patterns, with supporting evidence in the literature claiming females are more likely to direct their feelings inward whereas males are more likely to direct their feelings outward (e.g. Crick and Zahn-Waxler, 2003). Interestingly, females indicated that they self-injured while alone, whereas the males in this study reported that they self-injured both alone and with peers. Laye-Gindhu and Schonert-Reichl wondered whether males were more likely to self-injure as a "test of will" or strength, or in the context of a game, because males are given the gender role message that masculinity equals "toughness." For example, one male participant reported hitting himself in the stomach with a stick in order to "toughen himself up" (p. 455).

Summary. Yates (2005) indicates that it is important to recognize the reasons reported by individuals who self-injure and to understand why they continue to engage in the behaviour. The literature suggests that individuals continue to engage in NSSI due to the effects of external influences such as contagion, normalization, and connectedness. It may also be utilized to regulate emotions, for punishment and control, communication, and accessibility and pragmatics. The function may vary depending on the severity of the behaviour and the gender of the self-injurer. Even though NSSI may serve a primary function, some individuals may participate in the act for different reasons depending on the situation at the time.

Consequences of NSSI

The consequences of NSSI can be physically, emotionally, and socially detrimental. Physically, self-injurious behaviour can cause infection, scarring, medical complications, and death if the individual inflicted more harm than intended (Briere & Gil, 1998; Conterio & Lader, 1998b; Plante, 2006). Also, some self-injurers may become distressed about their lack of self-control and the addictive nature of their acts, which may lead to true suicide attempts. They may also be at risk for suicide attempts if the NSSI no longer helps them cope, creating feelings of hopelessness (Muehlenkamp & Kerr, 2010). Those with a prolonged history may be more likely to die because they might underestimate the lethality of their attempts (Stanley, Gameroff, Michalsen, & Mann, 2001) or because they become habituates to the behaviour, thereby increasing their risk for death by suicide (Van Orden, Merrill, & Joiner, 2005).

Individuals who self-injure may rely on it as a coping strategy to feel better and to regulate their emotional states. Although this method provides immediate and short-term results, the individual may never address or verbally express the feelings they are having. Thus, the individual may experience a buildup of negative feelings, which could lead to an eventual breakdown (Levenkron, 1998). Furthermore, complex feelings of anger, guilt and shame for having engaging in the behaviour may develop (Klonsky, 2009).

In regards to social consequences, individuals who self-injure often turn increasingly inward and away from others, abandoning real emotional connection with others. This *inward turning* may eventually reduce the individuals' sense of relating to others (interpersonal reality), which reduces their sense of reality in general (Levenkron, 1998). Considering these potential consequences, Muehlenkamp (2005) emphasizes the importance of early identification with the ultimate goal of stopping the behaviour and preventing reoccurrence.

Summary. Over the last ten years, researchers have taken notice of the high prevalence of self-harm in non-clinical adolescent populations (e.g. Hilt et al., 2008; Ross & Heath, 2002). Much of this research has focused on prevalence statistics and functions of the behaviour (e.g. Heath, Schaub, Holly & Nixon,

2009; Klonsky, 2007). It has been suggested that external influences such as peers and the media account for the rise in self-harm behaviour (Derouin & Bravender, 2004; Whitlock et al., 2009). The literature outlines two different pathways of self-harm behaviour: self- and accidental discovery and external influences. Individuals that are influenced by external influences tend to participate in the behaviour later in adolescence (e.g. 15) and participate in milder forms of self-harm behaviour such as scratching (Yates, 2005). This type of pathway and self-injurer is less understood by researchers. Because this area of focus has only gained attention in the last five to ten years, it would be beneficial to conduct a qualitative study that is exploratory in nature. Furthermore, little is known about how an individual begins self-harming and how the behavior progresses. NSSI behaviour is rarely described from the individuals' perspectives in empirical published research (Lindgren, Wilstrand, Gilje, & Olofsson, 2004).

Rationale for Study

Given that NSSI is not considered normative or adaptive by societal standards, Hodgson (2004) has questioned how an individual gains the idea to self-injure. It is possible that the increase in incidence in community populations is the result of external factors such as contagion, peers, and the media, and younger adolescents may be particularly susceptible to these influences. Because of the prevalence and potential consequences associated with the behavior, discovering the perceived origins of NSSI and why the behaviour is perpetuated could aid in a greater understanding of this phenomenon and assist in the development of prevention, clinical recommendations, and treatment.

Johnson (2006) states that more research needs to be devoted to under-researched populations such as community samples, adolescents, males, and ethnic minorities. Since NSSI often originates in adolescence and young adulthood, it would be valuable to obtain a more thorough appreciation of the behaviour as it unfolds during this critical developmental period. It would be advantageous to recruit participants in early adulthood because they have a greater capacity for insight into their behaviour than adolescents would (Arnett, 2006a). Arnett suggests that individuals may be particularly insightful during this period

because it is a time to be self-focused, and time alone allows for reflection and contemplations of one's life direction.

Pembroke (1998) asserts that the care and treatment of people who self-injure could be improved if they were given the opportunity to share their experiences because they are the primary experts with a wealth of knowledge that researchers and professionals need to learn from. Suyemoto and MacDonald (1995) recommend using narrative research methods to obtain a greater understanding of this behaviour. The present study attempts to address gaps in the knowledge of self-harm behaviour and will contribute to the qualitative literature using a community sample of young adults.

Research Questions

The purpose of this study was to explore the experience of NSSI from the individual's perspective. More specifically, I was interested in participants' stories and developing a greater understanding of self-harm by probing: (a) how did you begin engaging in self-injurious behaviour?; (b) how did the behaviour continue?; and c) what were your reasons for engaging in NSSI and (d) what function(s) did the behaviour serve?. These questions lent themselves well to narrative research, which captures the plot and sequence of events in research data. The methodology will be described in the following chapter.

CHAPTER III: METHODOLOGY

Introduction

The term *narrative* is used most synonymously used with the word *story* (Riessman & Quinney, 2005), which emphasizes that meaning can be created or constructed (Emden, 1998b). Narratives represent or re-present an individual's lived experience and are socially shaped, socially constructed, and dependent on social interaction for meaning. The belief is that what people think and mean is transparent and readily accessible from their narrative accounts (Martin-McDonald & Biernoff, 2002).

Narrative research does not have a single heritage, theoretical orientation, or standard methodology (Kelly & Howie, 2007). Thus, narrative researchers tend to draw upon diverse sources of influence (Emden, 1998b). Donald Polkinghorne and Jerome Bruner are two of the seminal scholarly voices who have shaped the conversation of narrative knowing over the past two decades (Kramp, 2004). Other scholars who have influenced the development of data analysis used in narrative research include Clandinin and Connelly (2000), Emden (1998a), McLeod and Balamoutsou (2001), and Riessman (1993).

Description of narrative research. Gil (2007) suggests that narratives are not comprehensible without an awareness of context. A narrative connects events, actions, and experiences and moves them through place and time. Polkinghorne (1998) describes narrative as a cognitive scheme that fills the space between *what happened* and *what it means*. Kramp (2004) indicates that what the participant *tells* is significant to the narrative researcher, whose purpose is to interpret and understand the meaning of a particular phenomenon or experience. Therefore, the narrative researcher pays attention to what aspects or details of events the participant shares because storytellers often mean more than they say (Kramp, 2004). Narrative researchers also listen to what participants are saying and one way they share this information is by formatting it into themes and stories. Fraser (2004) uses the metaphor of *sewing* to describe narrative research. She states that by piecing together fragments of the fabric of conversation, narrative researchers

may be understood to sew together ideas to form a coherent story to represent or re-present that individuals' or groups' experience.

Why I used a narrative research approach. A narrative approach was advantageous for my study because the goal is to reach an *emic* (how people think) understanding of young adults with a history of non-suicidal self-injury (NSSI). As well, narrative research gives voice to the participants. This was important because individuals do not often speak out about their experiences with self-injury due to the stigma that has been attached to the behaviour. Giving individuals that self-injure the opportunity to share their story illustrates that there is more than one reality and more than the view of the mental health practitioner (Holloway & Freshwater, 2007). Although other qualitative methods allow participants' *voices* to come through, narrative research methods stay close to the interview transcripts and attempt to use the participants' words as much as possible. Participants also have the opportunity to share their story, feel heard, and be validated. In the course of telling their stories they may also gain meaning and insight into their experience.

Sample

Purposive sampling was used to obtain participants who had stories of their experiences of NSSI. Purposive sampling is based on the assumption that if one wants to discover, understand, and gain insight into a particular phenomenon, it is necessary to select a sample from which one can learn the most (Miles & Huberman, 1994). The goal in narrative research is not to collect a representative sample but rather to analyze participants' stories in sufficient depth so that their voices can represent others who are not present (Beverly, 2000).

Inclusion criteria. The initial intent was to recruit seven to ten participants who have engaged in NSSI. Due to an overwhelming response and interest by potential participants to partake in the study, a total of eleven participants were interviewed.

The criteria for participation included:

1. Being between the ages of 14 and 24 when they began engaging in self-injurious behavior;

2. Being between the ages of 18 and 30 at the time of participation in the study;

3. Recurrent use of the behavior;

4. Willingness to discuss how the behaviour persisted and played a role in their life;

5. Ability to provide informed consent to participate in the research.

Participant recruitment. Participants were recruited by advertising (see Appendix A) in a local entertainment magazine (See magazine) and through the Graduate Student Association (GSA) at a local university. With the permission of the institutions, posters (see Appendix B) were displayed around the local university, college, community agencies, health centres, and local businesses throughout Edmonton, Alberta. The advertisement and poster explained the purpose of the study, the inclusion criteria, and contact information.

The advertisements and posters both requested that individuals interested in taking part in the study contact me via e-mail. I responded to 22 participants using an e-mail script (see Appendix C). Individuals who met the inclusion criteria and expressed a continued interest in participating were offered an initial interview, and a meeting time and location were selected. The first 11 individuals who arranged and attended an interview became part of the data sample. The other 11 individuals were thanked for their interest and were told that a sample for the study had already been generated. They were informed that they would be contacted if anything changed regarding participants' involvement with the study. At the initial interview, participants were given a more detailed description of the study and informed consent (see Appendix D) was obtained before beginning the interview.

Data Collection

Data collection occurred through two semi-structured interviews that each ranged in length from one-half to two hours. Interviews took the tone of a conversation style where storytelling was the goal rather than a response to questions. I began the first interview by asking participants to tell me about themselves as a way to get to know them and ease the process. This introduction

was followed by the statement, “Tell me about your story of self-harm.” The first interview was unstructured so that participants could lead in telling their story. The second interview allowed for follow-up questioning and to gather more information regarding their story of self-harm.

After obtaining written informed consent, interviews were audio-taped and transcribed verbatim into text. Transcripts of the first interview were read thoroughly prior to the second interview to determine what story themes needed to be elaborated on and what additional questions might be asked. An interview guide of possible questions was developed (see Appendix E). During the transcription process each participant was given a pseudonym so that their identity would remain anonymous and confidential. The names of other individuals in each story were also changed. Any other information that could potentially reveal the identity of the participant within the community was altered or removed (e.g. major in university, profession, name of country visited).

After the second interview, participants were e-mailed a representation of their interview data after the second interview as a coherent story. They were encouraged to read through it and make edits using the Track Changes feature in Microsoft Office. Participants were also asked to provide general feedback of their story via e-mail and asked to attach the revised story. Most participants stated that their story resonated with their memory and experience of self-harm. They either had no edits or minor edits were suggested. The only content changes that were made were extracting or modifying identifying information.

Some participants described how powerful it had been to share their story of self-harm, and that it was even more powerful to read their story written by someone else. One participant said, “I want to let you know that it was really important to me to be able to read over my own story like that. I certainly think of these things, events in my past, but it's a very different feeling to have them all laid out in a sequential narrative. It's really powerful and also empowering for me to read about what I have been through.”

A reflexive journal was kept (Craigen & Foster, 2009), which documented personal reflections such as potential biases and predispositions that could have

influenced the findings (K. Weaver, personal communications, March 28, 2006). Thoughts, observations, and assumptions elicited by the research data were documented. This information was incorporated in the analysis of narrative and themes. Additional information such as methodological decisions and rationale were also noted.

At the end of the second interview, participants were given an information sheet (see Appendix F) that provided a brief summary of the literature and the purpose for the research study. This sheet also provided my e-mail information and the contact information of my research supervisor. Participants were thanked for their time and were given a small token of appreciation.

Data Analysis

Researcher reflection. When I began participant recruitment, I was amazed by the overwhelming response from individuals. My committee thought it might be difficult to recruit ten participants, but surprisingly I had reached my sample size in the first two weeks and had to turn participants away. Although self-harm is often a private behaviour, participants seemed eager and happy to give a voice to their stories and to shed light on the topic of self-harm. Some said that it was important for people to know that there is no prototype for a self-injurer and even high-achieving, social, and athletic individuals could turn to self-harm as a method of coping. Another participant indicated that she was happy "a study like this was being conducted" because when she was self-injuring she had difficulty finding resources that fit her experience. One participant said she wanted to use her name in the study since it was her story and wanted people to know what she had lived and how she had lived.

Although posters were put up at academic institutions, agencies, coffee shops, and other businesses around town, the majority of participants were students from both the local college and university. It may be that students tend to understand the benefit of research and deepening the knowledge and understanding of various topics. When it came time to conducting the interviews with participants, I was also surprised how quickly they opened up and were willing to share their stories. Some participants even provided additional

resources that could offer insight into their self-harm such as journal entries, poetry, excerpts from a book chapter, and a website to a blog. I felt honored and fortunate that these individuals would share such an intimate and significant part of their lives.

The literature suggests that many people react negatively towards people who are self-injuring because they cannot understand how someone can inflict harm onto themselves. I found myself having a different reaction. I felt a deep sense of compassion knowing that participants turned to self-injury because they felt it was one of their only options at the time. I felt sad and disconcerted that they did not have others they could turn to or feel supported by.

Data collection was my favourite part of the whole research process, likely because it fits so closely with the process of counselling. I found that all of the participants were very open and shared rich stories of their experiences of NSSI and pertinent background information. Some participants were more detailed in their story-telling and provided longer interviews. It seemed these individuals had self-injured for a lengthier period and thus may have had more story to tell.

Some participants said it was easier to talk about their self-injurious behaviour once they had some distance from it. One said it would have been difficult to talk about it during the time she was self-injuring; another said that if he participated during his period of self-injuring he would not have been able to provide as rich of a story as time has allowed him to reflect on his experience and develop insights he did not have before.

I corresponded with my participants during the data analysis phase so that they could provide me with feedback on the story that I re-created for them from interview transcripts. During this process, participants provided updates regarding how things had progressed since the interview process. I was moved by the stories that they shared and by the knowledge that most participants were no longer engaging in self-injurious behaviour.

Process of analysis. Polkinghorne (1995) has identified two types of narrative research: *analysis of narrative* and *narrative analysis*. According to Polkinghorne, narrative analysis moves from the particular data gathered from

each participant to the construction of stories for each participant. The role of the narrative researcher is to set the stage, frame the time, sequence the events, and convey a sense of meaning and significance for the story of each participant (Kramp, 2004). This research study used narrative analysis as a way to represent the data. As well, an analysis of narrative was conducted across interview transcripts to look for themes in the research data.

I used Emden's (1998b) approach to developing participants' stories. I transcribed and cleaned (checked for accuracy of transcription and changed/removed any personally identifying information) each participant's interview and created a master file that held an electronic version of all original transcripts. A hard copy of each transcript was also printed and stored in a secure space. Each interview transcript was read several times over to obtain a thorough understanding of the narrative content. Extraneous content (e.g. "ums", "you knows") that did not appear significant to the meaning of the statement was removed. This information was saved under a separate electronic document labelled with the participant's pseudonym in case future reference was needed. I then returned to the full text as a way of checking that all key ideas were retained.

Because a story is set within a temporal framework and has a beginning, middle, and end (Polkinghorne, 1995), the text was also placed in chronological order. I went through the electronic version of the interview and added linking or explanatory information. Content that described key events were grouped together, given headings, and arranged in an order that made sense. Fraser (2004) reports that a story may start with a line such as, "It all starts with"…He also states that middle parts of stories seem to have the most details, such as commentaries and explanations. There were also signifiers to indicate that a story was closing, either by statements (e.g. "so that is how it happened) or when a participant appeared to lose interest in what they were saying and jumped to another story (Fraser, 2004). To ensure that events were placed in the approximate order, clarifying questions were asked. Once a core story was created for each participant, he/she was also given a copy for validation of its accuracy (Martin-McDonald & Biernoff, 2002). Participants had the opportunity to suggest any

changes, and this feedback was utilized to create final versions of their stories. It was determined that if a consensus could not be reached, that participant's comments would be provided below my version of the story so that each perspective could be represented. However, this was not an issue, and participants either felt satisfied with the version of their story that was created or suggested only minor edits.

A paradigmatic analysis of narrative was also conducted (Polkinghorne, 1995). This involved a thorough inductive analysis across participants' accounts and stories to uncover core areas and themes. A description of each sub-theme and theme was provided as well as excerpts from interview transcripts for illustration and voice.

Goodness. The goodness (Emden & Sandelowski, 1998; 1999; Guba, 1990) of this study has been addressed by criteria specific to narrative research: verisimilitude, integrity, and coherence.

Verisimilitude. "A well-formed argument convinces a person of truth by means of procedures of logical and empirical proof" (Oliver, 1998, p. 248). A narrative convinces by means of "lifelike-ness (Bruner, 1986) or "truth-likeness" of the data (Piantanida & Garman, 1999). Therefore, the expectation is that the data be believable and resonate with the readers own experiences, providing a compelling message (Alverman, O'Brien & Dillon, 1996). Verisimilitude is cited by both Connelly and Clandinin (1990) and Connelly and Clandinin (2000) as an important criterion on which to judge the value of narrative inquiries.

To meet this criterion, I stayed close to the original data when writing participants stories. I structured and re-presented each story using participants own words, phrases, and sentences as much as possible. In doing so, the information was provided in a format that readers could make sense of or relate to. This also allows for readers to make their own interpretation of the data when reading each story. The second analysis that was conducted looked for themes across participants' stories. Inductive analyses tend to produce information that is more formal and relies heavily on researcher notions and knowledge (Polkinghorne, 1995). To include participant voice, direct quotations from interview transcripts

were selected to illustrate the themes and demonstrate the "human-ness" of the information.

Integrity. The conceptual structure of the entire inquiry must flow together and be justified by well-reasoned connections between how the inquiry was conducted and the knowledge that generated it. The voice and stance of the researcher are congruent with the mode of inquiry and conveys the researcher's relationship to the study and study participants (K. Weaver, personal communications, March 28, 2006). This concept is similar to the concept of dependability (Lincoln & Guba, 1985), which requires an audit trail documenting how data were collected, how data were kept, and the accuracy of data. I made an audit trail by documenting the steps taken between transcribing participant interviews to generating participant stories. I also saved an electronic version of both interview transcripts for each participant as well as sections and drafts on the path to completion for each narrative.

Coherence. Coherence refers to the ability of the researcher to sort through a large amount of qualitative data and decipher how well the story "hangs together" (K. Weaver, personal communications, March 28, 2006). To establish coherence in the writing of the narratives, extraneous information not pertinent to my research questions was removed. I referred back to original transcripts as a way to check that the main ideas were retained and that the fragments of themes are brought together to form a coherent story.

Ethical Issues

The main ethical issue of a narrative study is that of ownership. The question arises as to who has final control and authority over the presentation and interpretation of the narrative. Since the narrative investigator gives his/her unique perspective on the participants' stories, it seems imperative that they claim some ownership and control over the narratives they study (Symthe & Murray, 2000). Bar-On (1996) agrees that once the narrative has been analyzed, it should be the narrative investigator's text as well as the participant's. Symthe and Murray also report that a common reaction of narrative research participants is that the investigators' analyses of their stories fail to capture them fully in their personal

uniqueness and individuality. They state that such reactions are inevitable when people's stories are transformed into instances of larger social or psychological phenomena. The purpose of narrative analysis is normally not to clarify what participants intended to say but, rather, to interpret the underlying implicit meanings behind what they say. I tried to address this issue by talking with each participant to discuss my version of his/her story to determine if it captured the components they deemed as important and allowed him/her to suggest changes if necessary.

The following chapter is broken down into a background description and story for each of the eleven participants. The narratives are a version of participants accounts based on their recollections of how they began self-inuring, how the behaviour progressed, and how they were able to move away from the behaviour.

CHAPTER IV: NARRATIVE ANALYSIS

Participant Stories

Laura. Laura was a 22 year-old female and was working at a local college. Her parents divorced when she was 12-years old and Laura and her younger brother went to live with her mother. Laura was not impacted by the divorce but rather how it affected her mother. Her mother moved to a farming town and her father re-married. Laura began self-injuring when she was 15-years old and in Grade 10. She moved to Edmonton when she was 18 to attend college and during her first year began dating her now husband. They met each other a through mutual friends and got married in the summer of 2009.

***Story*.** It was hard always being on the move. Every year or so my family and I would pack up our lives and relocate to a new town or city because of my dad's work. We eventually ended up in a small farming community outside of Edmonton when I was 10-years old. Life there was simple but nice. A couple of years later my parents divorced and I stayed with my mom. I had never really been close with my dad so it was not something that really bothered me. He had always been the absent sort of father and so I pushed him to the back of my mind. My mom was the one who initiated the divorce and when she kicked him out I told her I finally felt safe in my own home. It was as though my life started to feel stable. Although this change was something we both wanted, my mom struggled with complications from the divorce and I felt I needed to be the strong one. I wanted her to be able to lean on me, but I was dealing with my own challenges of being a teenager. On top of that, my grandfather passed away, I was having relationship difficulties with a boyfriend, and my father got re-married. To be able to deal with all these stresses and put on a strong front for my mother, I started to keep my feelings in. When I was upset or wanted to cry, I would just push those feelings back down. It got to the point that I was burying so much stuff that I was not able to feel anything….like I had trained myself to shut down that part of me. I was numb and became a shell that was empty inside. In dealing with all this stress I stopped feeling like doing some of the things I used to enjoy. I did not want to have to go to my piano lessons and have someone evaluate or judge me. It

was just easier to give up those things than having people control what I was doing. I wanted to be left alone. Needless to say, letting go of these activities just compounded the problem. I was 15-years old when I had hit my breaking point. I have always been a sensitive and empathetic person so not having any emotions felt unnatural to me. I needed to feel something again. In high school I had a friend who would injure herself to feel better. She was this tall, super skinny, athletic, smart girl so I thought, "something must be working for her." I decided that if self-harm could make her feel better than maybe it would help me…it was my last resort. I started on my ankle, using a pair of scissors to shave at the skin. It felt so good to finally feel something again, even if it was pain. It was never anything serious but my mom started to notice the marks and started monitoring my activities. She would sit on my bed every night until I would fall asleep to ensure that I would not hurt myself. However, my mother had to go to work and stuff so it is not like she could be around me all the time. Also, since cutting became one of my only ways of coping, I went to great lengths to engage in the behaviour. People will do what they think you need in order to stop…but there is always a way. I would wake up in the middle of the night to cut and if my mom confiscated my tools I would hide some around the house or use my fingernails instead. Putting such restrictions can even push a self-injurer more towards the behaviour. It's like you say to yourself, "I'll show you…I can be clever." Over time, I saw the toll my behaviour was taking on my mom and started to feel really guilty and ashamed. Unfortunately, these feelings also led me to cut myself even more. I did not like what I was doing to people. I became more secretive with my behaviour and eventually cut in places where I could conceal my scars better. I did not want to deal with the reaction of people anymore. I started cutting with a kitchen knife on my upper thigh and the line eventually got longer and longer. It began in the inside of my leg and went all the way to the outside. I also started cutting my wrists and I would alternate between the two of them. I never really cut deep enough to do any real damage, but enough to make the cut bleed. I would get satisfaction from seeing the blood because hurting myself somehow made me feel better. It provided me with a sense of control because I could make myself

bleed or not bleed. It was also a release because all those emotions that I had been pushing down finally had an outlet. I got to watch them flood away. My self-injury got so severe that I would basically have a panic attack if I was not cutting myself every day. I would have to cut every morning before I went to school just to avoid the embarrassment of hyperventilating in front of my classmates. It was something I sort of needed to do and then I would be okay for the rest of the day. Even though my mother suffered from depression, she did not understand my way of coping with depression or how to help me. She decided to get some outside support and brought me to see a therapist of some sort. The first therapist I saw seemed more concerned about my mother's reaction to the cutting rather than what I was going through. We would talk for a bit and then she would boot me out of her office saying, "Well, I will talk to your mom now because she is more upset by the whole issue" and I'm like, "Okay, whatever"! It was really frustrating that she was not interested in hearing what I had to say and that she downplayed the self-injury. She believed my behaviour was the result of teenage angst and a "cry for help." I think she truly believed that after I got the attention she thought I wanted that I would just quit. Unfortunately it was not so easy. My mom eventually took me into the city to see if I could receive better treatment there. After my first session with the psychologist I decided that although she was really nice it was not a good fit for me. She was really intimidating so it was kind of like I could only talk to her about superficial things…school and whatever. I could not really open up to her about how I was feeling. I went to see her for a while and talked to my friends but none of it seemed to matter. I just kept trying to hide it and tried to make people believe I was getting better, although not everyone would fall for the ol' "cat scratched me" story. At the end of my Grade 10 year, around the time of final exams, I encountered another stressful period. I went to see a doctor because I was having trouble with my period and she accused me of being a liar when I told her that my boyfriend and I were not sexually active. She assumed that because I was a teenager I must be altering the facts. She decided to do a pregnancy test and for some reason it came out positive. She managed to persuade me that I was pregnant even though I had never had sex before. The

doctor went on to say that since we were from a small town it would destroy my reputation and future to either have the baby or give the baby up for adoption. She made an appointment for me at an abortion clinic and that was just devastating for me. Two days after meeting with her I ended up getting my period but she thought it was just spotting and sent me anyways. When I went to the abortion clinic they informed me that I was never pregnant. Even after the abortion clinic phoned the doctor to let her know I was not pregnant, she still argued with them. It was such a horrible incident and so disorienting for me. That experience was like everything else happening during that time…I just held my emotions back and needed everything to just go away for a while. I was so tired of feeling pain and not feeling pain that I just wanted to disappear for a while. One week-end after work I took a bunch of pills prescribed for my panic attacks and a handful of sleeping pills. My boyfriend was at the house and knew I had taken a bunch of pills but did not think I had taken a lethal amount so he took me home hoping that I would sleep it off. When my mom saw me she knew that something was wrong. I could hardly walk and was not making any sense. She helped carry me out to the car and took me to the emergency. When I woke up, a nurse asked if I knew where I was. Looking down I noticed the I.V. attached to my arm, the bandages, two tubes stuck to the buttons on my chest, a tube stuck to the button on my stomach, and charcoal all over my shirt. It was at that point I remembered taking all of those pills. I was taken to a hospital in the city and felt so out of place…"how could I be lumped together with all of these crazy people"?, "is this what other people see me like"? When I took those pills I did not want to die. I just wanted to wake up totally refreshed and have all of my problems solved for me. It never even crossed my mind whether there would be any consequences. I could not believe I was almost 16-years old and in a hospital surrounded by adults with severe psychiatric issues. My roommate was an older woman with severe depression and I wondered if that was a "flash forward" to what my life might look like. One night I remember a lot of commotion because a lady down the hall was trying to use a broken light bulb from the recreation room to try and cut herself. It sounded so crazy and scary to me. That is what people had been telling me all along but it

never seemed "crazy" to me until then. I guess when you are on the other side and don't understand the desperation that someone might be feeling it can seem crazy to the people on the outside and very terrifying. I realized then and there the stress I was putting people through and decided that it was not the life I wanted to live. Shortly thereafter a bed became available and the staff sent me to a more appropriate ward so that I could begin doing therapy there. During my hospital stay my dad came to visit to see how I was doing. It was weird for me because we had never had a strong relationship and all of a sudden he was expressing all this concern about my well-being and how I was doing. He made a fuss in front of the psychiatrist and the rest of the staff and I started to wonder whether he was trying to make an impression and convince people that he was this "good father"…like if the public wants to see him a certain way, then he would give it 110% while the public was watching. Eventually the staff caught on to his antics and they decided that it was not in my best interest to have him part of the therapy sessions. His behaviour also worried my mother because she did not want him to shatter my hopes again. Fortunately I had already come to the realization that he had issues to address and was not going to change. When I began my counselling sessions, I met with a team of therapists. Although I was supposed to take part in family sessions, the psychiatrist and therapists met with me individually and then met with my mom. They decided to leave my dad out of the whole process, and it worked out for the better because he was unaware of what was happening in my life at the time. During my counselling in the hospital, the psychiatrist used a lot of humour, which helped balance the intensity of the sessions. That was the first time I started to think that, "not all therapists are terrible", which gave me a lot of hope. After about a week, the staff decided that I had enough supports outside of the hospital to keep me from being re-admitted. They were hesitant to release me at first because they knew I was bright enough to provide them with the answers they wanted to hear. Having an "awakening" during my hospital stay, I was able to convince them that I was not going to injure myself anymore and was not suicidal. I really did want to stop because I was scared. At first I was like, "Oh whatever, I will just tell them this" but then afterwards I was like, "I really I do

mean this. I really do not want to stay here." Although I was affected by what my behaviour was doing to other people, it did not bother me enough. It was not until I saw how bad it could get and what my future could look like that gave me the push I needed to stop. After I was released, I met with the psychiatrist a couple times individually and then with my mother and him. Although I was ecstatic to leave the hospital, returning home became another challenge. When you are from a really small town and something happens to you, everybody knows. Fortunately it was the end of the school semester and the start of summer so I did not have to see everybody right at once. The hardest part for me was going back to work at the grocery store. Everyone in the community would shop at this store and when people came in they would ask how I was doing. Some would even say, "So you were the one in the hospital"?, and you would have to be like, "Yeah, that was me." When people would ask questions about the self-harm it was difficult because I didn't know what they thought about it or how I should reply. When I was the one to bring up the topic, you could tell that it made them uncomfortable or that they did not want to talk about it. Instead you would end up talking about superficial things like the weather. When I started Grade 11, things seemed to return to normal. Enough time had passed for people to feel confident that I wasn't going to start cutting again or end up back at the hospital. It was interesting too because when other people at our school were depressed, they were more likely to come to me to talk about things. They would say things like, "This is what I am going through…How did you deal with this?…How did you deal with these emotions"? It was a good feeling because I was able to help people in the way that I would have liked and discouraged them to not take the path I had been on. I also started seeing a psychologist regularly. I met with him consistently for three years and then on and off sporadically for the past three years. We had a really great therapeutic relationship. He knew when it was necessary to push a little further, which was helpful for me…like, "You were biting your lip when you were saying it. Are you sure you are okay with everything"? Months had passed by that I had not cut myself and then one night I was feeling kind of low and thought I would try it again since it was something that had helped me before.

