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The Lived Experience of Adolescents Who Engage in Nonsuicidal Self-Injury

Erin Elizabeth Holley

THE LIVED EXPERIENCE OF ADOLESCENTS WHO ENGAGE IN NONSUICIDAL SELF-INJURY

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ERIN ELIZABETH HOLLEY

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This dissertation, by Erin Elizabeth Holley, has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University Santa Barbara in
partial fulfillment of requirements for the degree of

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Dissertation Committee:

_____
Steven Kadin, Ph.D.
Committee Chair

_____
Allen Bishop, Ph.D.
Committee Member

_____
E. David Klonsky, Ph.D.
External Expert

ABSTRACT

The purpose of the current study was to explore the lived experience of adolescents who engage in nonsuicidal self-injury (NSSI). Phenomenological interviews inquired about emotionality, conflict styles, and parental relationships among a clinical population of six adolescents. All participants met criteria for the proposed diagnosis of NSSI found in the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (American Psychiatric Association, 2013). Nine central themes emerged as significant: identification with an alternative to the dominant culture, inhibition of affect, difficulty managing conflict, suicidality, negative emotionality, feeling numb, negative internal monologue, self-harm as a temporary coping skill, and maternal conflict. The affect regulation function was clearly supported, as adolescents demonstrated low distress tolerance, poor affect regulation skills, and utilized NSSI to obtain temporary emotional relief. Results indicate that adolescent self-injurers are avoidant, as they suppress both positive and negative emotionality, and actively avoid initiating, managing, or addressing conflict. Findings revealed a need for clinical treatment to address the underlying affective disturbances associated with the behavior. The electronic version of this dissertation is available free at Ohiolink ETD Center, www.ohiolink.edu/etd.

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Chapter One: Introduction

Although considered to be a recently growing problem in the mental health community, nonsuicidal self-injury (NSSI) has been of clinical interest since the 1930's. American psychiatrist, Karl Menninger, was one of the first researchers to identify self-injury as a distinct clinical behavior (Conterio & Lader, 1998). Labeling it focal suicide, Menninger (1938) identified individuals who engaged in "localized self-destruction" (p. 229) of body tissue in order to keep negative affective states at a manageable level and prevent painful memories from surfacing. He recognized that self-injurious behaviors exist on a spectrum from normal nail biting to severe flesh digging.

Three decades later Graff and Malin (1967) documented a growing phenomenon of "wrist slashers" (p. 36), female inpatients who were flooding the local psychiatric hospitals. These patients engaged in self-mutilation through cutting their wrists, a behavior distinct from suicide. Graff and Malin (1967) found that the typical cutter "slashes her wrists indiscriminately and repeatedly at the slightest provocation, but she does not commit suicide. She feels relief with the commission of her act" (p. 38). Shortly after Graff and Malin's (1967) publication, British psychiatrist, Norman Kreitman, (1977) coined the term parasuicide, which he referred to as nonfatal, yet intentional self-injurious behavior resulting in visible tissue damage.

These early clinical observations were progressive in that they accurately identified a facet of self-mutilating behavior as being repetitious, distinct from suicide, and serving affect regulation purposes. Nearly eighty years after Menninger's (1938) initial observations, NSSI continues to afflict clinical and community (non-clinical)

populations. The following introduction section of this study will attempt to clarify the phenomenon of NSSI through exploring existing definitions, identifying problems associated with NSSI, and rationalizing the need for further research on these deliberate acts of self-injury.

Conceptual Definitions of NSSI

NSSI has been defined in recent literature as the intentional, self-inflicted destruction of body tissue without conscious suicidal intent and for purposes not socially sanctioned (International Society for the Study of Self-Injury, 2007). Alternate names for NSSI that have been used in both literature and clinical settings are deliberate self-harm, self-injury, cutting, self-mutilation, self-wounding, focal suicide, and parasuicide (Conterio & Lader, 1998; Favazza, 1998; Kreitman, 1977; Menninger, 1938). Although there are variations among these terminologies and encompassing behaviors, the commonly agreed upon feature is the absence of suicidal intent.

NSSI is demonstrated in a wide variety of behaviors, including but not limited to cutting, burning, hitting oneself, biting, scratching, pinching, chewing the lips or tongue, breaking bones, head banging, and ingesting toxic objects (Conterio & Lader, 1998; Muehlenkamp, 2005). These behaviors often cause moderate to superficial tissue damage, although individuals have reported accidentally injuring themselves more severely than intended (Whitlock, Eckenrode, and Silverman, 2006). Cutting, burning, and scratching the skin are the most frequently reported methods of NSSI, with most individuals using more than one method (Conterio & Lader, 1998; Klonsky & Muehlenkamp, 2007; Laye-Gindhu & Schonert-Reichl, 2005;Whitlock et al., 2006). Typical locations for inflicting NSSI are the hands, arms, legs, and other areas in the front

of the body, presumably because these are the easiest areas to self-inflict injury, as well as the easiest areas to conceal visible injuries (Conterio & Lader, 1998). Cutting on body parts other than the forearms is thought to be indicative of more severe psychopathology (Laukkanen, Rissanen, Tolmunen, Kylma, & Hintikka, 2013).

Discrepancies exist in literature and amongst clinicians as to what specific behaviors constitute NSSI (Muehlenkamp, 2005). An argument can be made that any behavior performed with knowledge that it might result in physical or psychological injury could be classified as self-injurious (Nock, 2010). It is important to make a distinction between behaviors in which bodily injury is the clear purpose from behaviors in which injury is an unintended result. Direct self-injury involves conscious intent and causes immediate tissue damage, exampled by cutting, scratching, and burning the skin **(**Walsh, 2006).

Indirect self-injury includes behaviors in which the intent is less clear and the effects not as immediate (Walsh, 2006). According to Nock (2010) indirect methods of self-injury include drinking alcohol, eating high-fat foods, and being noncompliant with medications, among other unhealthy behaviors. A study by Tice and colleagues (2001) found that individuals engage in self-defeating behaviors, such as eating fattening foods and procrastinating, if they believe that the behavior will provide a quick fix to relieve their level of distress. While the function of indirect self-injury is similar, NSSI involves more direct methods of tissue desecration, resulting in immediate damage, not just the potential for damage.

For the purpose of accurately addressing the phenomenon, it is important