When I made the cut I was surprised to find that it hurt and made me feel really uncomfortable. It didn't have the same sort of pleasing effect it had before and after that I never did it again. It is amazing to think that I went from feeling the need to do it every day to not doing it at all. I still may dig my fingernails into my skin if I need to calm myself down or if I am in a situation where I don't want to cry in front of someone. Just that little bit of pain is enough to distract me from whatever is going on at the time. The unfortunate part of everything is that my mom blames herself for what happened. It is ironic to think that I was so focused on trying to support my mom and be strong for her and all I ended up doing was worrying her. She knew I needed help but couldn't break through to me or the medical staff. They said they could not help me unless I actually overdosed or cut myself too deep. It is saddening to think that the health system would not help me until it was "too late" for the help to help. Looking back, it was a good thing that I ended up in the hospital when I did and had the awakening I needed to move away from self-injury.

Fiza. Fiza was a 20 year-old college student. Her parents were both originally from Kenya, where Fiza and her sister, Maya were born. Fiza's parents decided to move to Canada when Fiza was one year old and her younger brother, Anil was born in Canada. Fiza's mother gave up her career as a school teacher to work as a cashier at the Superstore. Her father worked as a pipefitter and his hope was that their children would secure a good job and would never have to struggle financially like they did. Although they wanted their daughters to get married one day, they said, "Make sure you have a good job and make enough money to take care of yourself so if anything happens, you can leave that door open." Since education was so important to Fiza's parents, they did not want their school work to be affected by social opportunities. Fiza and her siblings would sneak behind their parents backs so that they could spend time with their friends or go to parties. Although Fiza enjoyed time with her friends, she felt different and didn't fit into the stereotypical image of what a "brown girl" should be or the image of what a white girl should be. Her brother Anil was quite a few years younger, so Fiza felt responsible to "act" as her dad's son and be the strong one in the family.

She was already a tomboy, which made it an easy transition. In high school Fiza played football, lifted weights, and dressed in male clothing. Crying was another activity that didn't fit with her identity of being the "stronger one." Fiza indicated that she was overweight in comparison to her older sister and the other brown girls at her high school. She said these were the girls she grew to dislike in school because they were thin and more popular. Instead Fiza gravitated towards girls who also struggled with their weight so she didn't stand out within her circle of friends. People would comment that Fiza did not look or act the way a "brown girl" should and would claim she was "white-washed." This caused Fiza to feel like she didn't fit in anywhere. Fiza first began self-injuring at the age of 15 as a weight loss strategy.

***Story*.** It was at the end of Grade 10 when I first started cutting myself. All of my friends in high school were pretty much the same size so we never thought it was a bad thing to be overweight. It was not until other classmates of ours would stare, point, and even tell us how big we were. That never felt good. My parents never said anything about my weight because I think they figured it would eventually hit me and I would lose it on my own. After a while it affected my self-image. I started to blame anything negative that happened to me on the fact that I was bigger. I am not sure how the idea came to me but I started to think that, "If I ate less, then I will gain less." My friend and I started visiting "pro-anorexia" websites to learn tips for not eating and losing weight. They would suggest things like showering in cold water because your body would burn fat as a way to heat itself up. It was from one of those sites that I got the idea to harm myself and I started doing it because it seemed to work for the group that did it.

The first time I cut myself I did it on my arm but I could not get a great cut so I cut lines on my thigh. I thought at the time that the stinging of the cuts would help remind me not to eat. It would remind me to not "go over there", like to the fridge where "that" eating is just going to happen again. My cutting was not too bad when I first started and after about a month I decided to tell my best friend about it. I remember we were going for a walk when I told her and she was like, "It's not like you are doing it all the time…it is fine." She said, "You are not

trying to kill yourself…you are just blowing off steam." We never spoke about it again and I wondered if she just forgot about it. I think when I told her I was probably hoping for something from her but I cannot say for sure what it was. I felt my family didn't care and she was my best friend--that she should probably know. I guess I expected more of a reaction from her and when she made it out to not be a big deal, I thought, "Well then, it is all good."

Her response made an impact on my cutting behaviour because it continued and escalated from there. I must have known deep down that it was a big deal because I kept it hidden from everyone. I would cut where nobody would see it and would wear clothing that would keep it concealed. I would also hide my blades behind a little perfume container in the cupboard of the washroom because nobody would think to look there. So, I guess I knew but I did not want to believe it…Maybe I was too scared by that point to give it up. After a while the cuts stopped hurting so I would have to do it more often and cut deeper. I would also cut just before I would go into the shower and the water would hit the cuts, causing a stinging pain.

Although it began as a weight loss strategy, it somehow shifted and I was using it as a way to cope with negative feelings. There were times when I felt responsible for hurting people that were close to me, and so I would cut as a way to punish myself and to make myself feel better. If I said something to one person and the information got twisted, even if it was an innocent comment, then I would feel bad because it was like I instigated somebody else getting into trouble or angry. I believed that if I hurt someone then I should hurt myself in exchange. The self-harm was a form of punishment and the pain was deserved. Since people may not have known I was the source, I thought I had to hold myself accountable for my actions. I used to work at this restaurant and became friends with one of my coworkers named Russ. My sister came in for lunch one time and Russ showed an interest in her and he asked me for my sister's number. Although he was a bit older and I did not know much about him, I thought it was a great opportunity to set up two nice people. I later found out that he was married, had a child and his wife was pregnant with their second child. I told my sister right away and she

cancelled the date with him. She was a little angry but I think it affected me more because of how close I came to setting up my sister with a married man. I could not stop thinking about what "could have happened" and the disaster that would have resulted. I felt it would have been my fault because I created the possibility for them to meet up. My sister is so innocent and I could have ruined that for her. Her response to me was, "Nothing happened. It's fine."

Since I had such a hard time letting go of the situation, I dealt with those feelings through cutting. Usually they would be triggered by a specific event but I noticed that another part of my guilt feelings were the result of not taking more responsibility and action when I was younger. Being from a traditional family, my parents particularly my mother would rely on corporal forms of punishment, such as spanking and she had a hand like a brick. When my sister and I would get into trouble, I would often run away and hide and my sister would get the brunt of the punishment. I carry a lot of guilt and shame for leaving her during those times and not doing something to protect her. I know that my cutting was a way of punishing myself for the pain I avoided then. It also helped when I was feeling sad or had the urge to cry. If I got upset, I would cut and it would help me calm down and would stop the tears. Crying demonstrated a sign of weakness and since I was trying to be the strong one in the family, I did whatever it took to prevent showing those feelings. The cutting also acted as a release. Things would fall away for a little bit because that is all you think about for that moment. You manage to find a little spot where nothing else mattered. Nobody could come and bother you when you are in your own little world and it was kind of like everything around you stops; no matter what was going on everything just disappears and all that you focus on is literally the line and how the blood drips. It was a way to re-focus my attention and escape from the problems surrounding me at the time. Part of the escape was also imagining the bad feelings leaving my body through the cut. I would feel physically calm and my body would relax. I could go to bed and the next day my mind would also be calm and my thoughts would no longer be running through my head.

Although the cutting made me feel better, it was a quick fix so after a day or two all the stresses and problems would come back. Knowing that the relief was temporary didn't deter me because it still helped me in the moment. I used to and still have panic attacks and I think the cutting helped from the stress building and the anxiety from becoming overwhelming. I became so familiar with the cutting that even when there were no stressors in my life, I would do whatever it took to put myself in that kind of mood. I would mull over things from the past so that I felt "bad enough" to do it. I became addicted to hurting myself and I was doing it every day, sometimes a couple times a day for four years. Another reason it continued for so long was because I believed that if I am not hurting anyone else, then why not. People would say, "But it's hurting you" and I'm like, "No, it helps me." Even now that I have moved away from the behaviour, I still don't understand why some people view it as such a horrible thing.

When I would hurt myself, I always kept with what I knew and used razor blades. I only ever cut at home and there were always disposable razors around. I would go into the washroom, grab a razor, break off the bottom, and when I would make a slit through my skin it would make two straight lines. You would often have to do it more than once because the first attempt wouldn't be deep enough. I would make roughly 4-5 cuts in one sitting. Sometimes I would cut too deep and I would have to roll up tissue and tape it to the cut so that the blood wouldn't seep through my clothing. I also had this ritual of keeping the white part of the razor blade to see how many I would go through. After the blood would start rolling down, I would dab it with the white strip and spread it and as soon as it was all red I would put it into a little box where I kept them all and start the next one and then the next one. It was not even that I looked at them or anything. I just knew they were there and it made me feel like, "Okay, you are stronger." The blood served as a reminder of the pain I was able to handle, and in turn my strength.

During the period that I was harming myself, I'd "Google" search cutting and other self-harm behaviour. I'd try and read up on how other people did it and their reasons behind it. Maybe I was trying to make sense of my own behaviour

by learning more about it. It also influenced the methods I used. It is weird because you can get ideas from a website even if it is discouraging you from the behaviour and your are just, "Hmmm….." That is where I learned more information on how to write words in my skin. I got the idea initially because I saw the scars of one of my friends. Prior I had been using the whole razor blade so my cuts were fuller. When I saw the writing on her arm I asked how she was able to make the writing so clean. She taught me how to pull out the blades and use just one. One time I wrote, "My happiness depends on the happiness of others." It was less about the message at that time and more about how bad I was feeling about what I had done. Just as I would cut as a form of punishment, the writing would serve as a reminder of how I had caused hurt and pain on someone. I didn't have the privacy at home to utilize the outlet of a diary so the writing on my skin seemed to serve that function.

Another outlet I had was talking to a friend. I discovered that a few of my closer friends were also self-injuring so we decided to be a support system for one another. When you needed someone to talk to, you knew that they were not going to judge you or be angry with you if you did it again. Instead they would say, "Next time try this and next time make sure that you call me." I'd also be available for them in the same way. One of my friends was going through a hard time because her dad had passed away and she was in an abusive relationship. We would be on the phone until three or four in the morning until she had calmed down enough to go to bed and if she ever had the urge to cut she would call me before and I would try to work her through it. It was nice to finally be open with someone about how I was feeling and the things that I was doing. I was living such a secretive life at home that I could be myself when I was with my friends.

Eventually my sister found out about the cutting and flipped out. I was a little surprised by her reaction because it was a lot more extreme than how my friend responded to my behaviour. She said, "You have to tell mom and dad" and I replied, "No, I'm not crazy and I'm not going to tell anybody anything." At that time, my sister was leaving for a two-month vacation and she told my mom to take care of me while she was gone. Fortunately, she did not tell my mom about

how I was harming myself. When my sister returned from her trip she discovered that I was still cutting so she decided to tell my mother. I recollect it being really awkward to have to meet with my parents and talk about what I was doing. I remember going up to my mother's room and my father and mother were sitting on the bed. My mother was so worried. She was bawling and tears were rolling down her cheeks. She kept saying, "What did I do"?, How did I go wrong"?, and "I must be a bad mother." My father, on the other hand was like, "Omigod, they are going to send you to the psychiatric hospital", and "You are crazy" and "I don't want to send you there." He also said, "If you do this again, I am going to send you to the psychiatric hospital myself." My mother tried to stop my father from carrying on and told him to "shut the hell up." The fight ended with me trying to tell my mother that she was not "bad" and reassured them that "I wouldn't do it again."

I was able to live up to that promise for six months before starting up again. My parents discovered that I was cutting on three separate occasions of the four-year span that I was cutting. The third time I was caught my mom was like, "That's it…we are going to take you to see a counsellor and you are going to figure something out because this is not happening again." My mother brought me to see my family doctor who then referred me to the mental health unit at the hospital. When I arrived at the hospital, I met alone with the counsellor before the psychiatrist joined us and I told her how I try to make my parents happy and hide things from them. She encouraged me to be a teenager because I spent so much of my time working, at school, and focusing on schoolwork. When I met with both the counsellor and psychiatrist, I did not like how they pushed the idea of medication. I feel that medication is not required for everything and I do not like how doctors always jump to that as the solution. I said, "No, no medications…I just need to talk it through and can do this on my own. I am not about to kill myself and I am managing fine." They made me feel like I was crazy for engaging in a behaviour that was actually helpful to me. The whole experience was really awkward so I refused to go back again.

I didn't stop cutting after that session but it did become a lot less. The summer after I graduated from high school I went to Kenya for two months to visit my cousins, aunts, and uncles. When we were getting ready for the trip my mother waited to buy razors there because she didn't want me to have access to them while we were gone. She said if I needed to shave my legs then I could buy a single one, rather than a whole package. My cutting had pretty much stopped while I was away because there were so many people around the house all the time that it made it difficult for it to happen. When I got back from my trip I thought, "If I have gone this long without cutting I should continue trying *not* to do it." I didn't want to waste the fact that I had gone two months without an episode of cutting; otherwise, it would have felt counterproductive. However, it was a lot easier to refrain from harming myself while on vacation because everything is new and exciting, you feel good all the time, and you do not have the same stressors. Then when you return home things just kind of settle back into place and you're not as happy anymore.

Eventually I decided to make some changes in my life. I took a year off after high school to work and I started a diet program. I lost 50 pounds and a major transformation occurred, even to my personality. When I started to feel better about myself and my weight I started to care more about my appearance, wore feminine clothing and styled my hair. I even had my first boyfriend during that time. I definitely shocked my parents. Since high school there have only been a few incidences where I chose to injure myself. Once was after my mother and I got into an argument. She has diabetes and refused to take her medication because she was angry at me. We continued to argue and she took a piece of butter and put it in her mouth. I got so upset that she would put her health in jeopardy like that. It is just not what you do. I think that was the first time since high school ended and the first time I put a razor blade to my wrist. I remember following the line of my vein but purposefully not going deep enough to do any permanent damage since the purpose was not to die, but rather to have a release. I had to wear bangles for the next couple days so that nobody would find out.

Another recent time I found out a person at work was spreading rumours about me and I was like, "All of those are lies." I have a lot of respect for myself and there are things you do not want said especially if they are untrue. There was one person in particular who was saying all this stuff so I flipped out. The intensity of those feelings and the circumstance pretty much got me to do it again. The option still pops into my head now depending on the situation or how I am feeling, but I try to steer away from it. If it means I cry, I cry. I try to allow myself to feel certain emotions and it's not as bad as I thought it would be. When I notice myself taking full responsibility for circumstances and placing blame, I try and stop myself and reason out why it is not solely my fault. My friends are a big support with that. They tell me, "Fiza, you are taking on too much. It is not your fault and stop making it your fault." They help me realize what I am doing and so I try to stop the cycle and prevent myself from going down that same path. Talking with my friends helps to get me out of my head and they provide me with other opinions and perspectives. However, I still try and make my own decisions and not be too influenced by others say. I take in all the information and comments that are shared and evaluate how it fits in the context of my life. Then I try and make the best decision for me.

Lisa. Lisa was a 20 year-old university student. She grew up in Alberta with her parents and her sister, who is two-and-a-half years younger. Lisa described her family as ridiculously normal, yet "emotionally retarded." She said her mother has a lot of anxiety and does not deal well with confrontation. Lisa's lifestyle and self-destructive behaviour took a toll on her mother when she was growing up so she limited what she told her. Whenever they would fight, her mother was always at a loss of what to do and did not know how best to support Lisa. Her father was always distant. He was involved with Lisa and her siblings when they were young children, but when they got older, he was clueless as to how to interact with them so would invite them to participate in his hobbies such as woodworking. Lisa reported hating these activities with her father, but realized that was the only way he knew how to connect with them, especially when they were teenagers. Lisa began cutting in junior high, at the age of 12. There were a

lot of stressors occurring at that time such as the sudden passing of her grandparents and emotional abuse by her peers. By Grade 9, she "diagnosed" herself with Borderline Personality Disorder since she fit all nine of the "textbook criteria." She described herself as feeling things in extremes and when she felt an emotion, she felt it 100%. Lisa had black-and-white thinking so if something negative occurred and she received mild criticism, she would view it very harshly. After her high school graduation, she began working full-time in retail, where she met Dean. Lisa and Dean had an intense passionate relationship and they moved into an apartment together after a few months of dating. She had little money after travelling extensively so she moved back in with her parents. While Lisa and Dean were dating, Dean's passion soon turned to possessiveness and rage and she experienced physical and emotional abuse. She wanted to distance herself from him so she moved to Edmonton for school. At the end of her first year of university she met her current boyfriend, Kurt, which has been one of the best things to happen in her life.

***Story*.** I have lived about five different lives. My first life began in Calgary where I lived with my mother, father, and younger sister. We had a pretty normal life, but the theme in our family was the inability to express our emotions. My parents and sister had difficulty talking about their feelings. I, on the other hand, had the difficulty of expressing my feelings in a controlled and healthy way. The first time I remember feeling depressed was in Grade 5 and it mostly manifested as irritability. I used to act out and I would explode with emotion. In Grade 7, I was deeply impacted by the sudden passing of my maternal grandparents who had died in a car accident while on vacation. My mother was destroyed by the unexpected loss of her parents. She didn't know what to do or how to deal with her emotions. She already struggled with anxiety and began taking sleeping pills because she suddenly had an immediate sense of mortality. I contributed to my mom's stress because I starting going all "teenage" on her. I would stay out until two or three in the morning and not come home and not answer my phone when she would call. I would sneak in and I would sneak back out and she would be, "RAAAAHHHH…I can hear you sneaking out." My emotions and behaviour

continued to grow out of control and I began cutting by the time I got to Grade 7. I remember learning about it because I would read psychology textbooks for interest's sake. I had this kind of devil's curiosity and decided to try it. I was surprised when I didn't get the rush that tends to occur with harming yourself and decided this was not for me. I don't remember why I tried it a second time, but obviously it was somewhat effective since there was a second time. I started cutting using a Swiss Army knife that I had from camping. Ninety percent of the time I would cut on my left arm and wrist. In a way, I believed the emotional side of my brain was trying to attack its other side, the more logical part of self.

When I was at school, I heard through the whispers that other girls in my social group were also cutting and it eventually became a mini-epidemic. We were a weird group; really intelligent and gifted but struggled academically and socially. Some of us were friends for many years since we stayed in the same advanced program and had the same classes. We spent all of our time together. A few of the boys in our circle were emotionally abusive and that was the biggest starting point for the girls since it was so damaging to their self-esteem. Ryan was exceptionally bright but certainly sociopathic from a very early age. He and our other friend Jesse would make websites and would put pictures up of the girls in our group and write horrible things about them; like so and so is a "whore"…blah blah blah. Even with all this negativity we would still spend time together and go to the same parties. Grade 8 was our "experimental phase" and we would play strip poker, "Truth or dare" and "Seven minutes in heaven." We would take turns making out with each other and when I look back at it now it was all pretty incestuous and probably not healthy. The ironic thing was that I was the *captain* of this sexual exploration. It was not that I pressured anyone, but it was definitely my idea. Of course the boys were like, "Yay…boobies!" However, the closer you get to know someone personally and intimately, the more leverage you gain in knowing how to hurt them. We had weapons to use against one another and self-esteem became the biggest concern in our group. The girls ended up developing their own list of problems- cutting, disordered eating, drinking, and drug use. I

probably struggled the most and the cutting progressed throughout my teenage and young adult years.

I ended up reading a lot of psychology textbooks to try and understand my radical extremes in emotions. In my research, I found that I fit all of the criteria for Borderline Personality Disorder (BPD); particularly the self-destructive behaviour such as promiscuity and substance abuse. I also experienced the mood swings the way the textbooks described. It became really evident in Grade 9 because I was all over the place. It was difficult to follow any structure, which is the commonplace in school. Instead my activities were dictated by my fluctuating moods. I would have a boyfriend for a week and then I would be on to another guy for two weeks before going back to the other guy. It was always my game. I would be like, "That was fun. I don't like you anymore." It fuelled my ego and was my alternative to self-harm. Otherwise, I would turn to the cutting. You know, fail a test- cut myself, get into a fight with a friend- cut myself. It was mostly in response to failure or rejection. Everything would be fine for a few weeks and then I would have another breakdown and fall apart. I would start to think that I did not want to live anymore. However, I was never really suicidal. It was that I did not like myself and I did not want to live *that life* anymore. I had so much anger directed towards myself without many outlets aside from self-harm. It became cyclical though because following the self-harm would be the shame and disappointment, which would contribute to the self-loathing and future cutting.

By the time I got to Grade 10, it was getting hard to hide the scars on my arm so I moved to cutting on my hipbone. I also switched from using my Swiss Army knife to straight razors. I did a lot of experimentation with things like compass points, mechanical pencil, and shard rocks…basically whatever was there. If I felt a strong impulse and I had nothing with me, I would pick at the scabs or scratch over and over. It was around this time too that my mom found out about my cutting. She noticed that I always had my wrists covered up so I am pretty sure she had an idea. My mother brought me to see a child therapist and that lasted for about two sessions. The therapist would tell me to paint a tree and I would think, "What does painting have to do with anything. Dude, I am 15…too

little, too late." I think my sister was also self-injuring, but she was never as bad as I was. I told my sister that self-harm was not the solution, although I wouldn't judge her for her actions. I mean who am I to say…but I felt it is my responsibility as her older sister to guide her on a better path. Unfortunately she never really opened up to me. We were sisters but never really friends. It could have had something to do with the age gap between us and that we were two very different people with little to connect on.

In Grade 10 I also got into the punk phase but it was before the Emo subculture was cool. I had the bangs and spiked hair, the skinny jeans, the spikes, the drinking, the older boys, and the punk shows. We would get mickeys of vodka and beer and would chug them before the show. It was during this phase that my cutting was probably at its worse. I was hanging out with these older punk boys who had no filter and would tell you exactly what they thought. It was also the first time I fell in love and lost my virginity. Dustin was two years older and we had an intense relationship for two months on-and-off for about a year. He dumped me because of my cutting and I did not deal well with the break-up. The ironic thing is that after we split, I stopped cutting myself for almost two years. In some way, I think I was trying to say, "F-you…I will prove you wrong." But it did not mean the destruction ended. I found alternatives such as drinking, drugs, and burning. The burning was never severe. I would just take a lit match and then put it out or take a lit cigarette and roll it along. The next phase for me was getting into the rave subculture, which is a lot different from punk. It is "Hippies gone teletune"…free love, Ecstasy, cuddling…but still the older boys. Some of my friends were the same but it was a lot more positive environment. That was another reason why it was easier to give up the cutting for a while. We would spend most of our free time going to raves and would be high on Ecstasy. We would spend the entire night dancing.

My second life began when I was in my late-teens and met Dean. I left high school a semester early and was working in retail when we met. He was older, funny, charming, and interesting and we had a whirlwind relationship. We moved in together after only a couple months of dating. We got an apartment and

I played the role of the traditional housewife- cooking and cleaning. It was surreal. The honeymoon period was very short and Dean eventually became verbally and then physically abusive. I think deep down he thought he was doing me a service and was trying to save me. He would tell me to do this better, say this different, and to wear this instead of that. He also had this way of making everything "my fault" and I would internalize the anger I had towards him. Instead of fighting back or expressing these feelings to him, I turned towards the cutting again. This time it was more episodic and I would cut in response to a fight or intense feelings I was having at the time. Our relationship was very up and down and our money situation became tight. We had to move out of our apartment and lived in our van. It was at this time that we made the decision to move out West.

My third life was when we moved out west to save up money for travelling. We started in Vancouver and I got a job working as a bartender. Dean didn't like the guy I worked for and he made me quit before I had earned the money I needed. He also managed to get arrested twice in the short time we lived there. The police would intervene when they became concerned for my safety. They would say things like, "Did he hit you? Let me see your bruises" and I was like, "It is no big deal officer…it will boil over." When you are in a relationship like that you don't want to make things worse than they already are because things will get more physical as soon as he is back out. We left Vancouver after only a couple weeks and then moved to Victoria. My memory of my time out West is very patchy because there were a lot of drugs, lots of drinking, and I am sure there was cutting during this period. While in Victoria we did a bunch of cocaine and lived on the streets, sleeping in our van when we needed a place to rest. It was quite the clashing of worlds because we had this "street life" but then I also worked at this fancy restaurant and had a retail job at the mall so on the days I worked we would stay in a room at a hostel. It really was a double life. I would make a lot of money at the restaurant I worked but all of it went towards blow.

Dean would go away and drive up the island for a couple days and I would stay and work and hang out with people from the hostel or that I met on the

streets…*society's rejects*. They would feed me and treated me well and then Dean would come back and I would get back in our van and the fighting would begin. He would say, "Can you go and get me some more coke" and I would be, "No, you know…I don't want to do it anymore." I reminded him that the reason we were out West was to save money for our trip to China. I think he felt bad that I spent all of my savings on him and his habits so he managed to get enough money together and bought me a plane ticket to Asia. By that time I had wanted to go on the trip alone but Dean was my only way. I tried to focus on the good stuff in our relationship to make things easier. I was also too proud to go back home to my parents and wanted to keep up the façade that everything was fine.

Unfortunately nothing changes. Our first night there, Dean gave me a black eye. Since it is not customary for Asians to show emotion, our altercation to them was something out of the "Exorcist." But again our dysfunctional relationship continued and we would have screaming fights in the streets of this small town and there was the running and the hiding. Over those few months in China we would spend some days and nights apart but we would always end up back together. As much as I knew I had to leave him he would not let me. He would be like, "You can't be in a foreign country by yourself. You can't be in Asia by yourself." So, when my mom decided to come visit me in China, I had found my "out." I told Dean I was going back to Calgary with my mom so I would have that month to work and save money for university. I moved in with my parents and it was nice to have money and stability again. When Dean returned, he moved close by to my parent's house. It wasn't long before he was kicked out of the apartment for causing trouble. I was really unhappy in the relationship but I didn't have much success in breaking up with Dean. He was not ready for things to be over. In the summer of that year, I told him that I had to end things for good. It just got to the point where I had to leave. It didn't feel right anymore and I didn't feel safe in my own skin. Our relationship just got too volatile. He took his anger and emotions out on me and I took my anger and emotions on myself- through cutting words and cutting skin. I think I believed that if I cut enough lines there would be enough space between for the pain to

escape. At the time, I had applied to a few universities in hopes of getting accepted so that I could make a fresh start.

At 19, I embarked on the start of another life in a new city. It was like I was coming up out of the water, and finally I could breath. I wanted to have the "true" university experience so I moved into residence. It was not the smoothest transition because I still found myself being affected by my relationship and break-up with Dean. I started dating a guy name Jared, and at the beginning everything was great. After a few months of dating, his true colors started to show. He would spend a lot of money on people as a form of manipulation, so they felt ingratiated to him. Jared never came out and said it to me, but he seemed to think that I "owed" him something because he spent money on me. It became a horrible cycle because I continued to feel used but it never seemed like the right time to break up with him because of all he was doing for me. It made me feel like a horrible person because I was just this body. Even though we were dating, I felt like an escort. It really contributed to my low self-esteem and self-loathing. I finally found the "right time" to end things with him and started nude modelling to earn extra money. As much as people may think that nude modelling would maintain the cycle of low self-esteem and abuse, it actually created the opposite effect. I started to feel more appreciative of my body and I started to feel more sensual and confident. By the end of my first year of university, my life was on the upswing and it brought me to Kurt.

Kurt is probably one of the best things to have ever happened to me. Although he was quite a bit older, we just clicked. During the initial period that we were dating, I was so happy and had no need to cut. Even though I had been feeling better and stronger, I could not seem to escape my mood swings and episodes of low mood. When I would feel depressed, I would cut. There was no plan or conscious decision making. There was just "have to, "have to." That is all I would think about. It was like, "I am going to do it and I am going to do it when I get home and that is all that will make it better. I would cut deep enough and it would seal and scar, it was as though my pain was real and legitimized. When I was in these dissociative states there was no logic to it. One day, I got out of the

shower and my veins were really blue and I got this idea that I had to check to see if my blood was still red and I grabbed the nail scissors out of the drawer and began scratching and scratching at my skin. Reasoning must have started to return because I called Kurt and said to him, "I can't get it out of my veins" and he was like, "What are you doing?." He was able to talk to me and calm me down. When I was angry, it was different. I would be pacing and playing loud music and trying to find an outlet for the anger. I would often turn to drinking, drugs, sex, or something self-destructive. More often, towards the end of my journey I would turn to drinking. Another night of binge drinking, despite the liver scarring, seemed less damaging. It was very hard for Kurt to see me coping in this way. He would always say, "You are so beautiful, why do you have to do that?." It would make him really sad because for him it was like seeing this young, precious, beautiful girl slowly killing herself. He tried to be supportive in the best way that he could. I ended up bringing a lot of drama to our relationship but it was due to my tendency to see things in black-and-white. One day everything would be fine and the next day the "world was over" and I would go into crisis mode. An additional challenge was that my "crises" tended to occur late at night, like two or three in the morning. When Kurt had to get up at 6:30 a.m. for work, the late night wake ups would be rough on him. He would tell me that he wants to be a support and could be there for me if I called him in the day or evening and I would tell him, "But it's not a problem now." To try and find some balance I tried to rely on my friends who were also up at those hours and were online to chat with.

The summer after Kurt and I met, I went away tree planting. Planting is a very challenging job and it was hard on my self-esteem which was already fragile. You are faced with obstacles such as hot weather, rough terrain, poor land, and the knowledge that the other planters are better than you. By the third month, I was doing a little bit of cutting again. I think I just wanted to return to civilization, but we were five hours away from the closest town. We had satellite internet and found out while I was out there that both my paternal grandmother and an acquaintance of mine had both died. I really wanted to go home for the funerals but they told me they did not want to send out a truck because they kept breaking

down. It was heart wrenching that I could not be there with my friends and family. My dad was also in the hospital with appendicitis so everything was happening at once. I had to remind myself that there was only one week left before I could return home. Once that week was up I went to see Kurt before spending time with my family. Kurt and I are primary partners but we have always had an open relationship. When I got home, I went out with a few of my friends and slept with one of them. A few weeks later I found out I was pregnant. I had really bad morning sickness but I was so frail from tree planting that I was surprised I was healthy enough to conceive and carry a baby. I didn't find out whose baby it was but in my heart of hearts I knew it was my friend's, Christian's. I didn't feel right about keeping the baby because it was the product of one of my friends and not my boyfriend. Also I was still in university and didn't have the finances to raise a child so I decided to terminate the pregnancy. I don't think my body could have carried the baby to term or could have handled the birth. Even though the abortion seemed like the only option, I still struggled with my decision. I was hard of myself for letting something like that happen. I definitely had a lot of stressors that summer. Kurt though was really supportive and took really good care of me.

Although the "fall" was that summer, the "rise" came in the fall when I returned to school and began counselling at the university counselling centre. It was only four sessions, but I let out a lot of pain and frustration and realized that I was directing all of my anger onto myself. I discovered that I should not take full responsibility for situations and should look at all of the contributors. I learned to express and communicate my anger rather than internalizing it and found that counselling was a very positive experience. The last time I self-injured was probably in December [2008]. I was getting overwhelmed with all there was to do at the end of the semester and studying for finals that I began to have panic attacks. I cut as a way to release the tension and stress that was building before my exams but ended up over-reacting because I took a few days off from work and had the time to study and get caught up on everything.

My story of self-harm has been such a journey. It is hard to imagine I have had a relationship with self-harm for over eight years. I am 90% there on the road

to recovery. It has been both a conscious decision and something that has developed on its own. On this road it has been two steps forward and one step back. There would be times when I knew I should stop and would say to myself, "This is the last time…try and stop." However, the urge was often too strong to give it up all at once so I would turn to cutting designs to make the self-injury more controlled. The belief was that if I try to "prettify it", the action was more methodical, safer, and controlled. When I engaged in self-harm in this way, it would be the "last time" for a while until another crisis happened.

I also utilize the outlet of sex as a safer alternative. I participate in play that involves masochism and forms of punishment. The benefit is that it activates the same brain chemicals as cutting without the long-term consequences. I can achieve the same "high" without the shame and negative self-talk that cutting would bring. I also found another way of getting around the "wall" of negative self-talk and irrational beliefs; the voice that tells you, "I am not good enough." When you are able to move past this point you can start to look at the larger picture. Even if things seem like the end of the world…you failed a test, you had a fight with a friend, and your boyfriend just broke up with you…you need to remind yourself that that moment is just a small segment of your life story.

Silas. Silas, 25-years at the time, travelled and lived across different parts of Western Canada. He was born in British Columbia and has a sister who is one year younger and a brother who is two years younger. They had to flee when Silas was 7-years old because his father was abusing his mother and was a danger to the family. They were on the run for the first year because their father kept discovering their whereabouts. Although Silas' mother dated other men after leaving his father, she had only one serious relationship with a man named, Dan. He had an addiction to narcotics but managed to make it to work every day and provided financial stability for the family. Silas did not get along with Dan because he did not impart the wisdom and guidance he was looking for in a father figure. The one thing he learned from Dan was how to be a "functional addict." He looked to Dan's brother and his grandfather as male role models since he viewed them as responsible and productive. He also respected that both men were

in the military, were faithful to their wives, and were family-oriented. Silas experimented with self-cutting when he was a teenager, but engaged in self-harm on a more consistent basis when he was 21-years old and became involved in a drug-oriented lifestyle. There were some negative events that occurred during that one to two year period that motivated Silas to turn his life around. He stopped using drugs and moved away from self-harm behaviour. He also moved back home with his mother, began weight lifting, and participated in other pro-active activities such as caring for his dog. His first passion is to become a detective, but applied to a college program in environmental science as a secondary career route.

***Story*.** The problem with always being on the move is that I never went to a school long enough to establish a friendship group. I had an especially hard time meeting women. The girls I was interested in seemed to be attracted to the bigger and more aggressive guys and it made me feel inferior. To feel more masculine I started fights and would steal. My desire to feel masculine was one of my prime motivators to injure myself. I first heard about self-harm when I was 13- or 14-years old and was listening to music by Marilyn Manson. I remember watching him on stage cutting himself and it opened me up to the *idea* of self-injury. He never really gave an explanation in his music or interviews as to why he did it so it made me curious. Shortly thereafter I began experimenting with harming myself to figure out some rational reason behind it. I used razor blades and would cut along my leg. The cutting only lasted a month or so because I never really got into it.

When I was 16-years old I moved to live in with friends. I lived with them for about a year and a half and when they decided to move elsewhere I made the decision to move to Edmonton to live with my mother and brother since I was not making enough money to support myself. My sister had moved up North because she was fighting with my mother and needed some distance. About a month after my move, I started to feel stressed and smoked a lot of marijuana. I began hearing voices and messages while I was listening to my music so I checked myself into a psychiatric hospital to be assessed. They kept me in the facility for a month so that they could conduct a thorough evaluation and monitor me over a period of

time. I was diagnosed with schizophrenia and bipolar disorder. I was trying to use that time to determine what was necessary for a positive outcome and future. However, it didn't help that the medication I was on hindered my ambition and creative ability. It was also hindering to be surrounded by professionals that were in a higher position than me and did not foster positive self-growth. Since I was diagnosed with two psychiatric disorders the staff there expected that I would be on medication for the rest of my life. I chose not to take my medications because I did not like how they made me feel and it affected my ability to accomplish and achieve tasks. It basically sedated me. Moving back home with my mother and brother was positive because they were really supportive and didn't treat me differently because of my mental illnesses. I eventually moved out with the girl I was dating and lived with her for about two years.

When Jenny and I broke up, and I moved to an apartment in downtown Edmonton. I ended up meeting Cale and Drew and they moved in with me to share expenses. We were working and doing drugs from time to time. Then our friend, Sheila and her boyfriend got kicked out of their place so we let them move in. I was also smoking a lot and really wanted to quit. By that point I had tried the nicotine patch, nicotine gum, and even got a prescription to quit smoking from the doctor, without any long-term success. One day I was looking at my cigarette and thought, "I don't want to be addicted to these anymore." In a way to develop some self-control I decided that every time I had a cigarette I had to put it out on my arm. The rationale was that the pain from the burn may reduce my desire and the amount that I would smoke. At first, I dreaded the idea of putting the cigarette out on me and I was down to 12 cigarettes a week; a very low number for me. I would burn wherever there was available skin but usually it was on my arms because it was the easiest place to reach. I tried to avoid the inner part of my forearms because the area is sensitive and is the flesh covering the veins to the heart. It seemed too dangerous to me. I never wanted to go to the hospital for my self-injury. I focused on areas where there was more muscle and fatty tissue. When I started to run out of surface area on my arms, I would have my girlfriend at the time burn my back and shoulders or I would burn my feet. I really had to take care

of the burns on my feet because I didn't want my socks and shoes to cause friction and make the wounds worse than they were.

Once we were able to save up enough money we rented a house, which had a lot more space and room for everyone. We were doing a lot of drugs when we were living in the house and there ended up being a lot of people that would be in and out. We even had a few homeless people that would stay for a couple nights here and there. I started to feel overwhelmed by the amount of people in our house and not having any time to myself. I felt responsible to take care of them such as making sure that they were fed. I started to turn to the burning as a way to release the tension and stress I was feeling. Another reason I continued to injure myself was to feel strong and masculine. I made sure that I was sober during the whole process so I truly felt the pain of the burn. I was trying to prove to myself that if I could handle the pain caused by burning that I could handle anything that came my way. It was a source of protection because it would also inhibit others from attacking me because of the level of pain I could withstand. They knew it would take more than one stab wound to stop me. I would wear t-shirts around the house so that my wounds would heal better but it also meant that the *randoms* would see my scars and know about the self-injury. By nature, I am not an aggressive person and do not like fighting. Harming myself helped take away my fear and allowed me to feel safe in a world that was unpredictable and filled with drugs and violence.

I started to like the way the burning felt and continued doing it on a more regular basis. The initial sensation of a burn would be over the top and as it started to heal I would put it in chlorinated water. To reduce this risk of getting infections I would have to clean the wound well. It made me feel intelligent that I could tend to and take care of my own wounds, like I was a doctor. I would also use baking soda rather than hydrogen peroxide because the peroxide would just wash away the skin and not have the same burning sensation. It was a whole process and I did not want to miss out on any part of it. A lot of my friends would be high or drunk during their self-injury but that seemed to defeat the purpose and seemed like a show for other people. Instead, I focused on the pain.

My skin started to become very unappealing because of all the scars. I had a couple burns on my hands and they were got really red and swollen so I had to clean them well and bandage up my hands. I also started to have a build up of scar tissue on my arms. Since it was too difficult for me to stop at this point, I decided to be more intricate with my burning and made designs. I would take a safety pin and would hold it to a candle until it go hot and could make designs in my arm similar to tattooing. I made a witch symbol with a crested moon with lines and forks through it on my chest and a double anarchy bat symbol on both my biceps. I also burned X's and lines down both of my forearms.

Around the same time, Drew started to fall short on his portion of the rent so he had his friend, Joshua move in. Joshua was involved with a local church and was acting as a mentor to a guy named Sebastian. Sebastian's parents were living in another city so he and his brother bounced between staying at friend's houses to living on the streets. Sebastian was selling crack and stealing vehicles so Joshua and the rest of the guys in the house tried to support him to better his life. We helped him sign up for a program where he got his own apartment and enrolled back in school. Sebastian's younger brother Kyle seemed to have his act together. He was going to school and did not use drugs, not even marijuana. He would stop by the house once and a while to hang out or to watch a movie. Joshua would check in with both Sebastian and Kyle because he was acting as their legal guardian. Over the next following weeks, Kyle started to get into trouble such as drinking in public, carrying a machete, and was contentious with a police officer. He started to distance himself from us and one day we learned that Kyle was being charged with connection to a murder of a young girl. The only time he heard from him was when he wanted us to act as an alibi for him. This event really caused me to re-evaluate my lifestyle and I decided to make some positive changes to better my circumstances.

I moved back in with my mother and brother and stopped using crystal meth. It was hard to give up the drugs and lifestyle all at once so I participated in activities that were proactive and served as helpful distracters. I ended up weight lifting and drinking a lot of water. For a while, I would cut my thumb and dab

beef jerky in my blood before eating it. Although I was lifting weights, this ritual was another way for me to feel masculine. I was also trying to move away from more serious forms of self-harm such a burning and using drugs. It was not as difficult as I thought to give up the burning but this was likely the result of not being in the same environment anymore- it was not as necessary. To foster the transition to a more positive lifestyle, I also completed the rest of my high school courses and wrote my graduate exit exam (GED). Being in a college environment has been constructive because I am surrounded by people with goals and ambitions. I started to write down my own goals; both short-term and long-term objectives. For instance, "I have to work out today, do my laundry" and after I complete each task I cross it off. It is empowering to acknowledge what I have accomplished and it has helped me to feel better about myself. A long-term objective of mine is to become a detective. In the meantime, the focus will be on obtaining a college diploma and I will enhance my background to get into police and detective work. As far as I know, you have to be a police officer for four years before you can apply to be a detective. I will continue to exercise and stay in shape, keep a clean driver's licence, participate in volunteer work, and find people who can act as character references. One of my interests in becoming a detective is the positive image I have of the police department. The police rescued me and my family when my father was being violent towards my mother. I think it would be rewarding work to find answers and piece together information about murder cases, assaults, or missing persons. To keep busy, I have also been involved in martial arts and am writing an adult comic book I call a "horric." It is a horror epic and looks at how our society has been throughout history. It has required that I do some research and I have been reading psychology textbooks so I can get an understanding of different personalities. Things are really starting to come together for me and I can say I am truly happy where I am at in life right now.

Angel. Angel was 19-years old. Although she was born in Alberta, she moved to Southern Ontario shortly thereafter. Her mother and father were both married before and each had two children from their previous marriages. They had three children together- Angel's older brother Jack, Angel, and her younger

sister, Autumn. Angel felt closest to her maternal half-sister, Alexis because they shared similar experiences growing up and Alexis looked out for Angel. Angel also felt that Autumn had a more positive upbringing because she did not experience abuse the way the other children did. Angel started burning at age 9-years old and cutting at age 13-years old. She also struggled with depression, low self-esteem, and eating disorders.

Angel's family was Mormon and heavily involved in their church, particularly Angel's mother. Angel lived in Ontario until she was 14-years old and moved back to Alberta in time to start the school semester at a new high school. After graduating from high school, Angel took a year off to work and saved money for university. She is working at both a coffee shop and restaurant. She is considering psychology as an undergraduate major and then applying into psychiatry. Her own positive experience with counselling has inspired her to consider a career in that field. Angel moved in with her father when her parents separated and she does not have much contact with her mother. She was planning on living with her maternal half-sister, July for the summer before starting university.

***Story*.** For people who have met my mother, they view her as a saint. She was heavily involved in the Mormon Church, was a loving wife, and mother of six children. Behind closed doors she was different. She was physically and emotionally abusive, especially to Alexis and me. The hardest part was knowing that my mother had the capacity of being caring. She was so friendly and warm to friends and members of the church, but then cruel to her own family. I have an early memory of sitting in my sister's high chair and accidentally tipping the chair over. She hit me on the back of the head a few times and I was only 3-years old. She would grab me by the shoulders and shake me, even if it was for little things like dropping something on the floor or making a mess. My dad wasn't really aware of the abuse because he travelled a lot for work and wasn't home for periods at a time.

As we got older, the abuse became more verbal. My mother would tell me that I "had a pretty face but that I was too fat." She also told me that I was "never

good at anything" and that I would never make it anywhere when I was older. I remember her mentioning that I would not be able to hold a job because I was too forgetful and I was too slow. Another hurtful thing she would say was that I would make a horrible mother. It has been hard to let go of the things that she has said to me and not to accept them as "truth." It was especially hard as a child because you look to your parents for your self-concept and guidance.

My mom would take things out on us when our father was working out of town but as soon as he returned she would take things out on him. I think this encouraged our dad to travel more and more out of town. I remember one time he went to Brazil for almost a month and shortly after he came back he took off to Chile. In a period of six months I think I saw him five times.

When I was a child I remember my half-sister, Julie used to swish her finger through the flame of a candle and I started doing it shortly thereafter. One time I touched the wax and I remember it hurting. That is when I began harming myself although I did not understand it as self-harm then. I think I was 9- or 10-years old. My sisters loved candles and we would have them all over the house so when I was upset I would take the melted wax and pour it on my skin. My mother was the one who usually upset me by saying hurtful things to me. I used to have a competition with myself to see how long I could let the wax dry in my hand and to determine how strong I could be. I believed that if I could deal with the pain of the burn than I could deal with anything else that was happening at home.

In Grade 7, I started to become more preoccupied with my weight and what my mother thought of me. Up to that point she had always commented on my weight and how I should be skinnier. My sisters were all thin and she would say, "Why aren't you like your sisters. I feed you the same so you shouldn't weight this much. You are so fat." I had recently heard about anorexia and bulimia so one day after dinner I thought, "Oh yeah, I can do that." I started to skip breakfast or lunch as often as I could. I used to go between restricting my food to bingeing and purging. That lasted for about a couple years and then on and off the first years of high school. It was a strategy I turned toward when I needed to feel better. My four sisters all struggled with eating disorders as well. It

was probably the result of my mother putting so much focus on our weight and appearance. She would pick on me the most because I was the heaviest but she would still make comments to my sisters as well. Even when my one sister was horribly thin my mother would call her "fat." When my grandfather passed away, our aunt came to stay with us for a few days and she made a comment about how thin our youngest sister was getting. When our Aunt Janet spoke to Autumn she was like, "Well you know mom suggested that I go on a diet." One of the reasons my aunt was so worried was because when she was 18 she almost died as the result of an eating disorder. She revealed that she would restrict her food because our mom was also critical of her and would call her "fat." Aunt Janet spoke to our dad about her concerns and how serious it could become. It was at that point that my dad started to recognize the negative impact our mother was having on us.

I was really depressed throughout Grade 7 and 8. One of the reasons was that I didn't have a lot of friends, which affected my confidence. People would often judge me on how I dressed and how I looked. We didn't have a lot of money for clothes so I often dressed in huge baggy sweaters and whatever kind of jeans that were handed down. I remember being in health class one day and learning more about depression. The teacher told us that there are healthy and unhealthy ways of coping with depression and mentioned self-harm as one of the maladaptive strategies. I remember thinking, "If cutting helped these people than maybe I should start."

I can't remember the first time I cut but I remember the first time wanting to. I was sitting on my bed and had a pair of scissors and was trying to think of where I could cut myself where no one would see. I got the idea of cutting on my shoulders but did not go through with it at that time because my sister walked in. Eventually I started cutting with nail clippers because they were easy to carry around with me and I would take chunks of skin from my shoulders. A large part of harming myself at that time was to feel in control of my emotions. When I would cut, I would imagine all my "bad" feelings going away. It would help when I was at school and in situations when I couldn't show my emotions and had to put on a smile. I would also scratch my arms until they bled. It wasn't something I

planned or thought about. It seemed to just happen and I would look down and notice I had scratched off a large part of my skin.

On my last day of junior high, my good friend Tania insisted on giving me a makeover for this dance we were going too. Tania was friends with all the popular people in school and had great style so I was excited for my transformation. It felt great to be happy with how I looked. When we moved to Edmonton I decided I was going to put more effort in my appearance. My sister, Alexis had a hard time in high school so she wanted to ensure that it would be a positive experience for me. She helped me buy nicer clothes and took me for my first professional haircut. Those little things made me feel so much better. I was also going to a new school so I viewed it as a fresh start where people did not have any expectations of how I should be. I thought, "I can be anyone I want to be here." I decided that I was always going to be happy around other people and more outgoing. Even if I was feeling sad or depressed I was going to do my best not to show it.

My stressors in high school were different from what I experienced in junior high. In junior high, things were better at home with my mother but I was struggling with peer issues. My mother was trying to make positive changes in her life and didn't want our youngest sister, Autumn to know of her past behaviour. In high school, things started to get more stressful at home again. My mom stopped trying to hide her aggressive tendencies and things deteriorated from there. The positive was that things were getting better at school.

As my stressors changed, so did my methods of cutting. I would use razors and started cutting on my hip. Since I grew up Mormon I was not allowed to show my shoulders but one time I was invited to a pool party and didn't want to put my swimsuit on because of all the marks on my shoulders. After that I decided to switch to my hip bone area. Triggers that would make me want to cut often involved a fight with my mother or a fight with one of my sisters.

One time my sister, Autumn and my mom were having a fight and my mom threw up her arms and said, "I hate being a mother. I don't want to deal with this." In response, Autumn said "Fine, if you don't want to be my mom then I am

going to run away. It was around midnight and once Autumn left I said, “Mom, aren’t you going to do anything”? and my mom was like, “No, it’s her choice…she can deal with it herself.” I told my mom that I was going after her because she was too young to be out there alone and my mom said that I wasn’t allowed. I kept saying that someone has to do something and my mom kept going on about how she did not like being a mother and did not want have to deal with family matters anymore. That was a really hard time because my dad was out of town and nobody else was home at the time. I felt really helpless and really small and so I turned to cutting as a way to cope. I just couldn’t deal with what I was feeling and I was so worried about Autumn.

Another time things got bad at home was after I got into a big fight with my sister Alexis. Alexis was one of the only people I talked to and getting support from her was the one thing that helped other than cutting. When we got into a fight I had no one to turn to other than the harming myself. Those were the times when my cutting would get serious because no matter how deep I cut or how many cuts I made, the feelings did not go away so I kept doing it. I felt like killing myself that night because I just didn’t want to deal with the feelings anymore. Cutting was the one thing I could always turn to, to make myself feel better and even that was not working. I didn’t want to feel that awful and I was also feeling guilty for the pain I was bringing to people. However, I was so exhausted from all of the crying that I told myself, “I would end my life in the morning.” When the next morning came, I was still tired and I went about my day in a “fog.” As the days progressed, the suicidal thoughts went away. There were other times I would feel suicidal but the same thing would happen where I didn’t have the energy to go through with it. One night when the suicidal thoughts became more intense, I remember thinking that I would have to wait because I had to teach piano lessons the next day. My rationale was, “What would the parent tell their child about me? We can’t go to piano today because your instructor killed herself.” I used to think that if I ended my life, that it would not matter. That was the first time I started to think differently.

At the end of Grade 10, I read a book called, “Walking Naked” and it was about a girl who had a friend that self-injured and ended up killing herself. This book made me realize how serious things had gotten and the impact my behaviour was having on others. One quote that I found influential was when the character who was self-harming said, “I felt like killing myself sometimes but I want to give life a chance so I can learn to feel happy as easily as I feel upset.” I related to what she said and wanted to give my life the same opportunity. I didn’t want my self-injury to have a negative impact on the people that were close to me. I was cutting as a way to help myself, not to hurt others. Nobody knew about the self-harm at that time so I decided to tell Alexis. I opened up to her about the cutting and how I did not want to get to the point where I couldn’t control myself or the behaviour. I told Alexis and the end of the school semester in the middle of writing my exams. Alexis was supportive and helped me talk to our father about it.

My dad arranged for me to see a psychologist and he set up the first appointment. My mom eventually found out about the self-injury and thought it was ridiculous that I planning to go to counselling. She said, “Angel, it’s really no big deal. I did the same thing when I was your age. I was really just fascinated with the pain and it only lasted for a month. You don’t need to go to counselling and you don’t need to tell any more people about this.” When my brother heard about what she said he was like, “You need to get out of there right now.” He picked me up within that hour and let me move in with him while I dealt with the cutting. He didn’t want my mother to be an obstacle in my recovery. I lived with him for a while and then moved back home while my mom was at our cottage for the summer. When she returned I moved back in with Jack and stayed there until Christmas.

I met with a psychologist for our first appointment and we set up regular sessions until things improved. My mom was upset with my dad for supporting me with counselling and paying for the sessions. I think she was worried about the sort of things I would talk about in counselling. My mother was very concerned with “keeping appearances” and making sure we were perceived as this perfect Mormon family. Even at church she did not want us to talk to anyone about our

family. She said, “Family issues should stay within the family and are personal…that we need not talk about anything like that with members from the church.” My mom also said that when we go to temple and have an interview with the bishop, one of the questions he will ask is whether everything is okay with the family. She said that no matter what is going on at the time to always say, “Yes” and that that was one of the times it was okay to lie because the bishop did not want to be burdened with hearing about our problems.

Counselling was helpful because it was nice to have someone other than Alexis that I could talk to. It was an environment where I felt safe and could talk about anything that was troubling me at the time. The psychologist helped me develop a list of alternative activities I could try when I was upset and didn’t want to turn to the cutting. The hope was that if I learned healthier ways of coping that self-harm would not need a place in my life. I was able to reduce the severity and frequency of the cutting although I have turned to it during emotional crises. I found that it is difficult to find alternatives that are as potent when dealing with intense feelings.

The spring when I was in Grade 11, my dad just left one day. He left us this letter about how he was never coming back because he could not deal with the fighting between our mother and him. Since he was aware of how our mother was impacting us, he said that we would have the choice about who we wanted to live with. My dad also said some things in the letter that I found very upsetting. He had always acknowledged how difficult our mom could be at times but he had never blamed things on me and my siblings before. That is why the words in the letter hurt so much. My dad joined the Mormon Church because of our mom and being a long-standing smoker my mom wanted him to quit because it went against the principles of the religion. When things started to get tense in their relationship, our dad started smoking again. He kept trying to stop without success. One day we were on the way to church and they were fighting. My sister saw a cigarette butt in the backseat and she was like, “Dad, I thought you were not smoking.” The fight between my mom and him escalated and he tried to blame how bad things

got on us and on his decision to leave. That was one of the times where my "list of alternatives" was not helping and I turned to the cutting as a way of coping.

He ended up coming home after two days. My dad felt bad for what he said in the letter and took us each aside to apologize. He also did something special for each of us such as taking my sister to the conservatory. He corrected what he said by stating that it had nothing to do with us and rather it had to do with our mother. Even though he apologized, it was hard to trust him again and things were never the same between us. Although we are still close, we don't have a father-daughter relationship. I know he is trying to make it up to us. After he returned home when things would get bad with our mom he would take us out for a while. Things seemed to get bad on Saturdays when we would be cleaning so our dad would take us to the library and then out for dessert. We still had to deal with the wrath when we returned but at least we had a break for a while. So dad was always there to help us and support us.

In the fall, our dad decided to leave our mom for good. Since there was just Autumn and me at home by this point I decided to live with dad and she went back and forth between the two places. Where she was living at the time was dependent on who she was getting along with better and who was accommodating to her needs and wants. Around the same time that I moved in with my father, information came out about how my mother had been sexually inappropriate with me and some of my sisters. My sister Alexis started asking me questions about how our mom was with me when I was younger such as whether she would ever touch me in certain places. I didn't realize when I was a child that it was wrong or out of the ordinary because my mom would tell me that the only people that could touch us in such a way was her. It is for that reason that I never told anyone about it. My father still doesn't know about the molestation because he had a hard enough time dealing with the physical abuse. It is hard for him to not protect or defend our mother, even though they are now separated.

Since the molestation came out, I haven't spoken to or seen my mother. I saw her briefly when she stopped by around Christmas. Everything still felt so fresh so I told her that I couldn't talk at that time. The thing with my mom is that

she is in denial about the kind of mother and person she truly is. She will not acknowledge how we feel about her and thinks that we will all come home one day and will be closer with her once we have dealt with "our issues." It was still hard for me to talk to anybody about the molestation. When I went to visit our oldest sister Julie the following January we spoke about it again. Julie asked me a lot of questions and wanted me to be specific about what I could remember. It was not until then that I realized how serious the abuse had been.

I will be moving this summer to live with my sister. I just need to get away from everything for a while. I have been living with my dad but he has been working out of town a lot and he expects me to look after Autumn while he is away. It's frustrating because when I look after her she never listens and it limits the amount of shifts I can take at work. I can only work day shifts so I can be home in the evening with her. Although I have wanted to move for a while, I felt guilty because I was responsible for Autumn. It will be easier now because my oldest sister is buying a house with her husband and my father and Autumn will move in the basement apartment below. When my dad is out of town, my sister will be able to keep an eye on her. I'm looking forward to another fresh start and time with my sister. I'm also looking forward to starting university in the fall and studying psychology. My experience with counselling has allowed me to see the benefits it has had on me and how it can be beneficial for other people.

Katy. Katy was a 23 year-old college student in nursing. She completed three years of a university program then realized that science was not the most suitable career path for her and switched. Her mother is a teacher and her father is a real estate agent. She has a younger brother and a younger sister who live with her parents. Katy began self-injuring at the age of 16 and had not cut for the past two years.

***Story*.** I would have described myself as a depressed teenager. I was also a cutter; that was my chosen form. I first learned about self-injury through my friends and the first time I cut was after a fight I had with my boyfriend at the time. I was really upset and almost felt like I was in a daze. At a loss of what to do, the idea to hurt myself popped in my head. I thought, "If it helps my friends

then maybe I'll give it a try." The first time I cut was in my kitchen with a butter knife even though it was not very sharp. I used the serrated part of the knife and cut along the outside part of my forearms and was surprised to not feel any kind of relief. Nevertheless, I decided to try it again. My reasoning was that if it works for so many people than maybe I did something wrong. I started to think that "maybe if I went deeper" or "maybe if I did it more than it will work better." I started to do some research on self-harm and discovered that there were many methods and instruments to self-injure.

Just how there are "functional" alcoholics, I considered myself a "functional" cutter. People who knew me would have had no idea that I was harming myself. I was involved in extra-curricular activities, did well in school, had a close group of friends and was always dating. I only turned to self-injury when I was having difficulty coping with emotions, usually after a fight or break-up with a boyfriend. It would cause me to feel depressed and that nobody cared for me. Cutting was "my thing", it was "my little secret" and I enjoyed knowing that I had something to rely on as a last resort. Time and time again it would make me feel better. It put my pain that I didn't understand into a physical form. I could see it, I could understand it, it was on me. It made it easier to cope with life. Seeing the marks on my arm reminded me that I had "taken care of" that issue. I would go for a few months without cutting and then something would happen that would trigger an episode. Although I had low moods here and there as a child, I didn't experience that level of intensity with my emotions until I became a teenager. I think the reason why my emotions were so easily impacted by my relationships was that I would give so much of myself to them. I would be more vulnerable which would make the hurt more severe.

Not only did I experience feelings in a more intense way but I was also more sensitive to my surroundings. I would take things more personally and it would trigger a string of negative thinking. If I got a bad mark on a test, I immediately would think, "Omigod, I am so stupid" and I would think about it and dwell on the mark for days. If a boyfriend said something to me that I took offense to, even if he didn't mean it in that way, I would automatically think,

"Omigod, he doesn't love me. He doesn't love me because I am not good enough…and it is because I do this, and this, and this. This is what's wrong with me." In those circumstances, the cutting would also serve as a form of punishment because I would feel so bad about the type of person I was. I would concentrate on the words I was saying to myself to the point of self-loathing and it put me in a place where I felt overwhelmed and led to the cutting. So, it was never any large events that triggered the cutting. It was more about how I interpreted events and how I interpreted what that meant about me as a person. Usually the thoughts and feelings would build up before I would cut.

My feelings may not have overpowered me if I had people in my life that I felt I could talk to and rely on. I would talk to the guy I was dating at the time, but even in those circumstances, I didn't feel they comprehended what I was trying to say. They didn't understand my feelings of depression or what I was truly experiencing. Also there were times that I couldn't turn to them because my sad or hurt feelings were the result of something they said or did. I didn't want to open up to them about those feelings because it might make them feel guilty. It would have been like saying, "You make me want to cut myself." I knew that it was "my problem" and not theirs.

I had one friend that I was able to open up to. Lee had bipolar disorder and a history of cutting so he understood a lot of what I was feeling. We had an interesting friendship because even though we went to the same high school we never really hung out together. We would communicate via the Internet on MSN Messenger. We talked to each other about everything from family issues, school, relationships, and our moods. It was actually through him that I first learned about cutting and self-injury. He told me how he would have drastic mood swings and that the cutting would help him deal with his feelings. He explained what he would do, his instruments, and how it made him feel afterward. It was through him that I got the idea to cut as a way of coping with my depression. Our conversations eventually centred around trying to figure out why we were self-injuring because we never really understood it at the time or why it worked for us. My heart would sink when he would tell me he planned to cut, but we never

discouraged each other from doing it. I think we just understood where each other was at and that it was helpful. It was like, "Yeah, go and feel better." It was just a reality between us. The nice thing was that we supported each other in whatever way we needed. Talking with Lee at times even preventing me from cutting in that I felt calmer and relieved after having someone to open up to about whatever was going on at the time. I never felt judged by him, which I found to be an obstacle when talking with other people.

Even though my behaviour was functional, I was also very ashamed of it. There were a couple of times when people noticed the scars on my arms and I would make up a story such as the "cat scratched me" or "I fell at work." I eventually started cutting on my feet to keep the scars more concealed. I was really good at coming up with excuses but always felt bad about lying.

My cutting behaviour transformed in that I was taking apart and using a razor. It also became more about seeing the blood. I think I equated blood with more pain. I also developed a ritual to my cutting behaviour. Every stage of the ritual brought a level of fulfillment, similar to how a drug addict gets a "high" just from going to pick up the drugs from his dealer. I would put on music or re-read an excerpt from my journal that was upsetting to me to get as much into the cut as I could- deal with all of my emotions in a single action. The longer I engaged in harming myself, the longer it would take to me complete my ritual because I kept incorporating steps into the process and would take my time. I would cut and let it go as long as it would and then I would bleed out, followed by the clean up process. Even if it was a big cut, I would use a Q-tip and take my time cleaning it very gently. I was like a mother taking care of and nurturing their child when they are hurt. I was hurt emotionally but I was taking care of myself in a very physical manner. It was *my thing* and I was able to control all aspects of it. Even getting things ready helped to calm me down when I was feeling overwhelmed. When I would get in the shower the next morning and the water ran across the wound, it would sting and remind me that that *issue* was resolved, that I had taken care of it.

One time I was at work and had what I like to call a meltdown. I was in a management position and I was not feeling good about how the day was going.

For pretty much the entire shift, I locked myself in the office and I was crying. I also started to feel scared about what I might do- that it might be something more serious or extreme than cutting. I was feeling suicidal and did not trust myself to be alone after my shift. I had just broken up with my boyfriend and there was nobody I could really talk to. I decided to call my parents and tell them that I was depressed and that I was scared about what I might do. They became worried and encouraged me to write a note informing my boss that I had to leave early for personal reasons. Even though I am not that close to my parents, I just needed to call someone to help me get through the night. I talked to my dad since I feel closer to him and he told me to come their place for the evening. When I got to their house, I sat them down and opened up about how depressed I had been feeling. I was hesitant to tell them about the cutting, but decided that this was the best opportunity to talk to them about everything. When I revealed that I had also been harming myself, they were so surprised. I remember my mom crying and everything and they were really upset. They said they would do anything to help and would set up some counselling appointments for me. My parents indicated that money was not an issue and they would pay for private sessions if needed.

The unfortunate part about my story is that they didn't follow through with their promises of what they said they would do. My mom accompanied me to one of the appointments with my family physician and she expressed her concern to the doctor. She talked about the severity of the situation and the doctor discussed medication as an option. I went to two more counselling appointments and my parents never asked questions about how they went. They also never inquired whether my mood was improving or about my medication. It was as though we had that conversation and that was it. I do not think it was intentional. It was probably just too much for them to deal with or too difficult to talk about. However, it also left me with the feeling, once again that I had no one to turn to. I felt very unsupported.

Even though it would have been helpful to have the backing of my parents, I decided that if I wanted to get better than I would have to deal with the stresses of everyday life on my own. In order to lead a healthy life, it would be up

to me to make the necessary changes. It encouraged me to take initiative in my recovery process. To this day my parents have not asked how I have been doing. I have some feelings of resentment towards them because of this. I do not blame them for feeling at a loss of what to do, but I do blame them for not taking the steps to finding out what they could do. They could have done some research on the Internet, read books, done their own counselling, or asked me questions.

My boyfriend at the time, Charlie, was supportive of me getting help. All of my previous boyfriends were aware of the cutting. I think it was more challenging to lie to them because I saw them more and it was more likely for them to see the scars. Although my parents arranged my first appointment, it was Charlie who encouraged me to talk to a counsellor about my depression and be put on anti-depressant medication. After speaking with my family doctor, he said that I would be allowed three free appointments with a counsellor. When I met with my counsellor, David, I found it to be very helpful. He validated how I was feeling and confirmed a diagnosis of clinical depression. I also liked that he challenged the way that I was thinking. For instance, he highlighted how hard I was being on myself and the negative thinking I was displaying. I remember him saying, "Would you ever tell a friend some of things you tell yourself."

With being in a depressed state of mind, I confused the date of my third appointment and ended up missing the session. I think I was too embarrassed to call and book another appointment and did not really care enough about myself enough at the time. Even though three sessions would not have been enough to fully recover, the experience I had was rewarding. When I made the decision to go to my family doctor and attend counselling, it was as though I made a promise to myself that I was going to stop. I told myself that whether the professionals could help me or not, I was going to do my part to try and stop the cutting as much as I could. At first I was able to decrease the frequency and severity of the behaviour. I would compare it to quitting smoking because it was definitely a struggle. I had to not do it. After making a concerted effort to reduce my self-harm, the urges subsided over time. I also came to the realization that I wasn't coping with my stress or emotions very well and I had to learn healthy ways of

coping. I tried not to let my feelings build up and dealt with the circumstances as they arose. When I was a teenager I kept everything in and eventually there was an explosion and I felt overwhelmed as a result. Now I try to be a lot more honest with myself and other people. If I'm upset with someone, I will try and tell them how I am feeling and that has been helpful. I have also tried to be more self-aware of what I was feeling and tried to not be so afraid to feel.

Another thing that was helpful in my recovery process was researching and reading about self-harm. I researched what people had to say about it and what had worked for self-injurers who were trying to move away from the behaviour. Some of suggestions I found ridiculous like putting an elastic band on your wrist and snapping it when you have the urge to self-injure. The pain is not even comparable. Also, for me the urge was not something instantaneous. It was something that developed throughout the week until the tension was intolerable. The build up would occur and then I would injure myself when I was at home and alone. It wasn't something that could be fixed with a rubber band. There was also a period after I moved away from the self-injury that I replaced that behaviour with smoking marijuana. I was smoking every day and I was high all day. It was great because I just felt numb and didn't have the surges of emotions that I had before. At the same time, I didn't want to self-medicate and being a pothead was not something I wanted to be. One of the last times I smoked marijuana was on Christmas Day in my parent's bathroom and that obviously was not a good idea. I decided that I would have to learn healthier ways of coping. I cut from the ages of 16 to 21-years old and I have not injured myself for the past two years. When I look back on those years and read through my journals you can see that I was in such a different place mentally and emotionally. The cover song "Hurt" by Johnny Cash really represents what I was feeling and going through back then.

Martha. Martha was a 21-year old first-year university student and was taking English courses to put towards her degree. She described herself as a "pothead" and enjoys drinking with friends. Martha moved to Canada at a young age because her mother wanted to "return to her roots", to the reservation where she was raised and her family resided. Martha's parents separated when she was

the age of 3-years old and has not had much contact with her father since. When Martha got older her mother began drinking more heavily and began to neglect Martha. Children's Services became involved and she was put into a group home at the age of 12-years old. She started self-injuring shortly thereafter. Martha went between living in a group home and living with her mother. With so many moves and transitions, she felt like a loner for most of her life. Although her low self-esteem made her a potential candidate of becoming a young mother, Martha said she resisted the outcome that was the fate of so many Aboriginal women on her reserve. She said she wanted more out of life and was motivated to go to university and do something different. Martha's mother ended up having two more children from two different men that were living on the reserve. Martha was able to reconcile with her mother over the years, particularly once Martha considered the difficulty her mother must have experienced raising three children on her own. She engaged in self-injury from the age of 12 to 17-years old and stopped aside from a few relapses.

***Story*.** When I was 12-years old, I decided to let my mother go. She was on a hunger strike, and I remember her saying, "Martha, I might die and I want you to read my will." After I read it, I decided that it was time to let her *die* as my mother and live my life independent from her. She had lost her parental rights because she was not the kind of mother I needed her to be. I wouldn't listen if she told me to quit smoking and drinking, and told me to go to school. She became more of a sister after that day. I would let her love me and do things for me but I would not let her guide my life.

When we moved to the reserve, it was as though my mother forgot her role as a mother. She started to go out drinking all the time and every week-end she would be gone. I do not know where my mother got the money to support her habits. One week-end she was out drinking and I was at my gukum (grandmother)'s house. While I was there, my auntie pulls me into the room and says, "I want to tell you something and I don't want you to freak out." She said, Eddie was over at your Uncle John's house and he saw your mom and "uncle" in the room together. I was in shock. This kind of behaviour is not looked upon

favourably in the community and eventually people found out. My mom disappeared for two days and one of my uncles came over and said, "When your mother comes through that door, I will knock her out." I was so upset. I was like, "Why are you telling me this…that you have plans to hurt my mom." My mom's relationship with her *cousin* caused a separation in her family and they disowned her for her behaviour. Things became even more problematic when a couple of months later she became pregnant with his child. Everyone in my community knew that my new baby brother was an illegitimate child. My *uncle* is related to my mother through marriage but their decision to be together was still looked upon in a negative way. Now when people look at my mom or my little brother, you can tell they are thinking, "disgusting." It is unfair to my brother because he is still a human being. I do not care if he is the product of an incestuous relationship, he still deserves to be loved and treated with care. This was really hard on me because people treated me differently as well, and I was stuck in the middle of everything.

My mom was pretty self-absorbed during that time. She would do her own thing and was always drinking. She did not seem to care about me and did not care for me. One time I was doing a handstand and my left arm gave out and crushed my shoulder. I ended up breaking my collarbone and my gukum told me to find my mother to tell her what happened. It was heart wrenching to think that I had to go look for her; that I did not know where she was. It was my reality. Another time, I remember sitting in my closet one day because I felt so alone and thought of killing myself. Nobody seemed concerned about my whereabouts or what I was doing. I took one of the coat hangers from the closet and wrapped it around my neck. I was sobbing and hoping that maybe somebody would care enough to come look for me.

The next day I went to the principal at school and told him about how I was feeling and how my mother was absent all the time. He connected me with a social worker and we talked about whether it would be beneficial for me to move to a group home where I would be supervised or whether it would be better to work on my relationship with my mother to improve my circumstances at home. I

told her, “I don’t want to be around her, I don’t want to be here on this reserve. I just want to get out of here.” I also didn’t want to end up a young mother on the reserve with my own children. I knew at that point I had to do something to make a change for myself. That is why I decided to get help from my principal and a social worker.

The social worker took me from my home and brought me to a group home. It was such an adjustment because I went from being neglected to all of this attention focused on me. It was overwhelming. I ended up getting in trouble all the time because I was not used to rules or discipline. They would take away my privileges or I would be put on one-on-ones, where I had constant supervision. Even when I went to the bathroom, someone would be waiting outside for me. I also would get my walks taken away, which was a time I would be able to go outside for 15 minutes and have a cigarette. We also had the privilege of going out on Wednesday nights or going out on field trips so that was another thing that would be taken away from us if we broke the rules or misbehaved.

I was 12-years old when I moved to a group home and it was the start of when I began injuring myself. I cannot exactly remember how it started, but I remember hearing, “Don’t cut yourself or you will get in trouble.” I became intrigued and the cutting started shortly after. I started cutting with a Tona blade and it had really jaggedy edges. I was getting even more attention for cutting, and I liked that people were concerned and attentive, and thus the behaviour continued. If you were caught for hurting yourself, part of the punishment involved being sent to the counsellor’s office. I did not view this as punishment because I did not have to go to school, I did not have to sit in my room, and I was able to talk to someone about how I was feeling. Speaking to the counsellor was a good outlet for me but the irony was that I had to cut in order to access that outlet. I guess I would have been able to see him otherwise, but then my problems may not have been deemed worthy of a visit to the counsellor’s office. I also found that the cutting was what made me special to him. When I was not cutting, he would say, “Martha is a good kid. She just needs a little guidance” and would recommend that I be sent to a counsellor in the community. He viewed me as a

person of potential who was held back because of my emotions. I really enjoyed the time I had with Jason and felt comfortable with him so that is when I would respond with, "No, look…I am crazy. Look at how I hurt myself." It was my way of saying, "I need you…particularly you." I was looking for a way to fill the void of not having love from my father and Jason was the closest thing to resemble that figure.

Jason was also one of my only positive male role models. I wanted to be like him and help people. He inspired me to consider becoming a counsellor. When we would meet, we would have deep and intellectual conservations. We would talk about life and philosophize. He would tell me, "Martha, you are so advanced beyond your years." He had so much hope for me and he motivated me to not only want more for my life, but to actually go after it. Even after I left the group home I would still call him and talk to him and he would make me cds to listen to.

I ended up living at the group home for about nine months. I left just before my 13th birthday. I went home for a week and then I spoke with my social worker and she asked how things were going and whether I wanted to go back to the group home. I told her about my desire to move back so we revised a new plan that involved returning to the group home for two months and then moving to a group home in Edmonton until Christmas time. The social worker wanted to ensure that my relationship with my mother was improving and that I was ready to move back home. It was kind of embarrassing to return to my old group home because even though I wanted to go back, I was worried how the others would perceive me because they would have jumped at the opportunity to return home. I'm sure they didn't understand where I was coming from and my interest of going back there. I had an option where as they did not. Even though I craved the same freedom they wanted, I knew I would fare better in the group home than I would on the reservation. I would have died out there. Plus, Jason was the light of my life. He was the closet thing I had to a father. He was one of my only positive male role models and I was not ready for him to be out of my life.

A couple months later I was transferred to a group home in Edmonton. I was in that home for about six months. I had a room in the basement, which was pretty isolating. I felt pretty alone again and was always down there crying and was doing a lot of cutting. The cutting served a different function at this point. It was less about attention-seeing since Jason wasn't around anymore. I was hiding my cutting behaviour and was cutting to kill time. I was really bored and I just wanted to feel something. Even pain is better than feeling bored and feeling nothing. I had been a loner most of my life…always alone with no friends and no one to talk to. Time ticks very slowly when there is no one around. I used to think that people did not like me or hated me, which made it difficult to trust people or let them into my life. People would try to show they cared and would say things like, "You shouldn't be cutting. I will help you." The next thing you know, they are calling the police and I was like, "I can't trust you. That is not helping." All the police would have done would be to take me to a mental facility and leave me there to die.

I was also cutting to feel that rush afterwards. It was predictable happiness. I would go to my room, cut myself, come out of my room and would be laughing and joking with other people in the group home. I loved that I could transform my feelings so quickly like that. However, what goes up must come down and there was always the guilt that followed afterwards. I knew I was not only hurting myself, but those who cared for me. That is where the guilt came from- how my behaviour might be impacting other people. For instance, I would cut so that I would get to see my counsellor, Jason but then would feel guilty for disappointing him because he seemed to see so much good in me.

During my time in the group home, I was also visiting my mother on the week-ends. She had moved to the city and was trying to make a *go* at her relationship with my uncle. They were trying to make a better life for themselves and for me. They got their own place and were going to couples therapy. During one of my week-ends at home, I was emotional and started crying. My mom asked what was wrong, and I responded with, "This is such a lousy place and in a bad part of the city. Neither of you work and yet are both capable of making

money. You are just losers and I never want to end up like you." My uncle, Leonard overhead my conversation with my mother and took off. Their relationship started to come apart and six months later he left for good. I felt bad because I was not even referring to him. I was making reference to my mother and the lifestyle she always seemed to lead. He was one of the few men that I liked and I was sad when he left.

About a month after Leonard left, my mom found out she was pregnant. She told Leonard and his response was, "There's no way that you're having my kid." She was like, "Well, what if I am" and he said, "Well, it ain't my kid", meaning that was not enough of a reason for them to get back together. Leonard moved back to the reserve, and one night was partying with people from my family and his family and got severely beaten up. He ended up in the hospital with a metal plate in his head. Apparently there was still a lot of resentment towards him and my mother and two of my uncles expressed how they were feeling through physical means. I guess things can escalate quickly when there is alcohol involved. The unfortunate part was that he did not take any responsibility for my brother Damien. Even though I used to like Leonard, he ended up being just like my father.

After a few months in the group home, I thought I would try living with my mother again. I was 13-years old and about to start high school. It was there that I met my two best friends. One of them was also a cutter. We never talked about it but I noticed her scars. I just assumed that her reasoning was similar to mine- to block emotions by focusing on the physical pain. I found it very difficult to deal with emotional pain, especially when you are not thinking clearly. I wanted my pain to be purposeful. When I would see the blood it was as though my experience now had meaning. By making my pain more intentional I started to feel more in control of what I was feeling.

A few months into my first semester of high school, we had relatives come from out town to stay with us. The woman was older but we used to hang out before. She took me and her boyfriend, my *uncle* to the pharmacy to pick up some pills. My uncle was a pill popper and would take lots of them at a time. I had

heard about Gravol so when we were there I asked if she could buy me some. Over the next couple of days I took a few and by the third day the pack of Gravol was gone. My intention was to get high on the pills but instead it left me feeling sick. I called my social worker and she took me to the hospital to get some tests. The doctor that examined me jumped to the conclusion that I was trying to kill myself. His knowledge of my history of abuse towards myself likely influenced his impression. The doctor sent me to be assessed.

It was horrible there and I slept for the first three days. I met with a psychiatrist and his job was to determine whether it would be beneficial for me to stay there for inpatient treatment and supervision. The whole time I kept thinking, "But I wasn't trying to kill myself." He asked me all sorts of questions and some of them I knew were incriminating, and would keep me in the facility so I had to lie. One of the questions was, "Do you have a support system or people you can talk to"? I thought to myself, "I don't even have any friends" but I couldn't say that to him, so I told him "yes" in response to his question. There was a therapist that sat in on the assessment with the psychiatrist and she didn't even look at me. She just went through the motions, "blah, blah, blah"… "yes I do"…blah blah blah." I was originally supposed to be there for six months but they decided to let me go and I was released after one week. I managed to get home in time for Christmas.

My cutting got pretty bad in Grade 10 and I ended up getting a blood clot in my arm. I was going to a primarily visual and performing arts high school and the population was predominantly white. I felt like I did not fit in and had no friends. I was such a loner. I also ended up failing the year. We moved back to the reserve and I was able to take Grade 10 over again. Although my mother was not welcomed back to our community with open arms, our family is forgiving. They also tried to accept my brother because no matter what, he is still family and they wanted him in their lives. I was also making efforts to reduce the frequency of my cutting and conceal the scars well. I did not want my family to know about my cutting because they would have blamed my mother and it would have impacted

our family even more. Information about our family usually gets passed on in a drunk conversation later on, which just leads to more drama.

Eventually I ended up moving away from harming myself all together. I started to find other means of getting high so cutting was not my only outlet. It was also nice to be surrounded by family again and I started to feel more confident. I ended up growing my hair long and started to feel more feminine and more comfortable in my own skin. I was also going to school regularly and was starting to participate in my classes. I also made a friend who was a positive influence in my life. She was popular in school so I made friends with her group and my confidence grew even more. We had a lot in common and she taught me how to embrace both of my cultural backgrounds. My relationship with my mother and our living circumstances also started to improve. She started working full-time so I tried to be more understanding of her need to get out of the house once and a while and would watch the boys when she needed a babysitter. I tried to remind myself that she was single and raised three children on her own. She also started to realize that I was growing up and became more lenient and supportive of all the things I was trying to do in my life. I was doing some small jobs here and there which provided me with some spending money and I was too busy to feel bored. It also kept me busy from my thoughts.

Although things were a lot more positive for me on the res, once I graduated from high school I started to feel like a loser for still living at home with my mom. My friends encouraged me to get a place of my own, but I was like, “What am I going to do?.” One day I was feeling extremely low because my mom and I had a fight. She was calling me a “loser” because I was not working or contributing. She was fed up and was trying to kick me out of her house. I ended up going into my room and shut the door. I had wanted to end my life because I was so unhappy. However, I couldn’t muster up the courage to go through with it. I remember hitting myself and thinking, “Martha, you can’t do anything right. You can’t even commit suicide. You are such a coward.” I ended up turning towards injuring myself instead. I picked up a knife and started cutting the inside of my inner wrist and wrote the word “forsaken” on my skin. I wanted to remind

myself to never forget who I was. That word epitomized how I was feeling at the time. I felt like the Creator had forgotten me and my father had forgotten about me. It was also to remind myself that I was a person who was hated and a person who hates. I was so angry with everything, but especially at myself. I was disappointed that I was not achieving more for myself. I was not working and the jobs I had in the past I quit shortly after because I got tired of them. I was also smoking a lot of marijuana, which started to affect my enthusiasm for things. I was disappointed because I remember Jason always talking about my potential and his hopes that I would have a better life.

Since I was feeling so depressed and starting to lose hope, I decided to talk to someone. That summer I went to visit the physician and he put me on some anti-depressant medication. My mother also told me about a great program at a university and encouraged me to apply. I knew university would be challenging since I have never really been school-focused, but I decided to give it a try because my mom spoke about the rewarding experiences she had when she went to university. I was accepted into the program and moved in the fall. I was really committed to doing well and put forth my best effort in the classes I was taking. This semester I'm finding it more difficult and I may not return next year. I might take the year of to work in Edmonton and see how I do. A really positive is that I haven't cut since I've lived in Edmonton. Aside from a couple incidences, I really didn't cut from when I moved back to the reservation, until now. That is a period of almost five years and I hope that time continues to grow.

Jill. Jill was a 25-year old university graduate student. She had completed a Master's degree and planning to start a doctorate program. Jill's parents are both school teachers and she has a younger sister. Jill started self-injuring in high school when she was in Grade 11 as a way to manage her anxiety.

***Story*.** I was probably four-years old when I had my first panic attack and they continued to happen for the rest of my life. When I was a child, my parents were not too concerned because my mother had panic attacks too. Plus, they were not all they time and I seemed to be fine otherwise. The panic attacks however, were concerning to me. I didn't like that my body would be out of control and my

thoughts would become irrational. I would end up having thoughts that I found disturbing, which created even more fear and anxiety. I ended up experimenting with ways to distract myself with the sensations and thoughts I would have associated with my panic attacks. I would bite my tongue or would dig my nails into my palm. I found that if I could focus on something that hurt, like the sudden sharp feeling of pain, than it would often be enough to distract me from the feelings of panic until it eventually subsided. You are not going to be thinking, "Oh my goodness, my heart is beating too fast…I'm going to die." Instead, it would be, "This is hurting right now."

When I started high school, my anxiety became more intense and my panic attacks more frequent. I was putting a lot of pressure on myself to succeed in school and was running competitively in high school track and field. My panic attacks really started to scare me but I believed that if I tried to ignore them and dealt with things on my own, then eventually they'd go away. I didn't want to have to talk to someone because I had a real mistrust of psychologists. My mom used to see a psychologist for her depression and anxiety and I didn't like having to go into her sessions and talk about her to a professional. Plus, I didn't want to worry my parents because they were already stressed out as it was. My younger sister was diagnosed with Obsessive-Compulsive Disorder at a young age so I thought, "I do not want to add to what they are already dealing with."

One way I would cope with my emotions was by running. However, when I was 16-years old I got mono and couldn't run for about four or five months. Since I no longer had that outlet, my anxiety was a lot more noticeable and prevalent. I was having a panic attack every couple of days and I didn't know what to do. Instead of using my regular method of digging my nails in my palms, I found that scratching myself really hard was a more effective way of distraction. Around that time I came across another method of hurting myself that helped divert my attention from my anxiety. I had been sitting at my desk writing and was feeling upset. I noticed a candle that I had burning and began melting my pen in the candle. I realized that the pen had metal on it so the idea came to me to heat the metal in the flame and press the hot metal on my skin. It created an instant

feeling of calmness that was such a paradox to the feelings I had moments before. Not only did I find a method that distracted me from the feelings and thoughts I was having, but I also felt better.

I had been anxious for such a long period of my life that I didn't think much about what I was doing in terms of harming myself. It just made sense. I didn't wonder whether it was normal or not normal. I thought of it more as, "This is what I am doing and this is how I am dealing with it." I ended up burning on a regular basis. I would use it whenever I started to have a panic attack. I would often wait until I was having an attack rather than at the early signs of anxiety because I would think, "Maybe the panic will not come this time." It was never used as a preventative measure to avoid the attacks. I would use it as a way to cope with the attacks and reduce the length of time the attacks would occur. The pain would also serve as a distracter during those times when I felt claustrophobic in my own skin and body. When I would burn I would use all types of metals- pieces from pens, safety pins, metal jewelry. It eventually got to the point that I would turn to the burning when I was feeling other emotions as well. A lot of times I could not pinpoint the source of my emotions so physical pain became comforting because I knew the source. It created a sense of control. I could not stop the feelings or thoughts from coming, which were disturbing, but I could do something that helped once they did come. Even though there were times when I was feeling extremely bad, suicide was never something that crossed my mind. To say that I wanted to die would have felt like I was giving up; that I was failing. I just wanted to cope and make the bad feelings go away.

When I was at school and I had a panic attack, my options were a lot more limited. I would usually just go into a bathroom stall and stay there until I could calm myself down. I did not want to have a panic attack in front of my classmates. I would tell my teachers that I was not feeling well because people would not have known how to respond if they saw that I was upset. I was the person that people would go to when they were upset so it would have been alarming to my peers if they saw me distressed. I would also skip class or go somewhere like the open field on school property. One time when I was at school I used an Exacto

knife because it was the only way I could hurt myself with some level of intensity. However, I found that the cutting didn't have the same impact. It didn't hurt in the same way and so did not offer the same relief afterwards. I cut only a few times when burning was not an option but it did not escalate from there. Otherwise, I would try to keep myself really busy at school and then the panic attacks would not occur until later in the evening when I was at home and could self-injure in the privacy of my room.

Eventually I started to realize that I didn't do well without distractions or having something else to think about. If I was alone and didn't have much to do, it meant being alone with my thoughts, which would often lead to a panic attack. Other times, it would be when I had an overwhelming day and as soon as I had a moment to myself I would feel a panic attack come along. It was interesting because if something upsetting was happening, I wouldn't have a panic attack until later. It was like my survival mode kicked in to cope with the stressor in the moment, and then my body would respond afterwards, when I had the opportunity to deal with everything. I remember my last year of high school, I was in a really bad car accident and I didn't panic until after I had got home. I would have hopeful thoughts in those circumstances- "That maybe I was better; that maybe I would never have a panic attack again."

I wasn't too curious about why I was harming myself. It was almost something I had to keep doing fervently and didn't want to know more. I didn't want to discover any information that may dissuade me from wanting to do it because I didn't have things I could do otherwise. It was my secret; something that I contained within myself. I did not want to talk about it because my friends or family may have encouraged me to get help and then I would have to move away from the one thing that helped me with my anxiety. I thought that if I continued to deal with it the way I was, that my anxiety would not get worse. Since my parents invested so much time in getting support and help for my sister, I think they also relied on me to do my own thing, put my head down, and focus on getting good grades. There were a few times when I tried to talk with my friends about my anxiety but I never got the response I hoped for. I was the go-to

person so when I tried to seek my own support they didn't know what to do. I didn't feel listened to and felt misunderstood, so I came to the conclusion, "why bother."

When I was 18-years old I decided to tell a close friend about my how I was harming myself. My panic attacks were not as frequent but I was still using the burning to cope with negative feelings. I had decided to take the risk in sharing because I wondered whether it was something I should still be doing. I wasn't doing any permanent harm to myself or engaging in destructive behaviour such as taking drugs. I thought that if I was allowed to do my thing than maybe I could deal with everything in my life and the panic would go away. When I did tell her, I was hurt and discouraged by her response. She got angry and questioned why I didn't tell her or someone else sooner and why I would have turned to such a thing. She said, "What do you have to worry about? What are your problems? Why would you do such a thing? I felt so misunderstood and she made me feel awful for keeping my behaviour private and for ever doing such a thing in the first place. She made it seem that I did the worst thing in the world that I could have done. I never brought it up to her again. I also decided that I was going to continue doing it and avoided learning why she had such a negative response.

By the time I was in my first year of university my panic attacks had basically subsided and I was coping well. I only turned to the burning when I needed to cope with a crisis or was feeling angry. However, at the end of that year I had a resurgence of anxiety and my panic attacks returned. This was the worse they had ever gotten and for a few months I would not even leave my house. I couldn't deal with anything. I seemed to be having a lot of anxiety about my plans for the future. I had just ended a tumultuous relationship and felt like I was losing focus and control of my life again. It became hard to hide my anxiety from my parents because I was still living at home and they could see that I was isolating myself. When I opened up to them about the severity of my anxiety, they were shocked but supportive. My parents have both struggled with anxiety so they could relate with what I was going through. I decided not to share information that I was harming myself because I didn't want to overwhelm them with too much at

once. I also didn't want them to be angry for not telling them about the self-harm sooner. It took me a while to finally talk to them about it and they were concerned and alarmed. My mother is a junior high school teacher and starting to see a lot of self-harm behaviour in her students so I think she wanted to learn more. At first it was really difficult for them and they didn't have the warmest reaction. I also lost a lot of friends during that time because even though they didn't know about the burning, they could not deal with the fact that I was coming apart.

One day my parents took me to the emergency room because I was having such a severe anxiety attack and they thought there was something physically wrong with me. The physician gave me a tranquilizer and a prescription I could take once I returned home. I didn't want to take any more medication so I refused to fill the prescription. My parents decided that it was probably time for me to talk with a professional. I went to see a psychologist at the counselling centre on campus and saw them weekly for the first while so that I could learn to cope with the panic and anxiety. I also made the decision to take a semester off from school and from working. I wanted to use that time to get things back on track and be able to effectively deal with my emotions. My psychologist was very helpful and taught me how to manage my thoughts and my anxiety. Unfortunately, when I told her about the burning she was at a loss about how to proceed because she didn't have a lot of experience with that issue. She said, "I am not really sure what to tell you and I don't know anybody else who deals with this problem specifically." I was happy that she was honest with me but I was still unsure of what I was going to do. I knew it was not that common then or that people didn't really talk about it but I did not realize it was such a mystery. Even though my psychologist didn't know how to directly deal with self-harm, she was able to teach me skills and strategies to control my thoughts and ways to cope with the anxiety that I did not really need to hurt myself anymore. She also convinced to go see my physician and get a prescription for anti-anxiety medication. I started to do my own research on the topic of self-harm to learn more about why people do it, how it starts, and if there are any strategies I could try. The unfortunate part was that most of the material related to people who had Borderline Personality

Disorder or a history of childhood sexual abuse. There was no information on self-injury for individuals with panic disorder.

Once I started to feel in control of my thoughts and emotions, I starting to think that maybe I didn't have to turn to harming myself anymore. I made a commitment to myself and thought, "I'm going to try other ways to deal with my anxiety rather than self-harm." I felt more confident about my ability to utilize other tools and strategies. At first it was really challenging to stop relying on a way of coping that I found so powerful. There were times when I couldn't resist the urge, even though I tried all of my other methods for coping with anxiety and emotions. I just had to self-injure. Other times it was because I was feeling too bad or I was too tired to take each thought I was having and try to replace it with something more positive or comforting. To do the cognitive and behavioural work that was required of my recovery process was effortful. I found that even when a lot of time had passed since my last burning episode, it still had the same impact. Since it never lost its potency, I felt it was always something I could turn to as a last resort and I could feel better afterwards. However, I thought that if I was able to manage my emotions and stresses then I would try to live without it. I knew it would also help me to feel better about myself again.

Eventually the incidents of harming myself became further and further apart to the point that I was not burning or cutting at all. I have not hurt myself since I was 19-years old. I still have panic attacks once in a while and I still have anxiety but I find that if I have a physical outlet for that energy than that is effective for me. For instance, I have found running to be a very therapeutic resource for me. If I go for a long run I can clear my mind or think about things in a productive way. I feel productive when I run because it seems to symbolize moving forward and doing something positive. I also became better at taking my automatic thoughts and replacing them with something more rational and realistic. I would say it took me about two years before I was adept at challenging the negative or catastrophic thinking. I also feel like I have some control over my body and my ability to manage my emotional states. I have more self-awareness of what contributes to my anxiety and other events in my life.

Looking back, I realize how stubborn I was. I would think, "I don't need to talk with anyone and if this works for me." One of the hardest parts for me going to speak to the psychologist was admitting I had a weakness. I thought, "Why can't I deal with this on my own"? I also felt bad for having the anxiety in the first place, that I was flawed in some way. I thought my mind was defective and my body was defective. I wondered why I couldn't cope like the rest of the world. Now I realize how complicated anxiety is- that there are genetic, biochemical, and environmental components. Anxiety is something that a lot of people struggle with and I no longer feel ashamed. It is a part of who I am and who I have become.

Stacey. Stacey, a 22-year old university student, went directly to university out of high school and majored in sciences. She switched into the nutrition program after her second year. Her career goal was to become a dietician. She lived with her parents and younger sister, Emily. Stacey was heavily involved in dance, particularly ballet her first year of university. Her goal was to eventually perform with a ballet company. She would go to dance classes three times a week and would perform a few times a year. She found the commitment overwhelming and dropped to two classes a week. Stacey was a very high achiever and invested a lot of time and energy to be successful in school. Her efforts began to impact her social and personal life. Stacey had self-injured since she was a child.

***Story*.** I hated myself as a child and that is how it all started. I would hit myself on the head because I didn't like who I was. It was a form of punishment. I would end up with a sore head but I couldn't stop. This behaviour continued as I entered adolescence and started to take on different forms. When I was 18-years old and heavily involved in ballet, I would be in a lot of pain while I was dancing and performing. My instructor couldn't figure out what the problem but I would seize up during a routine and by the end I could barely move. Being a perfectionist, I felt like I was letting my dance team down. Class after class the pain would persist which frustrated me. Furthermore I was also frustrated with some of the other dancers. To prevent myself from crying during dance class and

practice, I would go to the washroom and scratch my legs. My leotards were thick enough that you could not see the marks. Scratching became a form diverting my attention to my feelings and became another method that I would injure myself.

Initially, I would also dig my fingernails into the palm of my hand as a way to distract myself from painful procedures such as vaccinations and cosmetic skin procedures. It was during these procedures that I realized this method allowed me to tolerate pain. I eventually used this same method to prevent myself from crying in front of people when I was upset or to distract myself from negative self-talk.

In my first year of university I majored in general science. I started the first semester by taking basic chemistry courses. I realized organic chemistry was not for me so I switched into biology. I soon realized that these subject areas were not appropriate fields for me so I decided to major in geology for my second year. The summer before school started I travelled to get away from everything. It was my first trip out of the country alone and I returned home feeling really happy and positive.

I started my second year on a better footing and in November I started dating someone whom I met through friends. Things were going really well with Zach until he broke up with me the night before my final exam. After that I fell into what I think was depression and I did not feel like the person I once was. A few months after, I had a falling out with my best friend. We were practicing the night before a dance performance and I ended up falling on Kristi during one of our routines. I was really mad at myself for hurting Kristi and was mad at our instructor for making us do a difficult move, but instead I took it out on Kristi. This was not the first time I wrongfully took my anger out on her during dance practice and she was fed up. She said she couldn't handle my highs and lows anymore and said that I needed to go talk to a counsellor about managing my emotions. She actually made it an ultimatum because she said if I didn't we could no longer be friends. I couldn't imagine her not being in my life and decided to take her advice to talk to someone Even though I sought professional help, we didn't talk much after that. We drifted apart because we were no longer in the

same Science program and she was spending most of her free time with her boyfriend. Kristi also left our team and dance that year. This made me feel lost and all alone.

I booked my first appointment under the guise of career counselling. I wanted to have some vocational testing done because I was unsure of which direction I should pursue academically and thought it would be easier to talk to someone if I brought up safer issues first. However, by the time the results had come in, I had already applied into a new program for the following school year. I decided to keep the appointment since things were spiralling out of control and I knew it was time to open up about the issues that were affecting me. I was so nervous the night before my session because it was difficult for me to open up to people and I knew it would be challenging to disclose information because I would be talking with a total stranger. I decided to first speak about my friendship with Kristi and our recent conflict. Although I was able to talk with the psychologist about the hitting and the other ways I injured myself, in subsequent sessions, my hitting behaviour actually escalated during this time.

That summer I went to New York for a dance competition. My dance team didn't want to compete so I formed a new team with older and more experienced dancers. My mother and sister moved out West so that my sister could train for a major sporting event. They were gone for six months and during that time it was really stressful for me. Although my dad was at home I hardly saw him because of our different schedules. I had to start doing my own cooking, laundry, and other extras around the house that my mother would be responsible for. Also, I started the Nutrition program and started focusing a lot of my weight. I would bring a healthy lunch and snacks to school and by the time I got home I was famished and would overeat. This would affect my ability to concentrate on my schoolwork because when I would sit down to study, my mind would start to race and I would think, "I had eaten this much" and "will I gain weight." It was really difficult for me to stay on topic and I would start to stress about how it would impact my schooling and grades. This stress would cause me to eat even more and it became

a vicious cycle. I was no longer eating just out of hunger but also as a way to distract myself from feelings I was having. It was all consuming.

My mom and sister came back during the winter semester and I was able to complete a summer course abroad. It seemed like a great opportunity because I only had class two days a week for half the day and the rest of the time we had off to do what we wanted. Although the first couple of weeks were fine, the course ended up being a lot more work than anticipated and was not the "escape" I was hoping for. Participation was a large portion of the course grade and I had never really participated in my classes up until that point. This created a lot of stress for me so I would stay up all night preparing for class the next day. While all of my classmates were having fun I was doing school work. Again a vicious cycle was created because the later I would stay up the less productive I would be during the day and the more work I created for myself in the evening. I would get frustrated because I was so tired during the day and couldn't concentrate that I started jabbing myself with a pen on my leg and sometimes my head. I wound up with bruises all down the sides of my legs. I would do this because I was angry at myself and would use it as a form of punishment. It also helped me to re-focus on the work that I was doing. The last night I was away was actually my worst. We had a journal assignment to do as our final project and nothing was coming to me to put down on the paper. There were fireworks that night and everyone was going out while I was stuck at home trying to write in my journal. I couldn't think of anything and I started to cry. People were also coming in and out of the house, which also made it more distracting. I tried to concentrate and tried to bring myself back to the writing but there was still nothing. I got so upset that I went outside and started hitting, started scratching my legs with my nails, and hitting myself in my face. My jaw was in so much pain the next day because I hit myself so hard.

After I finished my summer course, I stayed with one of my roommates to travel in Europe. I then flew to California to meet up with my family who were on vacation. Although I love travelling, I was still feeling depressed about my experience abroad and just wanted to go home. Also, I couldn't really injure

myself because my parents were around. However, I could still dig my fingernails into my hands when I started to feel overwhelmed since it was easier to hide. My parents were not aware of how I was secretly harming myself or how I was seeing a psychologist. I was really private with my family because I found it hard to open up to them about anything except talking about school and dance.

I was still feeling pretty depressed when the school term started and didn't really want to be in Nutrition anymore. I knew the year was going to be even more intensive because we had to prepare for internship such as doing volunteer work and the courses were going to be more challenging. I registered for five courses, which was a big mistake; however, I had to catch up because I lost a whole term of classes when I transferred into the program.

Things were very stressful and the hitting and other injurious behaviour escalated. I also started cutting, which was new. I would scratch my arm hard with the tip of the pen but would never really open the skin. Since I would spend a lot of time in the library I couldn't really hit when I needed to concentrate or focus so that is how the scratching began. I was using enough force that it would leave marks without actually making a cut. I also had a lot of classes and practices every week for dance and I started instructing dance classes for beginners. I was worried that people would notice my scars when I was in my leotard so I tried cutting on my stomach but it hurt too much. Fortunately, no one noticed the marks on my arms or chose not to comment. I would only scratch on my right arm which is interesting because that was the arm that I would write with. When I was not dancing, I would wear long sleeve shirts to cover up the marks. At first the pen cap would leave a red mark and would disappear shortly after but as it continued the mark would remain, as though it was a scar. I found that the scratching was very addicting in that I wanted to do it more and more. Sometimes when it wouldn't work I would use it in combination with the hitting. When I went into final exams, I also started digging my fingernails into my back because I would get so frustrated but didn't want to cry. It was enough pain to help bring my focus back to the exam questions.

In the Winter semester, I reduced my course load to four classes. Instead of reducing my stress level it allowed more opportunity for me to dwell on my work. Since I am a perfectionist, I ended up spending more time doing school work rather than doing other things such as going out with friends or exercising. I remember there was an incident when my injurious behaviour became serious. I had to write a paper for one of my classes and the professor didn't provide clear instructions of what she was expecting. I remember being at home and hadn't accomplished much after two or three hours. My thoughts started to race and I had trouble calming myself down. I was having a lot of irrational thoughts about where I should be at with my writing and about my self-worth. I went into my room and that is when I noticed the scissors lying on the desk. I began scratching my arm with the tip of the blade to try and manage the intense feelings I was having. The wound didn't bleed but it did leave a mark. Although my family was home at the time, it was the furthest thing from my mind. I was just focused on getting some type of relief. I was trying to prevent myself from crying and was trying to find a sense of peace within myself. After I had cut, I returned back to the writing and things turned around because my father helped me get started and I gained momentum after that.

I was also still using food as a coping mechanism. If I couldn't focus on my schoolwork, I would run downstairs into the kitchen and grab some crackers or whatever and engulf them before returning upstairs. I would return downstairs when I would lose my focus again and then my thoughts and attention would turn to the food I had just consumed and how I would have to watch what I ate the next day. Over-indulging in food would lead to negative self-talk and down the road to where I would start to hit as a way to punish myself as well as to stop the negative thoughts. It got to the point that I was avoiding going home after school because I was not able to control how much I would eat once I got there. I started to bring my meals to school with me and would stay at the library until I was so tired that I could go home.

I decided to sign up for a wellness group that was offered through the counselling centre on campus to try to find some balance in my life again. I found

the group helpful because it provided strategies for improving mood and managing stress. I also took the risk of opening up in the group about how I had been harming myself and was surprised by the response I received. When one of the facilitators asked whether anyone else in the group has ever self-harmed as a way of coping, all seven group members disclosed that had engaged in some form of self-injury. It was very validating for me and I no longer felt alone. After my disclosure and learning other strategies for coping there was a decline in my self-harm behaviour. I also started studying with a friend to prevent myself from falling back into the habit of scratching and hitting while I was doing my school work. It was enlightening to experience life again without the need to injure myself taking such a dominant role. However, once final exams approached, I started to hurt myself again as my anxiety and stress started to build. The positive was that behaviour was not as frequent and as serious as it was before.

Since I found the group therapy experience helpful, I decided to sign up for another group that dealt with social anxiety. I didn't want my parents or friends to ask questions about why I was going to the university I signed up for a Spring course to give me a reason to be on campus. That summer my family was planning a vacation to Southeast Asia. The flight was booked to leave a few days before my internship package was due, which was another challenge. I put a lot of pressure on myself because I wanted to ensure there were no spelling mistakes and I had included every document that was required for the application. I heard that the reviewers were very picky about things like that and I didn't want minor factors impacting my ability to get into an internship.

We didn't find out until September whether we were chosen to be interviewed for internship. I was happy that I was selected but it was also a stressful time because the school term was going to be intensive. Some time had passed between the interview process and being informed of whether you were accepted into the internship program. In the waiting period I started to doubt my ability to complete the program and become a dietician. Although my grades got better, my mood and ability to cope with stress decreased. My schooling was coming at quite a cost.

As a way to deal with the stress, I also started another method of injury. I would burn my wrist on my tea mug because it was another way to hurt myself that was inconspicuous to others. I would hold my wrist on the side of the mug so that I could still do my homework at the same time. This was one of the methods I would use to help me focus on my work. I also noticed that I started biting the inside of my lip when I was anxious or stressed. My anxiety would become prominent during exams or when an important project or presentation was due. There were other times that I wouldn't even notice I was doing it. It usually occurred when I was nervous around people and would do it to occupy my attention. It was just something I would start to do. It ended up getting pretty bad because my lip swelled and my mom ended up commenting on it. I was still scratching my arm during this time but I started to notice something else occurring. Whenever I would start to get anxious or something was bothering me, the tension in my arm would start to build and the urge would come to scratch it. Usually I would try and distract myself from the urge by shaking my hand to make it go away. The tension in my arm became an indicator that I was starting to feeling overwhelmed by stress or would be anxious.

Although I was always prepared on the day of a test or exam, I found myself panicking on the day of one of my mid-terms. I didn't feel I would be able answer all of the questions well in the allotted time frame. I wasn't able to calm myself down so I tried digging my fingernails into my neck and upper back as a way to re-focus. It took me over an hour to regain a bit of composure and even though we were given a time extension, I still couldn't get any answers down on the paper. I handed in blank mid-term and decided not to ask the professor for a re-write. A classmate reminded me of my strong academic background and that a mid-term exam wouldn't have a great impact on my overall average. Although I understood this on a logical level, things seemed to breakdown for me from there. I ended up scratching my arms pretty much every day that week. I was so miserable. I also started to question why I was putting myself through such stress by being in the program. I disliked every class I was in and did not like being at school anymore. My motivation was at an all-time low.

Eventually I started to open up to people about how I was feeling and they helped pull me out of the dark place I was in. My best friend dropped off a care package for me with tea and other things to pamper myself with. It also broke down the wall for us to be able to start talking again which was nice. I was trying to stay positive about my life and school and then we got our marks back for the mid-term. I got a grade of 45 percent. I was devastated because I have never received a failing grade before. My academic advisor suggested that I speak with the professor and when I met with her to discuss the mid-term she was very empathetic to my feelings and experience. She also encouraged me to "shred the test" and move on from the experience. She reassured me by stating that I was doing really well in the class and that it should not impact my ability to pass the course. I tried to think of it as a learning experience and reminded myself that the grade was a reflection of the state I was in rather than my knowledge and level of preparedness.

When I would try and alleviate some of the demands I putting on myself, I was constantly reminded of my competition to get into internship. I felt the pressure every day because we are all achieving the same grades. It made me wonder how I could stand out from my cohort. We only have to maintain a 3.0 to stay in the program and be considered for internship but I could not to let go of my expectation of achieving a 4.0. I wanted to lead a healthier lifestyle, find more of a balance in my life and reduce my standards, but I didn't know how. I decided to open up to a friend in my program about my difficulty in managing stress and how I had been harming myself. Her reaction was not what I expected. She had difficulty understanding why I would do such a thing. I tried to explain to her that it made me feel better and helped me to concentrate and highlighted that I couldn't seem to stop. She just said that I needed to "get it under control before I started internship." I knew that it was going to be impossible and that it would take me longer than that to get it under control and I was not going to delay internship to focus solely on my recovery. This was one of the reasons why I refrained from opening up to more people.. What I have found helpful is journaling on my on-line blog. It has been an opportunity to truly express how I

feel in the moment without fear of judgment. A couple of my friends in the United States have accessed this blog, although I am not sure whether they read it.

I wish I could be as open to my family and friends but I am worried that this would push them away as it did with Kristi. Although things have gotten better between us, I have never really opened up to her because I think that would be too much for her to handle. Even when I opened up to my friend Sandra, I said to her "I need to know if I am pushing you away because I will stop." When she said everything was fine, I still had the thoughts- "I probably shouldn't have said anything. I wonder what she thinks of me? I wonder if she will still be my friend?." I still haven't found that person, that friend who I can trust in that. A friend who I can be completely open with, who will reciprocate in sharing, and will let me know if she is dealing with too much to support me. It is also hard for me to open up to the friends I have now because aside from Kristi, they are all in my program. As my competition they may use what I have told them against me and may question my ability or readiness to be in the profession. I'm not able to open up to my parents either. We are just a private family.

Ironically, although I did not receive the support I was looking for when I told Sandra, I stopped hitting and scratching. I didn't even resort to using the fingernails because I didn't have the urges that I used to. It is unclear whether telling her had an impact on my injurious behaviour or whether it was the result of stressors being removed from my everyday life. It is possible that by telling more people, I started to feel accountable for harming myself Also there was a large reduction in my school work and stress level. By the end of the school semester, I only had one final exam to study for and one final project due.

This semester I have noticed a similar trend. I haven't had the same amount of school stress and there has less harming behaviour. I have only had a couple of urges to hurt myself since stopping last fall. One urge that was particularly strong occurred around the time that I had to arrange a guest speaker to attend one of our classes. I was feeling a lot of pressure from my group to take the lead and I spent a lot of time worrying, even about what to write in the e-mail. Around the same time, my mom was on the computer managing the finances for

her business. I transferred her information on a USB key so that I could use the computer and lost the information. I could tell my mother was on the verge of tears and I felt responsible. It was at the time that I felt a tightening in my arm and the urge to tear my arm open. I did everything I could to distract myself from this feeling and stayed close to my mother to prevent myself from doing anything. I think the urges are the result of letting stressors build up and blowing things out of proportion. Other triggers are anxiety, stress associated with school and with dancing, interpersonal conflicts, and personalizing- taking full responsibility for things that happen. I couldn't believe how intense the urge was during this circumstance. I even journalled about it as a way to get some perspective.

Although it has been difficult to find motivation or happiness in my program, I am hoping that internship with change that. Having the hands-on experience will help to determine whether I actually enjoy the work because a lot of what we have learned in class is not directly applicable. I've heard that internship is also really stressful so I am nervous about that. I will likely have to move away for my placement and that will add more stress. I will be in a city where I do not know anyone and will be pretty isolated. I am worried about how I might cope and whether that will lead to a resurgence of injurious behaviour. Since last fall I've not harmed myself aside from digging my fingernails into my hand or pinching myself if I start to feel anxious or uncomfortable. I have been achieving more balance recently by going out with friends and exercising but my resources will be more limited in a new city. I think my success will depend on my ability to foresee potential obstacles and stressors and develop a plan of what to do if those stressors arise or coping strategies to employ. I would also benefit from researching the city where I am placed and consider ways to meet people, activities to participate in, and ways to socialize so that I am not so isolated.

Jessica. Jessica was 18-years old and was living at home with her mother and younger sister. Her parents divorced when she was 15-years old. She said she was not impacted by her parents divorce because her father was not really "part of the family." Jessica does not have a single memory from childhood that he is part of. Her father was diagnosed with cancer and his priorities shifted. Jessica

struggled with her father's sudden interest in her life and said his behaviour bordered on "controlling." This was a struggle as she felt she "should" be there but also realized it was unfair that he expect her to be a part of his recovery

Jessica won a scholarship that gave her the opportunity to go school in Hong Kong for two years. She decided to come home early and completed her high school credits through a Correspondence school. Jessica said there are two parts of her: "Super Jessica"- the one who achieves high grades, obtains awards and scholarships and is recognized in the newspapers, also called "Fraud Jessica"; and "Real Jessica"- the one who struggles with Major Depression, Obessive-Compulsive Disorder, self-injury, conflict with her parents, and the average issues of a teenager. Jessica began self-injuring when she was 17-years old.

***Story*.** I went to a very academic high school and there were a lot of expectations about the grades I should receive and the number courses I should take per semester. In Grade 11, I started to feel overwhelmed by my course load and went to speak to the school counsellor. I was enrolled in full International Baccalaureate (IB) program, which is a comprehensive international program that is highly intensive to prepare for post-secondary education. Basically, it involves ten times more work than the basic high school curriculum but your grades are still being compared to those high school students in the regular academic stream. I was having difficulty sleeping and difficulty getting my work done. I would feel guilty as a result, which contributed to feelings of depression. However, I still felt the need to put on a *face* that everything was okay. I was a straight "A" student and was nominated for awards and scholarships. How could an overachiever such as me feel so sad and so lost? People saw me as "Super Jessica" so I gave them what they wanted. How I really felt was a different story.

There seemed to be a direct correlation to how I was feeling and how much make-up I was wearing. When I was feeling really low and sad, I would wear a lot of make-up to cover up how empty I was feeling. It was a distraction-people would see only the beauty and not the sadness. My struggles started in September of that year and it was in December that I decided to speak with the school counsellor. I was hoping to drop some classes to alleviate some of the

stress. I was really worried about going to speak with her, what she would think, and about my classmates seeing me in the waiting room because as soon as you walk through that door, you are instantly perceived as having issues. I was comforted by the fact that I knew Miss Dika from a course I took and remembered how nice she was. I told her that I was finding it difficult to manage nine classes and was struggling with French and Physics because they were new subject areas for me. I also shared with her some of the thoughts and feelings I was having and she asked whether I knew about or read anything on depression. My immediate reaction was, "That is not me", but she encouraged me to read more on the topic and re-booked for the following week to discuss dropping some classes. After doing the research like she suggested, I was amazed at how I fit all of the criteria and how much it resonated with my experience. When I met with her the following week she also had me complete a depression inventory to assess in more detail the severity of depression. We also spoke about the need to drop some of my classes and how difficult that would be for me considering I have always been an overachiever. I would just think to myself, "You just have to work harder" and "Over time things will start to make sense." It was helpful that Miss Dika was insistent of me dropping French and Physics because I may have rationalized why I should keep all of my classes. We also decided that I should drop out of the IB program and drop another course but waited until after mid-terms because there are no mid-terms in the IB program, which gave me some holiday time before switching to the basic academic stream.

By January, my mood was really up and down and I started to have some suicidal thoughts. I was struggling with the notion that I was depressed because to me it was a sign of weakness rather than a disorder. By February, my course load had been reduced to half. Miss Dika must have made a strong argument for my case to the principal because in Grade 11 you are only supposed to have one spare and I had three. I was really relieved because I had the extra time to get my work done while I was at school and access support if I needed it. It was not even the extra time I needed but rather having less work to do, and thus, less stress. It was definitely the right decision for me at the time. The one struggle I had was my

mother's difficulty in reconciling that I was depressed. She would say, "Jessica, you are just going through the normal emotions of adolescence" or "You are making things up." Her response was surprising considering she has suffered from depression herself for quite a long period. Another incident that off-set some of the progress I made was the upcoming birthday of a best friend I had lost contact which I coined, "Remembrance Day." Paula's birthday is on February 8 so that time of year has always been hard for me and would affect me in a tremendous way. It was a reminder of how close we used to be and a reminder that she was not in my life the way I would like her to be. We went from finishing each other's sentences to not speaking for four years. Even though we're not speaking, I would send her an e-mail on her birthday.

On February 2nd of that year, things started to deteriorate. It was like any other day in that I stayed up late and woke up late. The difference was that my thoughts became more irrational and delusional. Over the past months I had been having an upset stomach after every meal. A rational person would have thought that they may have been suffering from food allergies, an ulcer, eating too much junk food or something of the sort. However, I was in irrational thinking mode and had only one explanation in my mind. I had convinced myself that someone was systematically poisoning my food. I didn't have the walls I have now to block out the negative thoughts that repeated over and over in my head- "Someone is trying to poison me, someone is trying to kill me." This continued all night like a broken record until it escaped to my lips and I carefully repeated on the inhale, "Someone is trying to poison me" and on the exhale, "Someone is trying to kill me." As the chanting continued, I remember grabbing a boomerang from beside my bed and hugged it as I lay on my side hoping that everything would stop. I stared at my door, waiting for it to open since I was anticipating that someone was coming to kill me. My adrenaline was pumping as my body prepared for the fight. I threw the boomerang towards the door as if "someone" was coming into my room. The unfortunate part was that I did not see my cat, Whiskers come into the room and the boomerang missed her by two feet.

Even that scare was not enough to keep myself from chanting, "Someone is trying to poison me, someone is trying to kill me." Every thought I had in between informed me that this was not healthy and that I needed to find a way to stop. I had to stop no matter what the costs. As my voice was in autopilot, it was interrupted by some new thoughts, "Someone is trying to poison me. *You can do it! You like bruises.* Someone is trying to kill. *It'll distract you!* Someone is trying to poison me. *Just a few swings will knock you out of it.* Someone is trying to kill me." I sat up staring at the boomerang, which now became a weapon to me. Without a second thought, I took it in my right hand and swung at my left bicep as hard as I could. The blow brought some slight pain but nothing that could break through my defences. I swung again and again in the same spot in attempt to cause injury- a bruise or a wound that would give me something to attend to, that could distract from the never-ending thoughts. Since I don't bruise easily, I was not able to create enough force to possibly leave a mark from this wooden stick. I started to become frantic by this point because nothing I seemed to do helped me gain control. The only option that seemed viable at this point was to continue hurting myself as a form of distraction. I remember thinking, "If it works for other people, than maybe it will work for me." Trying to go to sleep or getting out of bed to watch television didn't cross my mind as alternatives. Those options would have seemed illogical to me.

Since the blows weren't enough to keep me from chanting, I had to give in to what my instincts were telling me and up the ante. I put my right pointer finger onto the back of my left wrist. I chose the back of the wrist because it was less Emo in my mind. I dragged my finger across my skin and pressed my nail down until I made a deep pinkish mark. I kept going up and down, rubbing a sort of pattern with my fingernail until the skin started to fold up. It created an oval shaped wound and I pulled off the excess skin. What was left was a shiny pink mark that almost reflected light. I decided I needed another and wanted to see blood. I kept making new wounds until I hit a mine of red blood. Although I could feel what I was doing it was not pain. Instead, I felt pure relief washing over me. Part of the relief was from noticing that I had stopped chanting aloud. The

thoughts were still faintly spinning in my head, so I decided to keep scratching, up and down as a way to take off more skin. I continued in an attempt to find more blood but after eleven attempts, I finally give up and collapsed into a deep sleep.

I woke up two hours later to get ready for school and was in disbelief about what happened the night before. Although it felt like a dream, the eleven wounds that were left behind confirmed what had actually happened. I thought to myself, "What did I just do"? I never thought I would be capable of something like that. The first time I had heard of self-injury was in my Career and Life Management (CALM) course. We were informed on what it was, how to do it, and how people who had depression may resort to the behaviour as a way of coping. When I was in the course, I couldn't understand how anyone could intentionally hurt themselves so I wrote an essay with the position that individuals that self-injure are attention-seeking narcissists and could never imagine engaging in the behaviour. Little did I know what the future had in store for me. I felt no pain the next day but my biggest concern was how my new scars would severely restrict my wardrobe. It also bothered me that there were not twelve scars since twelve is a nice even number. Eleven marks seemed as though there is still unfinished business. Although there was no pain there was a hint of good feeling for a couple days following that distracted me from the ever present emotional pain. It was a pulsing sensation and it felt amazing.

I decided to go to the school library and research more information on self-injury. I needed some explanation for this. I needed to know why, I needed to know what to do next, and there was probably a part of me that wanted to learn other methods. I was shocked to discover that this was not my first incident of self-harm behaviour. In my readings, I had learned that another form of self-injury was interfering with wound healing such as picking scabs. I had been picking the same two scabs since November, which meant that self-injurious had been my friend since then. It also meant that my recent occurrence of self-harm was an escalation of something I was already doing.

I thought back to my daily routine. Each morning, my first activity of the day was to pick off the scab which had formed over night from the inside of my

nose. I had multiple wounds in my nose, but I hadn't allowed any of them to fully heal since the previous November of that year. The benefit of the wound being inside my nose was that it was easy to hide from people, which helped me to maintain the façade that everything was okay with me. My ritual was to pick the scab, eat it, stick the finger back in my nose to get more blood, and then lick the blood off as well. I liked how the blood would pour out of me and I liked that the blood would act in the exact way I wanted it to every time. It would usually spurt onto my finger than up to my tongue. It was not only the sight of blood I needed but also the taste- the metallic sweet taste. It got to the point that I could tell how much blood each scab would bring and if a wound produced the type of scab that was thick and bumpy, I would have to stop whatever I was doing and go to the bathroom to rip it off and let it bleed. I had no self-control over it. I could not say how many times on average I would escape to the bathroom to indulge in my daily obsession but it was at least seven to fifteen times a day. The more time I had to myself or the more stressful my life was, the worse it would get. I became a slave to the craving compulsion to pick the scabs and to see the blood. I had come to the realization that the wounds on my wrist were just the next step of a potentially life-threatening addiction. How could the thing that provided me with a sense of control have taken control over me?

When I saw Miss Dika a few weeks later, I wondered how I would tell her about how I had been harming myself. Just as a person may not view themselves as a crack addict if they are not living on the streets, prostituting themselves, or begging for their next hit; I had not considered myself a self-injurer since I was not cutting with a razor blade. I was worried I would disappoint her and that I had failed considering all she had done for me. When I did open up about what happened, she comforted me. She told me that I wasn't alone and that about 75 percent of the students she saw in counselling had self-injured at some point. I was shocked by this statistic since it was such a high number. Although this provided some relief, I was also angry that I became part of the majority, rather than finding healthier means for coping with my irrational thoughts and emotions. I also wondered how I had changed from the girl whose biggest concern was

which shirt was most flattering and which colour eye shadow would catch the attention of boys to how I could get out of bed and get through the day without drawing attention to my illnesses?

Around the same time I went to see Miss Dika, my mom discovered the wounds on my wrist. We were at Costco and I was trying to conceal all 11 of them with a bracelet. My sister had noticed the red area under the bracelet and pointed it out to my mother. I immediately went into panic mode thinking about what I would say; what excuse I could come up with. I told them that it was a rash that I'd been scratching, even though I knew they were far too intelligent to believe it. Surprisingly they did, but likely it was the result of what they were choosing to believe. Since my mother had a hard enough time believing that I was depressed, I knew it would be impossible for her to believe that her daughter was deliberately hurting herself. People would much rather think of pretty nice things than consider a dark serious reality. My mother and sister were not the only people I lied to about my scar. I told Mr. Brown at McDonald's the summer before that it was a rash. I told Stewart in Social class that a cat did it. I told the girls in my Phys. Ed. class that I had an allergy test done the week before. When my friend Bryan asked, I deflected and said I would tell him later. There are a few people in my life whom have gotten a truthful response to the question, "What happened to your wrist"?.

I realized I needed to find a way to stop injuring myself since it had overtaken my life. Just as I wished I had cancer instead of depression, I wished many times that I was addicted to heroin rather than to harming myself. Dealing with an addiction to self-injury is a lot more complex because you cannot remove the temptation from the addict's environment the way you can for a drug addict. You can remove knives and razor blades, but it is not like the absence of these items had stopped me before. If desired, I could always access blood or create new wounds or injuries for myself. Even under supervision I could usually find some way of producing my red obsession. Although there are more healthy ways of coping, once you have tried self-injury, it is difficult to find another outlet that offers the same effect or high. Since there is no real replacement, it makes it

difficult to give up the drug. The only way to detox is to rely purely on self-control and distraction until the urges and desires eventually subside. When I first tried to stop picking my wounds and scabs, I didn't set realistic expectations for myself. I would think, "I am going to stop now" even though I had just engaged in the behaviour thirteen times the night before. Then I would feel so low and be down on my self because I was not able to resist the temptation. Eventually I was able to limit the behaviour to two times a day. I would only allow myself to pick in the morning and at night time. My counsellor had suggested other ways to find relief from stress while I was moving away from injuring myself but nothing seemed to work. I tried putting my arm in ice water, snapping my wrist with an elastic band, or marking my arm with red marker. Since the function of my injurious behaviour was more about seeing and tasting blood these methods were ineffective. Finding ways to distract my mind from the urges was more helpful, such as watching a movie or talking with friends.

Another way to move away from the temptation of harming myself was to escape from some of the stressors I was experiencing- escape from the pressures of school, distraction from my mental health issues, and getting away from tensions at home. I was finding it more and more difficult to live with my mother since she didn't believe how I was feeling or what I was experiencing. She chalked up what I was going through as part of the normal teenage process. It was hard for her to see me as depressed because she would see me put on this face at school or with my friends and then see me come home and cry in my room. She was like, "How could you be happy one minute and sad the next." I tried to explain to her that I was either acting happy or had brief periods where I was feeling better. I had already felt stuck as the result of my mood, so it didn't help that I felt stuck at home. I decided to apply for scholarships so I could attend high school abroad for a term. I just needed to be somewhere else for a while. When I found out I was selected, the committee decided to send me to Hong Kong.

When I first got to the school I didn't engage in any harmful behaviour. I had roommates and didn't have the privacy I did before. I viewed it as a new phase in my life and decided that I didn't have to do this anymore. I was also able

to start taking anti-depressants as the school's health insurance would pay. Even though I started taking medication to manage my mood, I started having irrational thoughts and by the third or fourth week, I self-destructed. I had woken up one morning and thought to myself that it would be good idea to cut off my left arm. My reasoning was that I could fulfill my urge to see blood AND get rid of the scars that were on that arm. My thinking was irrational because I was only focusing on the blood and getting rid of the "elephant" on my arm. I hadn't considered that such as action and the loss of blood could kill me. I had already started school by this point, so I had come home at lunch time and went to the kitchen of the boarding house and took a knife and went up in the shower. It had become common for me to take a shower at lunch time because of the heat and the humidity so it was a way for me to cool off.

I managed to reconsider my next step, and instead of cutting off my arm, I cut on a place that was more inconspicuous. I made two little scratches on my stomach and probably would have kept going if I didn't have to get to math class. That is how my brain worked- I still thought, "No, you have to go to class." I found that the stinging from the cuts helped take my mind off some of the crazy thoughts I was having. The next day I was able to take a step back to realize the seriousness of what I had planned to do. I decided that I should check myself into the hospital to be assessed. I was given an emergency appointment with a psychiatrist to determine if I needed to be admitted. She decided it was best that I went to the hospital because I was incoherent and really sensitive to light and sounds. I could n't check in until the next day so they kept me under supervision at the university clinic. Since I didn't have much money they took me to the cheap hospital and was admitted to the psych ward. I found it very intimidating and the first couple days I was there they put me on Xanax so I mostly slept. The philosophy at that hospital was to sedate the patients and keep them out of the public eye. They only had two nurses for the entire ward, which was ridiculous since most people on the ward had severe psychiatric issues and did not get the supervision or care they required. One of the reasons I likely got to the point was that I had given up one of my only coping skills when I moved to Hong Kong.

Since it was so humid there, my wounds would heal quicker and I could not keep up with the picking. I realized that I needed to go back to the self-injury until I found better ways of coping. During my stay, I used a butter knife and cut along the same part of my stomach where the other cuts were. It was just enough to calm me of my thoughts and feelings.

After a week in the hospital I was ready to be released but the staff wouldn't allow it. Even though I admitted myself, they would not let me or my mother advocate for that decision. Apparently the school had given over custody to the hospital so I had to lie in order to get out. I told them I was feeling better and didn't have thoughts of injuring myself anymore. I also chose not to tell the staff about the thoughts to amputate my arm because I knew they would keep me in the hospital for months. I was surprised that they believed me because how can you fix someone who has been suffering from depression and self-injurious behaviour for over a year by a week-long stint in the hospital. The only treatment they provided me with were daily doses of Xanax.

After I got out of the hospital, the cutting escalated to the point where I was doing it every night for a week. I just needed something to distract me from negative thoughts and the idea of completing more severe types of injury. Again, I would take a serrated knife and move it back and forth over the old wounds on my stomach because I knew it would draw blood. The same week, the principal at the school met with me and said how she didn't think the school was the best place for me and that it would be better for me to return home. I later discovered that the counsellor I had been talking to at the school told the principal about my depression and self-injury. I felt that I was being punished for going for help. Even though I knew I was not in the best mental state I was not ready to leave and was quite upset over the school's decision. I tried to tell the principal that I become easily stressed by school expectations but always get the work done and pull off the marks that are necessary. The principal didn't want to change her mind because she viewed my presenting issues as quite serious. She suggested that I "go back to Canada and get healthy" and that I could return once I got through the "tough time."

I had told my mom what had happened and she booked a flight to Hong Kong to come see me. I was hesitant for her to come because I didn't want her to pay the high cost for the flight due to the limited funds we had. Her main reason for coming was to advocate for me and see if she could change the principal and school's mind. A meeting was arranged once she arrived but it was pointless because the option of me staying was not even on the table. They said I had to leave "on my own accord" even though it was not my choice. They have laws in Hong Kong indicating they are not allowed to expel students. It was possible for me to have appealed their decision but I decided that I didn't want to attend a school with that type of principal. Even my mom said, "I can see this is not a good school for you and would be okay if you left."

I had already booked airline tickets to Malaysia for October break and couldn't get a refund for the tickets. The plan was for my cousin to meet me there so we could travel around together. The only difference was now my mother was going to join us and a couple friends from my school. We had a nice trip and had the opportunity to go scuba diving which I enjoyed. We travelled for almost a month so I was looking forward to returning home because it was the longest I had ever gone without counselling. I booked an appointment with a counsellor as soon as I got back to Edmonton so that I could process everything that had happened. I also wanted to consider what I needed to do to make some positive changes in my life and improve the way I was feeling. Another development was meeting with a psychiatrist to find a medication that would help with my obsessive and irrational thoughts and moods. I am on three different types of medications- two are anti-depressants and one is anti-anxiety, and have found that they had no effect on me whatsoever. I still pick occasionally but the frequency and intensity has definitely been reduced. Self-injury is not something that interferes with my life anymore. I don't miss activities or isolate myself to have more time to engage in the behaviour. It is something I turn to only when needed, such as if a major event or crisis occurs.

Although my circumstances are somewhat similar before I left for my term abroad, I am no longer depressed. I am also going to an alternative school which

provides flexibility to when I have to attend school and complete my work. My school schedule also allows me to work full-time, which I enjoy. It seems ironic that I had to take a trip across the globe to return to the same place. The difference is that I'm in a better place. I think an experience like that is eye-opening and makes you appreciate the things that you already have. I realized that living with my mother was not as bad as the "depressed me made it out to be.

Paul. Paul, a 21-year old university student decided to transfer to a technical college. He has two older brothers and an older sister who all live outside of the home. His parents are still married and he plans to live at home until he finishes school. Paul started self-injuring in university as a way to manage his depressive moods. He learned about self-harm from his girlfriend, who also used it as a form of coping.

***Story*.** My life started to unravel shortly after I met Desiree. I got out of a short-term relationship and my friend Malori decided she wanted to introduce me to her friend Desiree. Malori informed me that Desiree had also just come out of a relationship and that she was very "fragile." On our first meeting, Desiree and I decided to go out for lunch and we got along really well. After a few dates she started to open up about her past relationship because of some of the struggles she was still having. Desiree said her last partner was physically and sexually abusive towards her. Although they started their relationship as friends, Alex would pressure Desiree into more intimate situations until their friendship evolved into something more serious and Alex would manipulate Desiree into staying in the relationship. Shortly before they broke up, Desiree attempted suicide since she viewed that as her only escape. Her friends were eventually successful in getting her to leave Alex and the abuse. Although I was overwhelmed by everything Desiree had shared, I told her that I was "willing to take the risk" and see what could happen between us.

As time progressed, I started to see more of how Desiree's past was affecting her. Out of nowhere, she would completely freeze up and start shaking. It was like she was somewhere else and it would take saying her name repeatedly to get her to snap out of it. Other times she would breakdown and just cry. It was

so difficult to see her in this state particularly because I didn't know how to help her. After we had been together for a while, Desiree reached a breaking point, and had to be taken to the Emergency Critical Care Unit at the hospital for safety concerns. As soon as I heard, I went to the hospital to see how she was doing and remember sitting next to her in her hospital room thinking, "how did I ever get here"? One minute we were having an enjoyable lunch and the next minute I was sitting beside her bed in a psych ward. I continued to support and console Desiree through her emotional meltdowns and over time it started to impact my own mental health. Whenever she would break down I would help Desiree until she reached a point where she felt safe and stable and then I would go home and have a breakdown of my own. After a while, the stress contributed to feelings of helplessness, depression, anxiety, and suicidal thoughts.

The main method Desiree used to deal with her feelings and depression was self-harm. She often cut, and sometimes took handfuls of the medications her psychiatrist had prescribed her, just to numb herself. She said that Alex would cut and use drugs as a form of coping, so Desiree turned to cutting for the same reasons. At the time, I couldn't understand why she would want to do this to herself, and always told her it was unhealthy. When I would ask her about it she would say, "I just need to…even if it is just a little bit." On our first Valentine's Day together I had booked us a reservation at our favourite restaurant. My plan was to take her to dinner and then listen to a musician that we both enjoy. That afternoon, I got a telephone call from her. She was crying and barely able to speak. She asked if I could come over as soon as possible. Since she was bawling, I left the school where I was tutoring and rushed to her aid. When I got to her house I went upstairs to her bedroom and found her on the floor. When I saw her blade on the floor I realized she had been cutting that afternoon. When I tried to ask her about what triggered the episode, she couldn't even speak. Once she was in that state, it was difficult for her to talk and she would just shut down. If I put my arms around her she wouldn't even move. She was like a zombie. Desiree told me before that it was something that would happen when Alex would force stuff on her. She would shut down and let it happen, hoping she didn't get hurt. When

it happened after her break-up with Alex, it was the result of reliving those memories through flashbacks. When I left that night, I took Desiree's blade away from her to protect her from further injuring herself and cleared her room of every other sharp object I could find.

Since self-injury seemed to be helping Desiree, I started to think that maybe cutting would help me with some of the depressed feelings I was having. One night when I got home, after another particularly challenging evening, I desperately tried to think of any way I could to relieve the emotional stress I was experiencing. That was when I decided to try cutting. I took my pocket knife and started to think where I would make the first cut. At first, I was hesitant and afraid of what the pain might be like so I made small and light strokes on my leg with the knife. It was too difficult for me to push hard and make the first cut. Eventually I mustered up the courage to take the point of the knife and scratched it across my skin until I drew blood. I was surprised that it didn't hurt much and became fascinated by the whole experience. The cutting seemed to draw me away from the world and all my problems. As soon as I saw the blood it was the first time in a while where I felt calm and my mind was quiet.

Since this experience was so effective, I started to cut more often when I felt overloaded by my thoughts and feelings. As time went on, I was also able to be more forceful with the pressure I put on the blade. The cuts would be deeper and I was able to draw more blood. I would also make more cuts during each episode. Eventually, it became the first thing that I would think of when I felt overwhelmed by my relationship with Desiree and other personal issues I was having. My injurious behaviour got to the point that I was addicted and needed to do it on a regular basis. The trigger didn't have to be an event of huge significance. If I had a negative thought, my automatic response would be to think of cutting. I had always had low self-esteem but the decline of my mental health that resulted from my relationship seemed to exacerbate how I felt about myself and increased my anxiety. It became such a viable solution, which made it harder to think of other options.

Although cutting myself would help me feel better in the moment, it did not address the root of the issue and instead was a "band-aid" for my depression. It was as though I didn't care what happened to me. I was not deliberately trying to kill myself with the cutting, but also felt that if it did happen it would be a way to escape the pain I was feeling. In my earliest episodes I would cut on my leg, where I could easily conceal the scars. However, the behaviour progressed to where I was cutting on my arm and sharpening my pocket knife because there was the potential to draw more blood and be more dangerous. Most of the time I just needed an emotional release, but occasionally the underlying thought was, "Maybe if I cut deep enough, I might just bleed out."

Malori was friends with both Desiree and me and was well aware of the difficult times we were both having as a couple and individually. She had suggested that it might be helpful for me to speak with a counsellor at the centre on campus. My first appointment was in August of that year and I attended weekly counselling sessions throughout the end of summer and fall. Once I started to work on myself in counselling, I realized that self-harm was not something I wanted in my life. When I made that decision I did whatever it took to try and stop. It was challenging at first because it was still very present in my thoughts and the urges would be there. I found that when I moved away from the cutting, the urges became less and less.

That fall, Desiree had decided to do some volunteer work abroad. When she told me she would be leaving, I started to evaluate our relationship closer. The majority of our relationship consisted of tough times and I was uncertain whether there was a future for us. I told Desiree how I was starting to doubt my feelings for her and she broke up with me a few weeks later. A few days after we broke up, I found out she went on a date with someone else. I had a complete meltdown but fortunately had an appointment scheduled with my counsellor that day and was able to work through my feelings.

She called me a week later and asked if we could meet for coffee. Desiree said that when she broke up with me she was angry, but was sorry and preferred that we end our relationship on a positive note. I was still distraught from learning

she had already been dating again but we decided to meet on campus to talk. I probed her for information to see if she would come clean about her date. She eventually started crying and said she didn't plan on seeing him again. Although I was shaking with anger, we were able to talk about it more and I was able to get to a point where I could hug her and console her. We also reminisced about the fond memories we had and discussed our hopes for the future. An hour later, we were able to walk away feeling more positive about each other and the relationship we once had.

Even though Desiree and I had broken up and she left to complete her volunteer mission, I found myself being affected by her. I worried about how she was doing so far away from home. With Desiree gone, I was also able to focus on myself, which was quite overwhelming. I would have periods when I would feel low and depressed and one night I relapsed and cut again. I had such a surge of guilt and disappointment for returning to that level. So much time had past since my last cutting incident and I was upset that I allowed myself to succumb to the urges again. Instead of thinking, "Look at how long since my last incident", I would think, "Great, I am back where I started." I felt like such a failure and it was really hard to pull myself out of that state to continue working on my mental health. That was the theme in my recovery process. I would go a few weeks without injuring myself and then relapse. Whenever I would cut again it would be really difficult to remind myself of what I had accomplished and the goals I was still working towards

About three months after Desiree left, I was thinking about our relationship and how things deteriorated and had a strong urge to harm myself. I was in the state of mind where I was indifferent about whether I lived or died as the result of harming myself and I had felt suicidal a number of times since dating Desiree. Difficulties in the relationship, feelings of depression and low self-esteem all contributed to the suicidal urges. Although I used cutting as a way to cope, it also became a possible avenue for suicide. I would occasionally think that if I cut deep enough, I could allow myself to bleed out and not tend to the wound. This was one of those times where I thought of cutting myself more acutely to see

what happened. I went up to the kitchen and had several shots of vodka. Though the alcohol did have some effect, it was more the combination of alcohol with my mental fatigue that contributed to my numb and slightly dazed state. I went straight down to my room, grabbed my pocket knife, and slashed it down my arm. I must have drawn the knife quicker than I thought because I opened a fairly wide and deep cut on my arm, about a half a centimetre wide and stretched about an inch and a half across. I had cut through all the layers of skin so that most of the tissue was exposed. Even though I had intended to cut deep, I caused more damage than anticipated and started to panic. I dropped the blade and grabbed a bunch of tissue to put on my arm in attempt to stop the bleeding. I didn't know what else I should do and was freaking out. I texted Malori and told her what had just happened. She told me very sternly, "Paul you need to go to the hospital!" and all I could tell her was that I couldn't go to the hospital because "then they will know." I just kept repeating "then they'll know." I could tell that Malori was exasperated and was just as lost as I was. I managed to control the bleeding with gauze and more tissue. I held it closed with three band-aids and dressed it with more gauze. Over the next couple days I had to keep changing the dressings and made sure it didn't get wet. It was the deepest cut I had ever done and it would have been wise to go to the hospital to have the wound properly taken care of. However, I couldn't risk my family finding out about my cutting behaviour. I have managed to keep my family in the dark about the difficulties I've had in the past year with my relationship and my own mental health issues. I've never had the kind of relationship with my parents where I felt comfortable opening up to them about intimate details of my life. Part of the issue is that my siblings have their own problems, emotional and otherwise, and I didn't want to contribute to the stress in our family.

I have cut once or twice since then. One time was the night of Malori's birthday party. Desiree has just returned back from her volunteer mission and I suggested that we go to the party together as a way to address any awkwardness there was between us. I had tried to be pleasant with Desiree and even bought her

and Malori a drink. When I suggested that she finish the drink before we left, she told me that she was getting a ride home with Malori's parents.

I was upset since we had gone to the party together. When I got home, I decided to take a handful of ibprophen and Benadryl chased with vodka as a way to end some of the feelings I was having and to help me fall asleep for the night. I was still have difficulty calming down and thought that cutting would help. When I made the cut, I noticed that I had to start at square one, with tentative strokes and small scratches. After I got over the initial disappointment of yet another relapse, it made me proud to think that I had gone so long without harming myself that it was like I was starting from the beginning again. At that point I got the idea to pick up the telephone and call a crisis line. I called two times before I got through because I would let it ring and then would hang up right away. I guess I was still in denial about how serious my issues were. I didn't want to be one of those people who needed to call a help line. By the third time I told myself that I "have to do this." I think I realized I had taken a step backwards and was at the point where I needed some help. When I finally did get through to a counsellor I spoke to them for a while which I found quite beneficial.

The next day Malori called accusing me of trying to get Desiree drunk and said that I ruined her birthday party. Malori was my best friend so it was very hurtful that she would not listen and try to see my point of view. She said she couldn't deal with my problems and that she could "not be that person for me anymore." She "was done." I took that as her not wanting to have anything to do with me and was devastated. I just tried to think how I could put both Malori and Desiree out of my life and move on. I sent her a final text message stating, "I'm sorry I put this all on you. It has not been fair to you and I am sorry that you got hurt as a result." I thanked her for being there during everything. She responded by reassuring me that "we could still be friends and could spend time together but that she could not be my sole confidante- that she could not deal with my problems anymore." I was relieved that she would still be in my life, but disappointed because I had lost the one person that I could talk to.

Since I found it more difficult to cut during that episode, I found it easier not to cut again. I have not cut since. My cuts have all healed so I don't hide them anymore or keep them covered. A few people have asked, "Where is that from"? or "Did you do that"? and I would immediately respond with, "No, it is just a cut." I am still not ready to talk about self-harm with my family or friends. I still have thoughts of hurting myself but they are rare, and there is no longer the desire with those thoughts. In counselling I am focusing on how to improve my mental health and overall self-esteem. I have also started to strengthen the spiritual aspect of my life and have been attending weekly masses at the university and have been going to confession. I have met other Catholics who I've been able to talk to about my faith. In addition, I've been taking better care of myself. I am getting more sleep and have improved my eating habits. I am exercising and have started to go to tae-kwan-doe classes. For the social aspect of my life, I joined the dance club at the university which has been a nice way to meet new people. Although I am being open to the new people in my life, I limit what I share because I don't want to overwhelm them the way I did with Malori. Perhaps another part of limiting what I share is so that people can notice the changes I have made rather than the old me. I'll be finishing off my year at the university and then will be going to college in the fall to take a program that really interests me. I'm finally considering my needs and what I need to do to make myself happy.

CHAPTER V: ANALYSIS OF NARRATIVE

A paradigmatic analysis of narrative (Oliver, 1998) was conducted for the purpose of this study. In the process of uncovering themes across participants' stories, emphasis was placed on the context of text (*the what*), more than *how* it was said (Riessman, 2005). Interview transcripts were read over thoroughly and common areas across participants were extracted. Transcripts were then re-read to determine the consistency of these content areas among each of the participants. These content areas were examined closely to determine commonalities and to generate core theme areas. Four core theme areas were developed and a description of each is provided. The themes are: adverse circumstances in childhood and adolescence, emotions, sense of self, and function.

Adverse Circumstances in Childhood and Adolescence

Participants experienced adverse circumstances that occurred during their childhood. These events and circumstances caused negative effects for them and continued to have impact in their adolescent and even adult lives. Participants' experiences with abuse and neglect, grief and loss, separation and divorce, physical and emotional health issues within the family, lack of support, and relationship stress and conflict resulted in undue strain and poor coping mechanisms. Many spoke about how these early incidences in childhood and adolescence led them to turn to self-injury and other destructive behaviours later in life.

Abuse and neglect. Several participants reported experiencing some form of abuse as a child, whether it was physical, emotional, sexual, or neglect. Physical abuse came by the hands of a parent, and for one, later again by a partner. Angel described how the emotional, physical, and sexual abuse she experienced by her mother during her childhood had a large impact on her emotional well-being. In adolescence she struggled with depression, low self-esteem, and, an eating disorder. She revealed that one of the main reasons she engaged in self-harm behaviour was to prove to herself that if she could withstand the physical pain of burning and cutting, than she could withstand any emotional pain.

Even though they were the targets of abuse, participants reported having feelings of guilt, wondering if they were somehow responsible for the hurt that was brought on. When the abuse was a contributor to their self-harm behaviour, participants injured as a form of self-punishment for the guilt they felt and because they turned their anger inwards as it was not safe or acceptable for them to express their feelings. Fiza disclosed a time she injured as a form of self-punishment. She said she carved in her skin the words, "My happiness depends on the happiness of others." Silas spoke about the effects of abuse he experienced vicariously through his mother. He and his mother were always on the move to escape the threat of physical harm by his father to his mother. This transient lifestyle made it difficult to make friends and "fit in." He injured himself by burning to feel "tough" and "masculine" as he perceived those to be important qualities in the groups in which he interacted.

Participants also reported being victims of emotional and verbal abuse by a family member. Lisa experienced negative comments, slander, and cyber-bulling by her male peers. This type of abuse had a great impact on participants' self-esteem and confidence. Angel disclosed that she was the victim of sexual abuse by her mother. When she was a child, she was led to believe that it was acceptable for a mother to touch her child in that way. It was not until she was older and talked with her siblings that she truly understood the extent of abuse. Angel felt very confused and betrayed by her mother resulting in strain in their relationship and lack of contact. Neglectful behaviour by a parent was also something experienced. For instance, Martha was removed from her home as a child because her mother was doing an inadequate job of caring for her needs. Her father also left the family when she was young and these experiences caused her to feel alone and "forgotten" by key figures in her life. She said, the people "most important to me either left or got taken away," which highlights the sense of abandonment she felt and experienced.

Loss and grief. Participants shared the loss and grief they experienced in their childhood. Typically they spoke about the impact of losing a grandparent on their family, especially when the loss came suddenly. Lisa said her grandparents

were killed suddenly in a car accident when she was in Grade 7, and this had a traumatic impact on the family. Participants also experienced loss as the result of their parents separating or getting a divorce. The change of a parent moving out of the house and for some getting re-married created a re-adjustment period for them. Some spoke about the loss they felt by having a parent emotionally and physically absent in their life. When speaking of her father, Laura said, "He was always kind of absent, even though he was there." Other participants spoke about loss associated with the end of a significant friendship. For instance, Jessica used the phrase "Remembrance Day" to describe the birthday of a best friend she use to have. She said the start of every February began her "grieving period" as it reminded her of a friendship that once was and a relationship she greatly missed.

Physical and emotional health issues. Participants revealed that a stressor for them was the discovery that one of their parents or siblings was faced with physical ailment, emotional difficulty, or addiction issue. Fiza mentioned that her mother had a diagnosis of diabetes. She shared that her mother's condition would be stressful for her because her mother would not always follow the recommended diet, causing her to feeling worried about her mother's physical well-being. Laura talked about her father's diagnosis with cancer and how this inspired him to renew their relationship. Since her father was not "present" in her life until this point, it was too difficult for her to re-connect and consider his attempts for contact and time together.

Some participants also had mothers that struggled with periods of depression and anxiety in their childhood. Others had sisters that dealt with mental illness during their period of self-injury such as difficulties with inattention, depression, and anxiety. There also seemed to be a connection between the verbal abuse experienced in Angel's home and the eating disorders that evolved for her and two of her sisters. Non-suicidal self-injury and substance abuse were also among the issues documented.

Participants also had their own struggles with mental health issues, mainly anxiety and depression. Lisa said that when she reflects back on life she remembers how she began to "act out" as a child and describes this period as an

"explosion of emotions" and "very confusing." Many of these participants were not receiving treatment, counselling, or taking medication for their mental health issues until later on when the self-harm was discovered and alerted family members to some of their difficulties.

Lack of support. The majority of participants reported that they did not feel validated by their family members and friends in their emotional experiences. For example, Jessica stated that even when she had a letter from her psychiatrist about her diagnosis with obsessive-compulsive disorder and major depressive disorder, her mother would not believe it. She said her mother would make comments like, "This is not happening to you" and "You are just being a teenager." Jessica reported that her mother could not understand how she could go out with her friends and be social, if she was struggling with depressed mood. Jessica said she tried to take advantage of the days she felt more energetic and hopeful because she knew it was important to stay connected to her friends. She felt frustrated knowing that her mother would not believe her when she shared how she was feeling, particularly when she had a professional opinion to support her perspective. Jessica reported that it was more disappointing knowing her mother experienced depression herself and so should have been more empathetic.

Although initially some family members and friends expressed concern about participants' mental health issues, there was little follow-through of emotional support, questioning, or accompaniment to therapy. Katy said that although her parents initially responded in an appropriate way she did not feel supported as they did not ask about the effects of her medication or how therapy was going. In reference to their self-injury, the majority of participants felt that that their loved ones responded in a way that was unhelpful. For some, the behaviour was minimized and for others their experience was at the other end of the spectrum where the behaviour was met with intense concern, shock, horror, and/or judgment (e.g. "How could you do such a thing"?). Jill said that when she opened up to a close friend about her self-harm she was met with a "grotesque reaction." Her friend made her feel like she had no valid reasons to be distressed. She posed questions like, "What are your problems"? and "Why would you do

this to yourself"? Jill said this reaction made it impossible for her to open up to other people about her behaviour and forced her to be secretive with her self-harm. Participants reported that they often felt that their circumstances and behaviour was misunderstood by others.

Participants said that when there was a discussion about their behaviour and their emotional well-being it was because a parent or family member discovered that they were self-injuring. Otherwise, participants chose not to open up about their experience as they felt they did not have the type of relationship where intimate details of their life could be shared. For example, Stacey chose not to share about her struggles with stress, anxiety, eating issues, and self-harm because she was too worried about being viewed negatively. Rather, she journalled and wrote on her online blog, which allowed her to keep her anonymity.

Relationship stress and conflict. Participants disclosed that they had a tense or contentious relationship with at least one of their family members. These negative interactions and altercations were a large source of stress for them. Angel said that she started self-injuring in childhood because she thought the physical pain of the act would make her stronger to deal with the emotional pain caused by the relationship she had with her mother. Other participants, such as Laura and Martha reported having no relationship with a parent, either because they were physically or emotional absent. This "void" meant that they met their attachment and emotional needs through other means or other people in their life. Participants also reported feeling sensitive to conflict with a close friend or boyfriend/girlfriend and became quite distraught with the dissolution of a friendship or relationship. Katy said, "I don't know if it was immaturity or being a really emotional teenager or whatever but my cutting seemed to coincide with my boyfriends…when things went really wrong…that is when I felt deeply depressed and hopeless…like nobody cared about me."

Emotions

Emotional vulnerabilities. Emotional vulnerabilities and circumstances made participants more liable to turn to self-injurious behaviour later on in life.

The period of adolescence was a particularly vulnerable time because they placed a lot of importance on their peer and romantic relationships. Furthermore, it was the first time in their life when they felt intense and romantic feelings for another person, creating vulnerability and a greater likelihood for hurt feelings and upset in response to an altercation or dissolution of the relationship. Participants also described the tendency to experience intense and very strong emotions (e.g. a "bubbling") and an abruptness when their mood state would change ("from 0-100"). This period of high emotions could last hours and even weeks. It is during these times that they would be most vulnerable to "overreacting" to events such as failing a test. When describing her emotional experiences as a teenager, Lisa said, "everything would be peachy keen for three weeks and then I would have another breakdown and fall apart." She purported, "I would have a huge upthrust of emotions that it was hard to get rid of them all."

Emotional contradiction. Some participants also described how they were not as emotionally-minded and did not know how to identify their feelings and how to express them in a healthy way. Even with awareness as to how they were feeling, they chose not express themselves for various reasons. Many participants indicated they refrained from sharing because they believed that their friends or family members would not understand their perspective or experience, such as their struggles with low mood and depression. Katy said, "I would just bottle everything up." Others disclosed not expressing their feelings to avoid adding weight to an already stressful family circumstance. A number of participants withheld their feelings because the information had the potential to hurt another person's feelings and they did not want to feel guilty for hurting someone. They believed it was better to hold in the pain rather than create more pain for others. Several participants also spoke about "burying" their emotions so that they could be perceived as strong and act strong for others.

According to a few participants, this lack of expression would cause feelings to build up which led to the sensation of numbness or the opposite effect which was feeling overwhelmed. Katy said, "I felt disconnected from everything…really robotic." A continued feeling of numbness created the urge to self-injure as

feeling pain was better than feeling nothing at all. The sensation reminded them that they were "alive." Laura said that she was an emotional person so "turning off" that part of herself created consequences for her. She said her feelings compounded until she hit her "breaking point" and had to do something to "feel again." When participants felt overwhelmed by their emotions, they described this experience as an "explosion." Jill said for her, self-injury was a way to cope when she felt overwhelmed with feelings. She stated, "It was always in response to the anxiety and panic…and not knowing how to process the thoughts in my head or the feelings I was having." Participants said that common forms of coping, such a listening to music, did not work and so they needed to find other ways de-escalate. Participants said that self-harm behaviour was one of the few strategies that "matched" the intensity of their feelings and that provided relief from this experience. Jessica stated, I don't think anything has the same effects…which is why anybody who has done it will always be tempted by it."

Participants also used self-injury to maintain the image of "togetherness" and emotional strength. If they felt emotions coming to the surface or were about to cry they would engage in acts of self-harm as a way to distract themselves from the feelings they were experiencing. Typically participants would use milder forms of self-harm in these circumstances such as digging their fingernails into their palm. It gave them a physical sensation they could focus on other than the emotional reaction they were having. Again a contradiction exists because participants would use self-harm to feel and to not feel. Although self-injury allowed them to feel during times of numbness and emptiness, they did not like the idea of showing their emotions in front of others because this would be perceived as a sign of weakness.

Irrational thinking. On reflection, emotional reactivity was in part participants' perception of events. They highlighted their tendency towards the "irrational" and "black-and-white" thinking, which in turn contributed to a drastic shift in mood. For instance, "If I'm not perfect, then I must be a loser." Some participants said their interpretation of an event would start a cycle of negative thinking, often towards the self. They would dwell on the details of the event for

an extended period of time. Katy said, Maybe I messed things up with a boyfriend or maybe I wasn't doing well in school…or just that internal dialogue that I have…like negative comments toward myself. It built me up to wanting to punish myself somehow." Katy continued to say that there were so many things that set her off" and that it was not just one event that triggered her self-injury but rather it was her "being completely irrational about the event. This negative self-talk and self-loathing would lead to self-injury as a form of punishment. Some participants shared how they would personalize outcomes of events and interactions and thus would take full responsibility for things that happened. For example, if a conflict occurred between one of their friends they would believe that the fight was their fault and then would become angry towards themselves for causing upset and strain in a friendship. Fiza said, "I would often feel bad about what I was doing…and just how bad of a person I must be for having done something like that."

Relief. Participants reported that after the act of self-harm they often felt a rush of calmness or relief come over them. One participant described this period of calmness as lasting for an hour or more. A few participants also reported how they noticed an increase in positive mood or the experience of euphoria after the act of self-injuring as if it were a "natural high." Lisa claimed she loved "the endorphin rush…the high." She said, "You want it right now…the high…and the calm that washes over you makes you feel free. It can hurt in the moment but then after you are just…like lying on the beach."

Shame and Guilt. Although participants spoke about the relief and emotional gains they experienced following the act of self-harm, feelings of shame and guilt typically followed. These feelings came shortly after the act of self-injuring or when participants considered how they were perceived by others about what they were doing. Participants said they would cut or injure on a part of their body where they could conceal the injury or scars from others. Katy stated, "I did it mostly on my feet so I could hide it." They would also wear clothing such as long sleeve shirts and pants as a way to "cover up" the behaviour. Participants reported that they would even resort to denial and would lie to people if they were

asked about the cause of marks or scars. They felt ashamed by their behaviour and yet felt guilty for having to lie about it. Jessica said the scars of her arm reminded her of something she was "not proud doing." "I wear long sleeves more than I ever have because of the shame I feel…I tell most people I had a rash when I was little if they see my arm or ask about the scars."

Participants also felt guilt when their behaviour was discovered by a family member and they began to realize how their self-injury was creating stress and worry for their family. Laura reported that she felt extremely guilty when her mother discovered that she was cutting. She said her mother was worried for her and "would sit on her bed every night until she fell asleep" to make sure that she would not cut. Laura said, "To have that sort of reaction from a person was really upsetting for me…which made more upset and want to cut myself more cause it's like 'look what I am doing to people." She shared, "It made me disgusted with myself even more." A few participants also felt guilt and disappointment when they surrendered to their urges during a time when they were actively trying to reduce their self-injurious tendencies. This created a negative cycle since their guilt feelings about self-injuring often led them to injure again as a way to cope with the feelings.

Sense of Self

Participants joined in self-reflection and considered their way of thinking and perspective of themselves during their period of self-injury. They referenced having high expectations of themselves, a negative self-image, feeling hopeless, and identified themselves as a "self-injurer"/"cutter."

High expectations. Participants reported that they had very high expectations of themselves and some participants even aspired for perfection in what they did. They wanted to be perceived as the "good kid" as there were already stressors within the family such as a sibling who was dealing with mental health issues and so they did not want to add more stress to the family unit. Participants indicated that they would even withhold their feelings in an attempt to maintain this image and to appear strong. For example, Laura said her parents saw her as the "golden child" in comparison to her brother who would have

tantrums and was incorrigible. She worked hard to make her parents proud such as maintaining honor roll status. If she was upset with a family member she would withhold these feelings as she did not want to be perceived as difficult, like her brother. Participants especially did not want to share their struggles with mental health issues such as depression or anxiety because they believed it would conflict with the image their parents had of them and would create stress and worry. Jill said she did not want to tell her parents about her experience with anxiety because her parents were already overwhelmed by caring for her younger sister who was recently diagnosed with obsessive-compulsive disorder. Jessica described wearing a "mask" to conceal her true feelings. She reported that she found herself wearing more make-up and putting a lot of effort into her appearance so that no one would suspect that she was depressed. This meant using what emotional and mental energy she had to uphold the image others had of her.

Participants also had high expectations about the activities they were involved in and how well they did in these activities. Jill felt a lot of pressure because she was running competitively for the track team and yet was trying to do extremely well in school. Many participants spoke about the excessive pressure they put upon themselves when it came to school. They discussed incidences when they would self-injure in response to this pressure, stress, and when they did not perform as they would have liked on an assignment, test, or exam. Stacey said, "I think I set unrealistic goals for myself and I think that would fuel my perception of where I should be with my school work." She would work constantly on school assignments and stay up late to "perfect" what she was doing. However, this proved to be an ineffective strategy as she would be tired the next day, which would impact her focus and concentration. This would trigger a self-harm episode and she would hit herself as a way to regain focus.

Negative self-image. Negative and irrational thinking, particularly towards themselves, was a battle, particularly when participants believed they failed at something such as school or relationship. Therefore, a fight with a friend or getting a low mark on a test would automatically be interpreted as a failure. As mentioned, it was difficult for participants when they would not "measure up" to

the expectations they had of themselves. This type of thinking resulted in feelings of low self-worth, feelings of depression, and self-harm as a form of punishment. Participants indicated that once an event was perceived as a disappointment it would trigger negative thinking and self-loathing that it would result in a self-harm episode. For example, Lisa said that being involved in an emotionally and physically abusive relationship made her think negatively about herself. She viewed the abuse and the problems as her fault. When she felt anger her partner, it was internalized. Her self-injurious behavior at that time was the result of the anger and disdain she felt towards herself. Martha revealed that a marking and scar on her arm is to remind her that she is a person "who is hated" and that these feelings are mostly a "hate towards the self."

Hopelessness. Participants also spoke about experiencing a sense of hopelessness during their period of self-injury. For those who chose to open up to friends and family members about their experiences with stress, depression, anxiety, and self-injury felt disillusioned when they did not receive the validation and support they had hoped for. When it came to their self-injurious behavior they had one of two responses- either their actions were minimized or there was a negative and fearful reaction because of the stigma and often misperceptions attached to the behavior. "On one side I wanted to talk to someone about it [self-injury] because I did want help…but on the other hand, people were so upset by it. It was like you couldn't really talk to them about it. You just knew there would be an adverse reaction."

Participants also reported feeling hopeless during their struggles with depression and low self-esteem. Some revealed times when they were so overwhelmed and unable to see ways to improve their circumstances that they felt suicidal. It was not that they wanted to end their life but rather wanted to end the feelings they were having at the time. They used phrases such as "I was tired of feeling pain", "I wanted to escape for a while", and "I just needed to take a break from everything." It was particularly distressing when self-harm behaviours were ineffective in providing them with the relief they were looking for. Since it was one of the few ways they had to cope, their feelings of desperation and the desire

to die increased. Angel said, "There were times where no matter how many times I cut and no matter how deep I cut it [negative feeling] wouldn't go away…and so I would just keep doing it. Those were the times when it got bad." She continued to say, "It is supposed to be this thing that I could always turn to…and if that wasn't even helping then what was the point."

Although a clear distinction was made between self-harm as a way of coping as self-harm as a way of committing suicide, participants reported that when they were suicidal they were less concerned about lethal consequences of their self-harm. Paul said he switched from cutting on his legs to his arms because "it had the potential to draw more blood and it had the potential to be a little bit more dangerous for himself."

A few participants became addicted to their self-harm behavior and felt distressed or anxious if they were not able to participate in the act. Laura claimed, "I would have a panic attack if I did not cut before she went to school." Fiza said her cutting got to the point where she was doing it every day, even a couple of times a day for a period of four and a half years. Even when things were going well in her life, she would think about something that was negative from her past so she could do it again. Fiza purported, "You wanted to be able to do it….so you would put yourself in that kind of mood…and it kind of just made it happen again and again." This need to engage in NSSI added to their sense of hopelessness and despair. A behavior that provided participants with a sense of control of their emotions began to take control of them.

Identity. After habitual use of self-harm, participants began to develop an identity associated with their behaviour, or as some would say, a "self-injurer"/"cutter." What was interesting was the description they provided to fit with this identity and image. Participants said that there is often this perception of someone who self-injures; someone who is overly sensitive, dark, depressed, has tattoos and piercings, dresses a certain way and listens to punk or alternative music. They said that from their outside appearance and what people knew of them (e.g. good student), they would not suspect that they were cutting or self-injuring. Most reported that they were academically focused, ambitious, athletic,

and social. They blended in with their high school peers. However, participants found it difficult to manage their "inner world" and self-harm was something they did secretly to maintain balance. Jessica compared herself to a "functional alcoholic." She said, "People in my life didn't know. They still don't know and it is very much a secret. I still got good grades. I was still involved in sports. If I was walking down the street, I would think there was no way you could guess." Self-harm became a way to "self-medicate" as a way to deal with stress, conflict, isolation, difficult feelings, and mental health issues.

Function

Participants reflected on the reasons why they turned to self-injury and the function(s) the behavior served for them. Their reasons for self-injuring have been classified into four sub-themes: distraction/coping, punishment/self-hate, control, and behaviour management.

Distraction/coping. The most predominant reason participants' reported for their self-injury was to distract themselves from uncomfortable thoughts and feelings and to cope. Seven of the participants spoke about their struggles with mental health issues such as major depression, panic disorder, and obsessive-compulsive disorder that preceded their use of self-injury. Some turned to NSSI because they learned through friends or another source (e.g. boyfriend/girlfriend) it was an effective way to distract oneself from the racing and irrational thoughts and to manage the physical and emotional discomfort often associated with these disorders. "It appeared to work for them so I thought I would try it." Participants were able to distract themselves from their emotional state because the action of self-harm was quite consuming and because it allowed them to temporarily forget about their problem(s). Fiza said, "It was like a release…like things kind of fall away for a little bit because that was all you think about…Nobody can bother you when you are in your own little world and it is like everything around you…just disappears." The immediate pain from the injury also allowed them to focus on the physical aspect of their world rather than the emotional. For instance, Jill said that her body would start to feel out of control when she began to feel anxious. She would start to shake, could not think straight and would have disturbing

thoughts. Jill would bite her tongue or dig her nails into her palm as it gave her something else to focus on. Hurting oneself gave a focus and everything that felt stressful or overwhelming seemed nonexistent in that moment. Fiza reported, "Whatever is going on kind of just disappears and all that you're focusing on is literally the lines and how it drips…and it is all that you care about at that time." Even the pain from the wound the next following days (e.g. stinging) would serve as a distraction and as a reminder that "that" situation was dealt with. In describing the follow-up of a self-harm episode Jessica said, "The good feeling lasted a long time." "I was able to concentrate on the pain in my wrist all day instead of the ever present emotional pain in my mind."

Self-harm provided enough distraction during upset that it could prevent certain participants from crying. This was important at times when these participants did not want to become visibly upset in front of others, particularly family members. They did not want to create worry and more stress during already turbulent times. Participants also spoke about how the act of self-harm allowed him/her to feel physically strong, and thus emotionally strong. For instance, Angel said self-injury made her feel that if she could "deal with that pain" then she could "deal with anything else." She revealed, "It used to be a competition, like how long I could let the wax stay on my hand…that I could be 'that' strong."

The "be strong" and avoid feelings resulted in the experience of numbness. Participants reported that at these times self-injury was used to intentionally inflict pain as it was better than feeling nothing. This was a function for experiences of intense boredom, solitude, or aloneness. Martha said that at the time when she moved back to the group she was "cutting to kill time." She stated that she "was bored and wanted to feel…that feeling pain was better than feeling nothing." The act of self-harm also gave them something "to do" to cope with these feelings and other forms of distress. When participants felt alone, particularly after a fight with a friend or family member, they felt comforted in knowing that self-injury was something they could turn to that would make them feeling better. For some, it was used as a "last resort", knowing it could give them

the results if needed. Katy's self-harm behaviour became a complex ritual. Getting ready to cut, the action of cutting, and the clean-up gave her the "something" that she was looking for. This process helped to calm her down and made her feel better. Tending to wounds provided the nurturance some needed. As stated by Katy, "It was almost like a little kid that gets hurt and their mom takes care of them. I was hurting [emotionally] and so I was taking care of myself in a very physical manner."

Some self-harm behaviour was episodic in nature. It was triggered by stressors such as academic pressures, relationship difficulties, and conflict with a family member. Stress would result in a buildup of feelings and tension and the act of self-harm would provide a "release" from these feelings. Stacey said she would feel this tension under their skin and compared it to an itch that needed to be scratched. It was during these times that the idea to scratch or cut would take precedence.

For participants who engaged in cutting behaviour or interfered with wound healing, this "release" was symbolized by seeing blood and by watching the blood (and "emotions") leave the body. Bleeding seemed "purposeful" and the greater the amount of blood the greater the release and expression. Others viewed blood as a connection to strength and control. Jessica sad, "I liked how the blood would pour slowly out of me…colouring my skin in such a controlled way. I liked how blood was predictable and how it was something in my life I did not have to plan or feel anxious about. The blood acted in the exact way I wanted every time."

Not only did self-injury provide relief from negative thoughts and emotional distress but it also created positive feelings such as calmness and euphoria. Some participants described the after-effect as a "high" and that they became "addicted" to their self-injurious behaviour. It progressed to the point that they were self-harming on a regular basis. Jessica said her self-harm got to the point she was doing it "15 times a day." "It was like an urge…that I had to do it" and "it was so hard to stop."

Participants reported that self-injury, usually hitting, also resulted in improved focus and concentration. Self-harm was a behaviour that became negatively and positively reinforcing.

Punishment/self-hate. As mentioned earlier, participants would self-injure to punish themselves for not performing the way they would have liked or meeting certain expectations they had for themselves. Participants would also turn to self-injury if they felt they had hurt someone in some way. These types of events often led to negative thinking towards the self and thus, self-injuring as a form of punishment. This tendency towards negative thinking, coupled with depressive symptoms, often led to feelings of self-loathing and a cycle of self-injury.

Need for control. Control was reported an important function of self-injury. Most described how emotional events and negative emotional states caused them to feel out of control and how self-injury was something they could do during these times to create a sense of control. Jill said, "If I can't change what I'm thinking right now, which is really disturbing and I can't change what I am feeling right now, which is really disturbing so, I want to be able to do something…" Self-injurious behaviour was something predictable because it provided a similar effect each time, which was comforting, especially in an emotional crisis. Self-injury was a way to "contain feelings" and make them "neat and tidy so that no one would have to deal with them." It also allowed participants to create the feelings that they wanted to feel, whether it be pain, relief, or a sense of calm.

Behaviour management. Another rationale for why participants self-injured was to manage and reduce other behaviours in their life. The two behaviours that were highlighted by participants were smoking and over-eating. Based on the accounts that were provided, it appeared that self-harm acted as a form of positive punishment: A noxious stimuli was added followed by a reduction in behaviour. Therefore, the pain and effects of self-harm (e.g. stinging sensation) prevented two participants from engaging in these behaviours they were trying to move away from. There appeared to be success in this method and

the target behaviour was reduced. In terms of smoking, the pain from the burn was aversive and so it reduced the amount Silas indulged in a cigarette. For the reduction of food and caloric intake, the “stinging” from the effects of a cut became a reminder for Fiza not to eat. The irony about this method is that participants engaged in a “negative” behaviour in order to reduce or stop what they viewed as a less desirable behaviour. Over continued use, the self-harm behaviour took on more reinforcing qualities such as a release in tension and improvement in mood.

CHAPTER VI: DISCUSSION

The purpose of this final chapter is to provide a summary of the study and themes discussed in Chapter Five. This section will also look at how these findings fit within the current literature and will also highlight a new finding. Strengths and considerations of the study, application of findings, and recommendations for future studies are also included.

Summary of the Study

This study provided an in-depth look at self-harm from the perspective of those who have self-injured. Eleven participants were interviewed on two separate occasions about their experiences of non-suicidal self-injury (NSSI). The aim was to generate stories that illustrated how participants began self-injuring and the progression of the behaviour. Additionally, content areas were extracted across participants' stories and then reviewed to determine commonalities and to generate core theme areas. A description of each core theme area, sub-themes and examples was provided.

Themes and Links to Research Findings

Adverse circumstances in childhood and adolescence. Participants consistently made reference to the adverse circumstances they were struggling with prior to and during their engagement with NSSI and the impact it had on the behaviour. Findings from both clinical and community samples support the role of adverse childhood experiences in the aetiology of NSSI (e.g. Kaess et al., 2012). Cerenutti and his colleagues (2010) found an association between NSSI and specific life stressors such as childhood sexual abuse and the loss of someone important. The experiences of childhood sexual abuse, physical abuse, emotional abuse, and neglect had an effect on emotional well-being and decision to self-harm. Other researchers have found an association between parental criticism, emotional abuse, childhood sexual abuse, physical abuse, and neglect and self-injurious behaviour later in life (Boxer, 2010; Fliege, Lee, Grimm, & Klapp, 2009; Gratz, 2003; Gratz, Conrad, & Roemer, 2002; Weidig & Nock, 2007;Yates, Carlson, & Egeland, 2008; Yates, Tracy, & Luthar, 2008).

As found in previous studies, grief and types of loss are associated with NSSI. Results from a longitudinal study shows that risk from NSSI is greater for children of separated or divorced parents (Beautrais, 2000). Madge and her colleagues (2011) discovered associations between the reporting of a stressful life event and self-harm history in the past year. Participants that experienced the death of someone close engaged in episodes of NSSI. Naughton (2013) supports the finding that self-harm can follow a significant trauma such as bereavement. Grenklo and his colleagues (2013) discovered that youth that lost a parent to cancer were twice at risk for self-injuring that their non-bereaved peers.

Individuals in the present study experienced family stressors such as having a family member diagnosed with a physical ailment. Madge et al. (2011) discovered that serious illness of a family member or friend was also considered a significant life event and found 69.8% of participants reported one episode of self-harm in past year and 75.5% reported multiple episodes of NSSI in past year. Hankin and Abela (2011) discovered that individuals that participated in self-injury had mothers that were diagnosed with depression. It is believed that children of mothers with depression begin to experience depressive symptoms themselves and self-injure as a way to cope with low mood (Hankin & Abela). Emotional health difficulties were faced by all, particularly anxiety and depression (Jacobson, Muehlenkamp, Miller, & Turner, 2008; Moran et al., 2010).

Lack of support has also been documented as a contributing factor for NSSI by Sinclair and Green (2005). Participants in this study reported that their parents failed to validate their circumstances, recalling that they were "not heard" or that their story was considered unimportant. Swales (N.D.) claims that lack of support is the meditating factor between risk factors such as abuse, loss, and mental health issues, and NSSI. Thus, if an individual's emotional response to a distressing event is not validated or acknowledged, this will result in a sense of powerlessness and the incapacity to understand and manage difficult feelings. Furthermore, mental health issues will go undetected and unsupported. Researchers have found a link between low levels of perceived social support from caregivers and friends and NSSI (Hankin & Abela, 2011; Heath, Ross,

Toste, Charlebois, & Nedecheva, 2009; Muehlenkamp, Brausch, Quigley, & Whitlock, 2012). Poor attachment to caregivers has been documented by individuals who self-injure (Bureau et al., 2010; Crowell et al., 2008), which could account for why some participants in the present study did not feel comfortable opening up to their parents about their concerns. McDonald, O'Brien and Jackson (2008) found that although parents expressed interest in how to understand self-harm in their child and the best course of action to take, they also encountered difficulties in combating the negative emotional effects for themselves and others in the family.

Consistent with the results of this study, interpersonal situations and stress are of high relevance for individuals that engage in NSSI (Hawton and Harriss, 2008; Hilt et al., 2008), including difficulties in familial relationships (Byrne et al., 2008; Hawton et al., 2003; McDonald et al., 2007), and poor relationships with friends and partners (Dimmock, Grieves, & Place, 2008; Hawton et al., 2003). Vonderlin and his colleagues (2011) found that adolescents who participate in NSSI, compared to the control group, report greater problems with family members and peers. Adrian et al. (2011) discovered that family relational problems had a direct association to NSSI, whereas peer relational problems were indirectly related through emotional dysregulation. Factors such as abuse, mental health difficulties, and relationship stress have an indirect relationship to NSSI through emotional dysregulation (Hilt et al., 2008; Linehan, 1993) and the lack of support (Swales, N.D.) to manage the intensity of these difficulties.

Emotions. In describing their emotional experiences it became apparent that there were vulnerabilities that contributed to participants' self-harm behaviour. Participants made reference to how they were "sensitive" and were quick to personalize the outcome of an event, ruminate about the details, and/or experience an intense emotional response. Linehan (1993) has labelled this vulnerability as emotion dysregulation and hypothesizes that it consists of greater emotional sensitivity (low threshold for recognition of or response to emotional stimuli) (e.g. Domes, Schulze, & Herpetz, 2009), greater emotional reactivity (increased amygdala activity (Donegan et al., 2003; Herpertz et al., 2001), and a

slower return to baseline arousal (Stiglmayr et al., 2005). Linehan believes that individuals have difficulty regulating their emotions due to their biological disposition and growing up in an invalidating environment. An invalidating environment is defined as one in which a person's emotional experiences are not responded to in an appropriate or consistent manner. Such an environment does not allow individuals to learn how to regulate intense emotions in an adaptive way and trust their own experiences as valid and real. Thus, these individuals rely on short-term, impulsive strategies to restore emotions to a tolerable level.

An emotional contradiction was revealed in participants' accounts. Difficulty expressing feelings resulted in feelings of numbness or being overwhelmed by their emotions. Several studies have indicated that individuals who engage in NSSI are not able to perceive their feelings at all, or sometimes they perceive them much too strongly and aversively (Nock & Mendes, 2008; Stiglmayr et al., 2005). Zetterqvist and his colleagues (2013) fount that 45.6% of their participants reported engaging in NSSI to stop feeling numb or empty. Thirty-eight percent of the sample indicated that self-harm allowed them to "feel something even if it is pain." Other researchers report that individuals with a trauma history and a tendency to dissociate will use NSSI as a grounding technique and to bring them back to a state of reality (Nock & Prinstein, 2004, 2005; Penn, Esposito, Schaeffer, Fritz, & Spirito, 2003).

When individuals experience intense emotions associated with high arousal, both appear to increase rapidly and can be reduced only by extreme measures such as NSSI (Nock & Mendes, 2008). Muehlenkamp et al. (2013) found that the most common reason endorsed for engaging in NSSI involved managing aversive internal states such as coping with uncomfortable feelings. Although individuals who withhold their feelings over time can go on to experience either numbness or a flooding of emotions, it is unclear in the literature what may cause them to end up on one end of the spectrum versus the other.

High emotional states were accompanied by a magnitude of aversive thoughts, which in turn would intensify and maintain undesirable feeling states.

Najmi, Wegner, and Nock (2007) discovered that participants engaged in NSSI as a way to suppress these aversive and unwanted thoughts. They claim that thought suppression mediated the relationship between emotional reactivity and the frequency of NSSI. Furthermore, participants with a higher tendency to suppress unwanted thoughts reported engaging in NSSI to reduce aversive emotions (e.g. "to stop the bad feelings). Nock and Prinstein (2004, 2005) discovered that self-harm for the purpose of affect regulation manages both aversive feelings and thoughts.

Results from this study confirm the model that high negative arousal states such as anxiety and tension precede the act of self-harm and a reduction in these negative affect states and a sense of relief follows (Armey, Crowther, & Miller, 2011; Champman & Dixon-Gordon, 2007; Klonsky & Muehlenkamp, 2007; Muehlenkamp et al., 2009; Nock et al., 2009).

Consistent with the findings of Klonsky (2007), Nixon et al. (2002), and Suyemoto (1998), participants reported that the relief produced by self-harm was temporary and was followed by feelings of guilt and shame. Gratz (2006) indicated that the likelihood of self-injury may be exacerbated by feelings of guilt, shame, and isolation that results from NSSI. He goes on to say that the individual may be trapped in a painful cycle of negative emotional arousal and self-injury.

Sense of self. The finding that school stress, a high commitment to extra-curricular activities, and a driving sense of perfectionism associated with self-injurious behaviour can be compared to the findings of Adler and Adler (2007). Sax (2010) has found this trend in female participants. Female self-injurers tend to set high expectations, particularly when it comes to academic and social goals. Flett, Goldstein, Hewitt, and Wekerle (2012) also found that among women, NSSI was associated with dimensions of trait perfectionism such as parental criticism and social prescribed perfectionism. Manger (2011) claims that the attitude of young girls today is that self-harm is a normal way of managing stress and pressures.

Negative thinking created the urge to self-injure, typically for the purpose of self-punishment. A recent study demonstrated that negative cognitive style

differentiates youth who engaged in self-injurious behaviour from those who did not (Hankin & Abela, 2011) and predicted NSSI at a two and-a-half year follow-up (Hankin & Abela). High levels of criticism and negative self-concept have been observed in people who self-injure (Adams et al., 2005; Chapman & Dixon-Gordon, 2007; Glassman et al., 2007; Sim, Adrian, Zeman, Cassano, & Friedrich, 2009). It is possible that this negative thinking style is a symptom a depression because of the strong link found between self-harm and depression (e.g. Guertin, Lloyd-Richardson, Spirito Donaldson, & Boergers, 2001).

A sense of hopelessness also became a part of self-injury. Participants began to feel isolated from their family and friends because they could not open up to their loved ones and were secretive with their self-harm behaviour. When family and friends became aware of their distress, they did not validate these concerns or provide support. In Sinclair and Green (2005), participants also highlighted the relationship between feelings of isolation, despair, and hopelessness.

They also felt hopeless about their ability to manage their self-harm behaviour. Comparable to findings by Lewis, Rodham, Gavin and Denis (2011), some became addicted to their self-harm behaviour. They started to feel desperate when they began losing control of the behaviour as self-harm initially was a way for them to gain control of their feelings. There is accumulating evidence that self-harm may have addictive properties for some individuals (e.g., Nixon et al., 2002) and the more individuals try this behaviour, the more they may be at risk for repetitive self-injury.

Disillusionment occurred when self-harm did not provide relief from emotional distress. Taliferro and his colleagues (2012) found hopelessness to be a factor that differentiated the NSSI group from the control and constituted the leading factor to increase the likelihood that youth who self-injured also attempted suicide at some point in their lifetime. Another group of researchers indicate that there is a 30-fold increased risk for completed suicide in individuals that self-harm compared to those that do not self-harm (Cooper, Kapur, Webb, Lawlor, Guthrie, & Mackway-Jones, (2007).

Self-harm allowed participants to manage their stress and feelings so that they could preserve their secret of how they were feeling on the inside. To outsiders, it may be surprising to learn that they were a "self-injurer" as they were able to maintain good grades in school, participate in extracurricular activities, maintain social relationships, and be emotionally strong for their loved ones. Yates et al. (2008) discovered that 1/3 of their participants, who were children of of highly educated white-collar professionals reported engaging in NSSI during the previous year. These rates are higher than those observed in most other school settings (e.g. Laye-Gindhu & Schonert-Reichl, 2005; Muehlenkamp & Guttierez, 2004; Ross & Heath, 2002). Luther and Becker (2002) believe this higher prevalence rate is the result of increased pressure to contain their emotions and achieve at superior levels.

Sax (2010) reported that this description of a self-injurer is true for females rather than males. He states that it would be unlikely to see a male youth self-injure if he is captain of the football team, popular, and doing well for himself. It would be more typical to see in a boy who is feeling ostracized and isolated from his peers and family. However, it would be very likely to see self-injury in a girl who is captain of the basketball team, popular, and doing very well is school. Sax purports this is because the female self-injurer has not been living, but rather performing and so this comes with a lot of expectations, stress and pressures. This hypothesis appears to fit with the majority of female participants in the present study, especially the account of Jessica who described having two selves- Real Jessica, how she truly felt inside and Super Jessica, the façade she put forth to maintain her image of a high achieving, award winning student of an International Baccalaureate (IB) program.

Function. The most notable function for NSSI was to distract and cope with difficult feelings. Many researchers propose that NSSI can be regarded as a response to managing or inhibiting aversive emotions, thus representing a maladpative emotion regulation strategy (Klonsky, 2009; In-Albon, Burli, Ruf, & Schmid, 2013; Nixon et al., 2002). Klonsky (2007) purports that the affection

regulation model has gained the most empirical support, both in adolescent and adult populations.

Self-harm as a form of punishment occurred because participants experienced negative thoughts and feelings about something they did or did not do. Zetterqvist and his colleagues (2013) indicate that participants listed, "to punish yourself" as one of the main reasons for self-injury. Thus, it is not surprising that "hit yourself" was the second common method used to self-injure by participants in their study, after biting yourself. Other researchers have reported that punishment and self-hate are main reasons behind why participants engaged in self-injury (Chapman & Dixon-Gordon, 2007; Klonksy & Muehlenkamp, 2007; Muehlenkamp et al., 2013; Swannell et al., 2008). For individuals with an abuse history, Glassman and his colleagues (2007) purport this self-punishment may be the re-enactment of repeated abuse or criticism experienced. These researchers have found that the relationship between childhood abuse and NSSI is mediated by adolescent self-criticism. Klonsky (2009) found that participants endorsed both affect regulation and self-punishment as reasons for self-injury; although were more likely to consider self-punishment as a secondary reason for NSSI.

Participants in the present study reported that self-harm behaviour also provided them with a sense of control when other aspects of their life seemed out of control. Laye-Gindhu and Schonert- Reichl (2005) and Gratz (2000, 2006) support this function.

Unique Finding to This Study

Although research has demonstrated that adolescents who engage in NSSI may be more likely to smoke cigarettes (Matsumoto & Imamura, 2008) and engage in maladaptive eating behaviours (Hilt et al., 2008) no known research has highlighted or investigated self-harm as a form of behaviour management and modification. A unique finding to this study was that two participants reported that they engaged in self-harm as a way to manage less desirable behaviours such as smoking. They believed that the pain associated with the self-injury would serve as a reminder and deterrent to not engage in the target behaviour, which

demonstrated to be successful. Over time, the function of self-harm evolved from behaviour management to affect regulation as it took on more reinforcing qualities such as improvement in mood. It could be that in other research studies, participants reflected on primary reasons for engaging in the behaviour (e.g. affect regulation), and may not have considered other reasons that initially led them to self-harm in the first place.

Strengths and Limitations

This study is part of a trend in the last decade to investigate NSSI in community-based populations. The strength of a qualitative research study is that it provides an in-depth analysis and understanding of a topic of interest. I stayed as close to the research data as possible as a way to respect each participant's experience and story of non-suicidal self-injury. Given this was an exploratory study loose parameters were used in sample selection criteria. Fortunately this provided an opportunity for a diverse sample to be accessed. Of the eleven participants that were interviewed, two participants were male, two participants cited strong religious upbringings (Mormon, Muslim), some participants had diverse ethnic backgrounds, and many of the participants had attended either college or university at some time in their life. This diversity contributed to the uniqueness highlighted in participants' stories.

There were also some challenges with conducting this type of study. Protecting the identities of participants was a concern and therefore, I had to limit or alter what was shared in terms of family background and details about participants' personal lives (e.g. place of employment). I also had to create pseudonyms for participants and the people in their lives. Although advertising of the study was conducted through a variety of means, there was a sample selection bias in that only participants who volunteered were interviewed. Thus, there may be a difference between those participants who participate in research and those that do not. For instance, many of the participants who volunteered were students attending college or university and thus may have understood and appreciated the importance of research in an academic setting.

Application of Findings

This study provides insight into the perspective of participants regarding the progression of their self-harm behaviour. It provides an in-depth understanding of the experience of self-harm, as well as how the behaviour can start, progress, and end. Since external influences such as learning about NSSI through peers was a large reason why individuals turned to self-harm in the first place, prevention initiatives should consider these factors. Muehlenkamp et al. (2013) suggest a program that fosters a culture among peers that emphasizes adaptive ways to build intimacy so that it distracts from the social bonding allure of NSSI. Public awareness campaigns can be another avenue to prevent individuals from participating in NSSI. Since public awareness forums run the risk of providing vulnerable youth with the "idea" of self-injury, resources and campaigns should provide limited information regarding the act (e.g. tools, methods) and benefits of self-harm. Instead, the consequences of NSSI and alternatives to the behaviour should be highlighted.

Most participants in the present study reported having difficulty with identifying emotional states or expressing their feelings to others. Consequently, they would experience a "build up" and then an "explosion" of emotions. They reported feeling overwhelmed and lacked the skills to cope with the feelings they would experience. Some were brought up in an environment where feelings were not expressed or avoided and so when faced with those emotions they were often at a loss. This experience is not limited to the participants in this study, and is likely common among many children and adolescents who are not taught healthy ways to address the problems they face or the emotions they are struggling with. Since parents or guardians may not always be the best resource for modeling these skills, it would be beneficial to provide an early intervention program in the elementary schools or junior high schools. A program could look similar to the health education programs in that an outside professional could come in present on various topics for a certain number of weekly sessions. Students would benefit from psycho-education on feeling identification and expression, healthy coping strategies such as journaling and relaxation, problem-solving skills, mental health

awareness, and resources for students who are struggling with mental health issues.

Socio-emotional programs such as MindUP and Zones of Regulation are becoming more popular in school systems and teachers and school counsellors are being trained in how to implement these programs to students. Not only are teachers and parents seeing the benefits in being able to manage emotions and social relationships but this programming in having a positive impact on children's academic performance (e.g. Kuypers, 2011). Muehlenkamp, Walsh, and McDade (2010) developed and investigated the efficacy of the Signs of Self-Injury program, aimed at reducing NSSI in adolescents. This is the first known NSSI school-based prevention program for adolescents that attempts to increase knowledge, improve help-seeking attitudes, and behaviours, and decrease acts of NSSI.

One intention for conducting this study was to better understand the phenomenon of NSSI and how best to support those that are self-harming and clinically, the most effective way to work with clients that are self-injuring. In my clinical practice, I have often heard colleagues express a lack of knowledge, experience, and training when it comes to working with individuals that are self-injuring. Some mention a discomfort because of their uncertainty as to whether they should refer a client who is self-injuring to another professional. The need for public awareness campaigns and training of professionals regarding NSSI is supported from a self-injurers' perspective. There has been as expansion in professional development opportunities and resources (books, journals) available on this topic that professionals can access.

Suggestions by participants included the need for more advertisements, leaflets about mental health organizations the resources they offer, and talks by helping organizations. Parents would also benefit from understanding the complexities of self-harm and how to access treatment for their child. One idea would be for helping organizations to offer information sessions for parents. Based on the current literature and through feedback by participants, public awareness campaigns would not only be effective at informing the public on the

topic of self-harm but it could help to reduce the stigma associated with the behaviour, and possibly the prevalence of self-harm. Raymond (2012) found that individuals who were exposed to information about NSSI in a classroom setting held fewer stigmatizing attitudes towards NSSI.

A common theme throughout participants' accounts was that it would have been easier for them to open up about their self-harm behaviour and access support, if they were responded to in a way that was open and non-judgmental. This information is important for clinicians to keep in mind if they have a client disclose a history of self-injury. In this circumstance, it would be beneficial to proceed with a curious stance and inquire in a respectful manner why they have participated in the behaviour and the function it serves for them as it could inform alternative coping strategies and treatment. During the interview process, participants in this study also shared recommendations of what they thought would be helpful for those who are self-injuring based on their own experiences with self-harm. As one way to disseminate the results of this study, a user-friendly self-help booklet will be created based on these recommendations to be made available to clinicians, individuals that are self-injuring, and the general public. When I began the research for this study, there were limited books and resources on the topic of self-harm. An interest in doing a narrative research study was that it lent itself naturally to writing and publishing a book in this area. My hope is to write a book that can appeal to both clinicians and individuals who would like to better understand the behaviour and ways to overcome it. Most books that have been written on the topic of self-harm have been written from the perspective of researchers and clinicians. Although there have been books written from the perspective on a self-injurer (e.g. autobiography) this may be one of the first to share multiple voices. Another way share this information with a larger audience, particularly an adolescent population would be to publish these stories via an Internet forum.

Recommendations for Future Studies

Since this was an exploratory study, future research could look at conducting quantitative studies on some of the themes and findings that were

discovered to determine if they could be replicated. It would be interesting to see if the emotional process revealed by participants could be determined with a greater number of participants, especially emotional contradiction. Future studies could also test a hypothesis for why such a contradiction exists. Why would some individuals start to feel numb after suppressing feelings whereas others perceive a build up? Another thought-provoking study would be to investigate whether the different sensitivities of the nervous system highlighted by Stuart Shanker in his work on self-regulation plays a role in NSSI. For instance, an individual with a hypo-sensitive nervous system may turn to extreme forms of stimulation such as self-harm to recalibrate the nervous system whereas someone with a hyper-sensitive nervous system could fit the description of someone with self-regulation deficits and thus turns to NSSI for this reason.

Individuals with a history of self-harm were chosen for the present study to understand their perspective of self-injurious behaviour and what would be helping in addressing this issue from a clinical perspective. Future studies could also be designed to interview clinicians about their experiences on working with self-injuring clients. Their clinical expertise may be able to shed light on some important aspects of recovery that have not been addressed in the research. It would also be valuable to investigate the effectiveness of initiatives and projects aimed to reduce self-injurious behaviour in adolescents and young adults. For instance, The Butterfly Project (http://butterfly-project.tumblr.com/), is an initiative that provides a way for individuals to move away from their self-harm behaviour and instructions of what to do when an urge to self-injure arises. The author recommends taking a marker or pen and drawing a butterfly on the space where self-harm typically occurs. Another suggestion is to name the butterfly after a loved one or someone that wants the individual to get better. The butterfly was selected by the author as a symbol of transformation, growth, and hope. Individuals are also asked to post photographs of their butterfly as a way to inspire hope in others that are requiring support to reduce their behaviour. Although I have heard about the effectiveness of this strategy in my clinical

practice, there is value to investigating the efficacy of such an approach for individuals that self-injure.

Conclusion

The present study has contributed to the qualitative research on self-injurious behaviour. It is a narrative research study to look at how an individual begins engaging in self-harm behaviour, how the behaviour progresses, and attempts to move away from the behaviour. This study documents the complexities of NSSI because individuals who are self-injuring want to be able to open up about their behaviour and other circumstances in their life but can only do so in an environment and relationship where they know they will be listened to, heard, and not judged. Individuals that are self-injuring want a chance to share their perspective and secrecy and shame only come when that hope and request is denied by others. An intention of this study was to de-mystify self-harm behaviour so that friends, family members, and professionals can better understand the phenomenon, provide a sense of empathy and compassionate, and be a positive support to individuals they may know are self-harming.

POSTSCRIPT

From the outset of this research I felt I needed to select a method of inquiry that honored the experience of my participants. A narrative approach was the most suitable choice as it allowed participants' untold stories to be shared. This research was the opportunity many had been hoping for, as prior attempts to tell their story was met with minimization, judgment, and criticism. I wanted to keep participants' ownership of their stories intact so that their words were kept alive. However, I also had an obligation to the university and academic community to make a sense of the data and stories provided. This tension was addressed my conducting a paradigmatic analysis across participants' stories so that insights could be provided regarding themes that emerged in the data.

I felt fortunate be able to stay in contact with my research participants after our final interviews together. When I emailed participants with a version of their story to comment on, many responded with an update regarding how they were doing and what they had been up to. "Stacey" shared that she had not scratched since we spoke and suggested that sharing her story might have contributed to that change. She also said being in stable relationship, reconciling with her best friend, and having a positive experience at internship were other contributors. Jill completed her Ph.D. in Scotland and is now teaching at a university. She shared how valuable it was to read over her own story. Jill continued in saying that although she reflects on her past, it is more powerful to read about it in a sequential narrative. In my most recent correspondence with "Angel", she had not self-harmed in a year and a half. She said that moving to a new city and living with her sister was the best change she could have made. "Angel" said was in a happy relationship and was engaged. She declared that participating in the research helped her because it gave her the opportunity to examine what happened in the past and then leave it behind. Angel revealed although she rarely speaks to her mother, it was never "because of the past" and more about "what she is still doing." In my last contact with "Lisa" she said she was keeping busy starting her own business. "Martha" reported that although it was difficult to read her story, she felt is brought her closure. Even though this

study has come to an end, I will be happy to present participants with a final copy of the document and hopefully will hear back from them with comments, feedback, and perhaps additional updates.

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APPENDIX A

Advertisement

UNIVERSITY OF ALBERTA RESEARCH STUDY:

Looking for young adults (between the ages of 18 to 30) who:

- Engaged in self-harm behaviour (e.g. cutting) when they were between the ages of 14 to 24 AND
- Engaged or are currently engaging in self-harm behaviour on a recurrent basis.

I am conducting interviews as part of my graduate research to learn the stories about individuals began engaging in deliberate self-harm and to understand the stories of how it continued or persisted. All interviews will be confidential. Being in this study would involve two face-to-face audio-taped interviews in which I will invite you to "tell your story." You will then be able to read this story and talk about it further.
If you would like to talk about your experience, please contact Mandy at:
myork@ualberta.ca or phone (provide office number at university here once assigned)

This project has been reviewed and approved by the University of Alberta HREB.

APPENDIX B

Poster

RESEARCH STUDY

Understanding self-injury from the view of those who have experienced it

Are you between the ages of 18-30?

Have you engaged in self-harm actions (e.g. cutting) when you were between the ages of 14 to 24?

Have you engaged in self-harm actions on a recurrent basis (more than one occasion)?

I am a doctoral student in Counselling Psychology at the University of Alberta. I am interested in learning more about the experience of deliberate self-harm from the perspective of young adults. I will be conducting interviews to learn the stories about how individuals began engaging in self-injurious activity and the stories about how the activity continued or persisted. Participation in this study will involve two face-to-face audio-taped interviews in which I will invite you to "tell your story." You will then be able to read this story and talk about it further.

If you feel that you would be appropriate for this study and would be willing to talk about your experience, please contact Mandy at: myork@ualberta.ca.

This research project has been reviewed and approved by the University of Alberta HREB.

Adolescent Study
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APPENDIX C

E-mail Script

My name is Mandy York and I am a Graduate Student in the Counselling Psychology program at the University of Alberta. I am conducting this research as part of my Ph.D. dissertation. The purpose of this study is to explore the perspective of young adults regarding their experience with the onset and persistence of self-harm behaviour.

I am conducting interviews to learn the stories of how an individual begins or chooses to engage in deliberate self-harm. I am also interested in the story of how an individual continues to engage in the behaviour. This study would require that we meet for a face-to-face interview, with the likelihood of a second interview to gather additional information.

Inclusion Criteria:

1. Have you ever engaged in self-harm behaviour?

* Deliberate self-harm is when you purposely inflict harm on yourself without the desire to end your life. The impact of this harm is also noticeable immediately.

2. Are you between the ages of 18-30?

3. Did you engage in this behaviour when you were between the ages of fourteen and twenty-four?

4. Did you engage in this behaviour on a recurrent basis (more than one occasion)?

5. I am interested in understanding self-harm from an individual's experience and am looking for participants who are willing and able to talk in depth about their experience. Does this sound like a study you would like to become involved in?

Additional Questions:

1. What day(s) and time(s) would be best for you to arrange the initial interview?
2. Do you have a place in mind that is mutually convenient to conduct an initial interview?

Thank-you for your time and I look forward to meeting with you soon. If you have any additional questions or need to reschedule the interview, my contact number is:

APPENDIX D

Consent Form

Reading between the lines: The stories of young adults experience with the onset and persistence of deliberate self-harm behaviour.

Principal Investigator: Mandy York, Graduate Student

My name is Mandy York and I am a Graduate Student in the Counselling Psychology program at the University of Alberta. I am conducting this research as part of my Ph.D. program. The aim of this study is to learn about the experience of deliberate self-harm from a young adults' perspective. Limited research exists on adolescents and adults in the community that self-harm. I am interested in how individuals start participating in self-harm behaviour. Furthermore, I am also curious about the stories of how an individual continues to engage in the behaviour. I am asking young adults to participate in two private interviews. The first interview will ask you to tell your story about deliberate self-harm. The second interview will be to gather additional information regarding your story. Each interview should last approximately one to two hours. After the second interview, I will provide you with a written version of the story and you will have the opportunity to provide comments and suggest any changes you would like to make.

Your participation is entirely voluntary, and you may withdraw your consent to participate at any time, without penalty. You can refuse to participate in any aspect of the study and choose not to answer questions you do not wish to answer. Some participants may find it difficult to share their story or have their story re-told. Please let me know if this occurs or if you find this process to be too overwhelming for you emotionally. We can discuss options such as connecting you to support services, or discontinuing your participation in the study. Each interview will be audio-taped, transcribed. This will ensure that the information you provide is well documented and will assist in the collection and analysis of the data. You will also be given a pseudonym (fake name) so that your identity

remains anonymous and confidential. Any other information that could reveal your identity within the community will be altered. The audio-tapes and transcribed interviews will be stored in a locked office. The audio-tape which contains information from your interview sessions will be destroyed upon five years of completion of this research study.

Any questions may be directed to me at the addresses provided below, or to my supervisor, Dr. Robin Everall at (780) 492-1163. There are no known benefits to you associated with your participation in this research, however, your participation, if you choose, is greatly appreciated.

Contact Information
Mandy York
c/o Department of Educational Psychology
University of Alberta
Edmonton, Alberta T6G 2G5
Mandy York: myork@ualberta.ca Dr. Robin Everall: reverall@ualberta.ca

Consent:

Consent:

I acknowledge that I have read and understand the above information, the description of the research and the nature of the procedures. I have been given an opportunity to ask questions as well as have questions answered. By signing, I am indicating free consent to participate in this research.

Name of Participant (please print):

_____

Signature: ____-

_____

Date: _____

"The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Chair of the EEA REB at (780) 492-3751.

APPENDIX E

Interview Guide

The first interview will be unstructured. I will start with a "grand tour question, "tell me about yourself and then, tell me about your experiences with self-harm." I will allow the participant to control the interview, as I want to hear their story as they construct it. However, below are some questions related to some specific areas that I will probe for at the end of the first, or second interview.

1. Tell me about your experiences with self harm.

2. Tell me what you mean and understand by self harm?

3. Can you tell me the story of how it all started? Probe for context, relationships, etc.

4. Can you tell me stories about why you continued/how it helped or became part of your life?

5. Tell me about the last time you self harmed. Probe for similarities and differences between first time and most recent time?

6. Can you tell me a story about how doing this really helped you? How did it help you? How did it make you feel?

7. If still self-injuring- Have you made any attempts to stop self-injuring? If they have stopped, ask how have you managed to move away from engaging in the behaviour?

8. Have you sought help or counselling for this issue? What worked and what did not?

APPENDIX F

Information Sheet

Reading between the lines: The stories of young adults experience with the onset and persistence of self-harm behaviour.

Principal Investigator: Mandy York, Graduate Student

PARTICIPANT INFORMATION SHEET

Thank you for your participation in a study exploring the experience of self-harm from the perspective of young adults. We hope that the findings of this study will aid in the understanding of self-harm, such as how individuals begin to engage in self-harm behaviour and why they continue to participate in the behaviour. Recent research suggests that the rise in deliberate self-harm in community adolescents and young adults may be the result of external influences such as the media, the Internet, music, and peers. The sharing of your story may provide a greater understanding of deliberate self harm in community populations and insight as to how to develop or improve current prevention and treatment strategies for others that self-harm. Attached to this letter is a list of counselling services and supports, if you would like to access them.

Thank you for your time and effort concerning this project. We hope this experience has been both thought-provoking and interesting for you. Please feel free to contact either of us listed below if you wish to receive further information on this study or have any questions, concerns, or ideas related to this research project:

Mandy York email: myork@ualberta.ca

Dr. Robin Everall email: reverall@ualberta.ca telephone: (780) 492-1163

address: Department of Educational Psychology

Edmonton, Alberta T6G 2G5

APPENDIX G

List of Counselling Services and Support Lines

The Support Network, Walk-In Counselling Program Ph: (780) 482-0198
301-11456 Jasper Avenue, Edmonton
Offers free counselling on a walk-in basis by experienced, qualified counsellors.

The Support Network, Distress Line Ph: (780) 482-HELP (4357)
or 1-(800)-232-7288
The Distress Line is a confidential, non-judgemental listening service available twenty-four hours a day, seven days a week. They provide support and referrals for people experiencing difficulty in their lives.

The Support Network, 211 Ph: 211
211 is a telephone service that provides you with information regarding community programs and services and can help make appropriate referrals.

Youth Crisis Website
www.youthone.com
Provides crisis chat and peer support through an Internet-based (online) forum. The website also provides articles and information of resources that are relevant to youth needs and issues.

University of Alberta, Clinical Services Ph: (780) 492-3746
1-135 Education North, University of Alberta
Provides free counselling by supervised graduate students; $50 administration fee.

University of Alberta, Student Counselling Services Ph: (780) 492-5205

2-600 Students' Union Building, University of Alberta

Provides free counselling to undergraduate and graduate students attending the University of Alberta.

Catholic Social Services, Therapeutic Counselling Ph: (780) 420-1970
8815 99 Street, Edmonton
Provides counselling on a sliding-fee scale

Capital Health, Adult Crisis Response Services (Crisis Team) Ph: (780) 482-0222

Provides assessment, consultation, intervention, and stabilization services to adults experiencing mental health crisis. This service is available twenty-four hours.

APPENDIX H

Moving Away from Self-Harm Behaviour: Recommendations of Participants

In telling their stories, participants discussed what they deemed as helpful in moving away from non-suicidal self-injury (NSSI). They also shared what would have been helpful at the time they were self-injuring and the insights they have had in their journey to recovery. The first section is devoted to parents, caregivers, and friends as strategies are provided of how best to support an individual that is self-injuring. The second part of this chapter is written for individuals who are self-harming because it illustrates what has been most helpful for participants in moving away from self-harm behaviour. This chapter was written in a concise way so that it can be referred to as a self-help resource.

For the professional and concerned parent, friend, or partner

Approach

1.Be open and non-judgmental.

If you think someone close to you may be self-injuring, it is very important that you come from a place of "zero judgment." Even if you have beliefs and views about self-injury and are experiencing intense emotions (e.g. shock, horror, fear, panic), you must do your best to "contain" what you are thinking and feeling so that you can best support your loved one. Being open and non-judgmental will help the person to open up and accept support from you and/or other resources. Then in your own time, and when you have more information, you can find opportunities to reflect, analyze, and work through the feelings you may be struggling with.

2. Be inquisitive.

Take the time to understand the perspective of your loved one and what they might be going through. Be curious and ask questions in a gentle manner. You may first want to begin with the circumstances and stressors that led them to self-harm. If both you and your loved one feel comfortable in talking about their

self-harm behaviour, you may want to inquire about the reasons why they self-injure and how you can best support them.

3. Be supportive

Offer and provide support to your loved one. This could involve seeking information as a way to understand their self-harm behaviour and it could also involve seeking information about issues and circumstances your loved one is dealing with (e.g. bullying, depression). It may also entail accessing resources and ways to support the individual through this time (e.g. counselling). Although you will be concerned for your loved one, try not to monitor them incessantly and/or confiscate tools unless there is reason to believe he/she is suicidal. Otherwise, this may cause your loved one to become panicked and more secretive with their behaviour as it may be the only form of coping they know. Instead, do periodic "check-ins" to see how they are doing and/or sit down with him/her and help them to identify healthy alternatives to their self-harm behaviour. Explore and consider the function(s) the self-behaviour serves for them and what could be an appropriate replacement. For instance, if your loved one says they cut as a way to release the tension they feel, you could suggest other ways to release this stress such as exercise, mindful meditation, and massage. This list of alternatives can be a resource they could turn to whenever difficult feelings or circumstances arise.

4. Provide validation

Once understanding is gained, provide validation of what they might be going through. Many individuals just want to know they have been heard and feel understood. Although you may not agree with how your loved one has been coping, you can acknowledge the feelings and circumstances that may have led them to the behaviour. As an example you can say, "It seems that you are really hurting. I want to know more about what you have been going through and how I can support and help you."

Address self-harm and underlying issues

5. Do not just tell your loved one to stop

Be aware that self-harm is a complex behaviour and that it is not as simple as telling him/her they need to stop. Your loved one would not be engaging in self-harm if he/she were not experiencing some emotional distress or found the behaviour to serve a particular function for them.

6. Find a balance between self-harm and the presenting issues.

Recognize that self-harm is a serious issue. If an individual discloses that they self-injure do not "downplay" their behaviour. Some people may disregard scars and confessions of self-harm behaviour because they assume that the individual is trying to gain attention. If your loved one makes such attempts to be noticed, then they are likely in distress and are making a "cry for help." It may be that they do not know how to communicate what they are feeling or do not know how to ask you what they need. Although it is important to acknowledge the self-harm behaviour and consider ways to reduce the harm and risks associated with the behaviour, the reasons behind the self-injury also need to be addressed.

7. Help the individual to "fix" the underlying issue.

A loved one or professional should help the individual to explore the underlying issues in his/her life that led them to self-injury and why the behaviour continued for them. Once this awareness is gained, the individual can be supported to develop a plan to address his/her concerns. For instance, if your loved one reports he/she has been self-harming as a way to cope with racing thoughts and feelings associated with his/her anxiety, then it would be beneficial for them to develop coping strategies to manage these symptoms appropriately. If the individual becomes confident in managing their anxiety and notices a reduction in symptoms, the "need" for self-harm in their life would be reduced or eliminated.

Increase understanding of NSSI

8. Professional development

Professionals, such as counsellors and psychologists, need to be better informed and educated about the topic of self-harm due to the increase in prevalence of behaviour in adolescents and adults. There has been as expansion in

professional development opportunities and resources (books, journals) available on this topic that professionals can access.

9. Public awareness campaigns.

The public also needs to be better informed on the topic of self-harm and the resources available for those who are self-injuring. Most knowledge that people have of self-harm behaviour comes from the media and/or peers and so there may be some inaccuracies in their understanding of NSSI. Public awareness campaigns about self-harm developed and executed by professional associations such as the Canadian Mental Health Association (CMHA) will help to increase public knowledge and will reduce the stigma associated with the behaviour.

For the Self-Injurer

Support

1. Access support

Consider people in your support network that you trust and feel comfortable enough to open up to. Accessing support from friends and loved ones can be invaluable during a difficult time. If you know of someone who is also self-injuring, you might find it easier to talk with them about your behaviour as there will be less fear about being judged or misunderstood. Furthermore, you can offer a "buddy system" to one another if the goal is to reduce self-harm and support is available when urges arise to self-injure.

If this support does not exist within your immediate circle, you might want to consider accessing counselling and treatment for your self-harm behaviour. Counselling can be an important resource even once your self-injury has stopped because you can develop with your therapist new coping skills and a plan for relapse prevention. There are also supports available that protect your privacy and provide anonymity such as 24-hour distress lines and forums/chat rooms for self-harm behaviour.

2. Consider getting a pet

The unconditional love given by a pet can be transformative, especially if you are experiencing feelings of loneliness and isolation. Owning a pet also requires a high level of responsibility, and so this "busy-ness" can service as a

powerful source of distraction from difficult feelings or urges to self-harm. The presence of a pet may also dissuade you from self-harming in the moment as you may find it difficult to injure yourself in front of someone or something that you love and care for.

Moving away from the behaviour

3. Make the decision to stop

Consider your mindset and make a conscious decision to stop harming yourself. It may be helpful to review the reasons and benefits of moving away from the behaviour. To help in this process, you can distract yourself from difficult feelings that arise and delay the urge as much as you can. You may find that after a certain period or time lapse that you do not want to self-injure anymore.

Remember that any time and length of time that you are able to stop is a demonstration that you can stop and could be an opportunity to try and move away from the behaviour. For instance, if you were able to refrain from self-injuring while on a family vacation you may want to see if you can continue to abstain once you return home.

4. Reduce the harm associated with the behaviour.

If it is difficult to stop the behaviour all together, look for opportunities to reduce the harm associated with the behaviour. Try and limit the amount of times that you injure in a given period and try to reduce the harm and outcomes that result from this action (e.g. wrist banging rather than cutting). A strategy that you might find helpful in this process is to create obstacles or eliminate access to the resources that you tend to harm yourself with. For instance, you could throw out all of your razor blades and use other forms of hair removal such as waxing. Scarification can also be a method to reduce harm and reduce the frequency of self-harm behaviour. Scarification is when the self-injurer moves a blade in a controlled and methodical way to create a design in the skin. Since it is seen as more of an art form, it can "prettify" scars and create new meaning about how self-injury can be used by the self-injurer.

Cope with thoughts, feelings, and stressors.

5. Challenge negative and irrational thinking

It is also important to become more aware of your thoughts and the influence they can have on your emotions and behaviour. Negative thinking can have a large impact on you mood and how you feel about yourself. If you notice the tendency to think irrationally about events and perceive a situation as "your fault", take a moment to consider if you are viewing the circumstance in an accurate way. Ask yourself questions such as: "Is this really a big deal"?, "Should I really take all the blame for what happened"?, "How will I feel about this event a week/month/year from now"?, and "If a friend came to me with these thoughts what advice would I give her?." When you start to think more realistically you will find that your moods will improve and there will be more stability in the positive feelings you have.

6. Learn how to regulate emotions and try alternatives.

In addition to becoming aware of your thoughts, it can also be beneficial to develop a self-awareness of your feelings and the associated body sensations with that feeling. For instance, how do you know in your body when you are starting to feel anxious (e.g. racing heart, sweaty palms). Once you have a sense of how you might be feeling, give that feeling a name (e.g. anxious) and acknowledge that you are feeling that way. Just noting when you are feeling a certain way and sitting with that feeling for a while can reduce the intensity of that feeling and keep it from building. Remember that feelings are natural and that you do not need to be afraid of them. Allowing yourself to feel does not mean you will lose control and go "crazy." In actuality, the avoidance of feelings is when people start to encounter certain problems (e.g. feelings of numbness). Feelings are temporary and even though they may reach a certain level of intensity they will only stay at that level for a short time (e.g. 15-20 minutes) and then will gradually decline until you return to your natural state.

Once you have identified how you feel in a given circumstance and have allowed yourself to sit in the feeling for a period of time, you can engage in activities that will also have a positive impact on how you are feeling. You may want to create a list of healthy coping alternatives ahead of time so that you can

refer to that list rather than trying to think of something to do in the moment. Think of activities you can engage in or a resource you can access that will help you return to an optimal level of alertness and calmness (e.g. listening to uplifting music, cuddling with a pet). It may also be helpful to consider if different strategies need to be applied depending on your mood and create a list of resources for each. For instance, if you are angry you may need to go for a walk to cool down before communicating your feeling but if you are feeling sad you may want to participate in an activity that feels more nurturing such as having a warm bath or curling up in a cozy blanket.

7. Address the anger you may be internalizing.

In the process of learning how to identify your feelings, it is necessary to look specifically at the anger you might be feeling and the role it might play in your self-harm behaviour. Many self-injurers do not acknowledge the anger they are feeling and thus turn their anger inward, towards themselves. This internalized anger often leads to self-injuring as a form of punishment. Either through counselling or on your own, determine if you are experiencing any unresolved anger and consider ways you can express these feelings in a respectful way to people that have "wronged you." Consider other healthy outlets for your anger such as physical activity and artistic expression.

8. Distract yourself from negative thoughts and urges.

Consider ways that you can distract yourself from a triggering event, negative thoughts, and/or the urge to self-harm. A source of distraction can be anything that is engaging enough to act as a source of distraction from what you are thinking and feeling. Many self-injurers report that being around people or talking to someone either in person or through other methods of communication can be a powerful method. Other methods can be activities that can consume your interest and attention such as watching a movie or playing a video game. What you will likely find is that most urges last for about 10 to 20 minutes so if you can distract yourself for that amount of time you may find that you no longer want to self-injure in that given moment.

9. Learn ways to reduce and manage stressors in your life.

Become aware of the stressors that might exist in your life. Having multiple responsibilities and commitments can be perceived as a stressor if you are finding it difficult to manage your time effectively. In this circumstance, it may be necessary to give up one of your responsibilities or reduce the amount of time spent in each. Other stressors can include having an altercation with someone (family member, friend, or romantic partner), experiencing a negative event (e.g. being made fun of in front of a group of people), and academic pressures. Some stressors may be outside of your control and so if there is little influence you can have on the event, know that you can have impact on how stress impacts your emotional and physical well-being. Consider ways to "release" stress through activities such as exercise, meditation, and relaxation. Additional strategies that were reported include addressing issues as they arise, journaling, and spending time with friends.

Creative outlets

10. Express your emotions through written and artistic expression.

Writing in a journal, particularly regarding an event that is upsetting or overwhelming can be a helpful way to express and release emotions. Journalling provides the opportunity to truly express what you feel without the worry of censorship and it can provide a cathartic release. Since your thoughts and feelings are projected onto paper it will provide some distance and objectivity from the emotions you are feeling. This process may also allow for reflection and thus insights about what you need and what you want to do to move forward from the event. Writing poetry or song lyrics can be a more indirect and less threatening way to express how you are feeling, especially if you have concern about someone discovering your journal. Drawing, painting, sculpting and other forms of artistic expression can be additional avenues for expressing feelings.

11. Listen to music that resonates with how you feel and/or can have a positive impact on how you are feeling.

Listening to particular types of music can be a powerful medium of expressing emotions, releasing energy, and improving overall mood. When you are faced with a particular feeling (e.g. sadness), you may find it beneficial to

select a song, melody, or type of music that resonates with the feeling you are having. You may also find it therapeutic if a song's lyrics are impactful and relates to what you are experiencing. Furthermore, music can help evoke feelings that you know are "sitting below the surface" and need to be acknowledged and expressed. After you have had some time to sit with those feelings, you may find that switching the music to something more uplifting and energetic can actually change your mood state to something more positive. Dancing while playing this type of music can help in the expression of emotions (e.g. "blowing off steam") and can improve mood.

12. Physical and sensory outlets can also be therapeutic.

Physical and sensory outlets can be transformative in helping you to move away from your self-harm behaviour. Try to incorporate regular exercise (e.g. running) and physical activity into your life. Physical outlets can be very helpful in releasing stress and built up emotions. They also provide a "boost in endorphins which helps with mood. Although physical activity is a good prevention strategy in addressing stress and emotions, it can also be an important resource to deal with feelings in the moment (e.g. feeling overwhelmed). Since this type of outlet helps to bring arousal down, you will start to feel a level of calmness and can think more clearly, can problem solve more effectively, and can communicate your feelings in a more productive way. Activities such as molding clay can be helpful if you feel you are a more "tactile" person (e.g. are drawn to the way things feel) and are looking for this type of outlet (tactile/sensory) to address your feelings and emotional needs. The texture of the clay and the action of molding the clay can release tension and be very calming. Other tactile/sensory activities such as stroking the fur of a pet, self-massage, asking for a hug, rubbing a smooth rock, and squeezing a stress ball/fidget toy can also be beneficial.

Self-growth.

13. Take care of yourself and your needs.

Taking care of your physical needs can have a profound effect on your emotional needs. Achieving and maintaining a healthy lifestyle (e.g. upholding

proper hygiene, eating healthy, exercising, and getting adequate sleep) can actually create a level of emotional stability. This is particularly important during times of stress as a way to counterbalance the effects stress can have.

14. Be assertive and communicate you needs and feelings.

Be assertive by saying "no" when you need to and by expressing your needs in a calm yet confident way. Using "I" statements ("I feel ____ because _____. What would help in the future is _____) are a great way to communicate feelings without asserting blame. If you find the tendency to withhold feelings because you are worried about hurting someone else's feelings, remember that if you are being respectful and careful with the wording that you use, this outcome would be unlikely. This openness of communication also prevents feelings from building up.

Thus, by taking care of your physical needs (e.g. healthy lifestyle) and emotional needs (e.g. communicating feelings), you are communicating a message to yourself that your needs matter too; which in turn leads to increased self-esteem.

15. Build self-esteem and confidence.

Finding ways to build your self-esteem and confidence can be another way to move away from self-harm behaviour. When you begin to accept yourself and acknowledge the strengths you exhibit, others will start to accept you as well. Other strategies to build self-esteem include attending school on a regular basis, improving your relationship with family members, and expanding your social network. When you begin to feel better about yourself, you will likely notice less desire and need to self-injure. This reduction in self-harm also contributes to enhances self-esteem creating a positive cycle of recovery.

16. Engage in positive activities and endeavours.

Participate in activities and endeavors that are proactive such as sports and volunteering. This will provide you with the opportunity for attention, acknowledgment, and accolades through positive means. It will also contribute to your own sense of inner pride.

17. Develop and achieve short- and long-term goals.

Remind yourself that you can have influence over your life. Create a list of short-term goals and long-term endeavours. For short-term goals, generate a "to-do" list and try to complete items off your list within a 1-3 day period. You will likely feel a sense of productivity and accomplishment upon when the task is completed and "crossed off" your list. For long-term goals, create a time line for how and when you wish to accomplish each goal. Make sure that your goals are realistic and attainable and consider what actions need to be put forth and what resources need to be utilized in order for your goals to be achieved. Also consider any obstacles you might face in working towards the goal and potential solutions. By "doing" and working towards the outcomes you want, you will increase the chance of having the life that you want and achieve happiness.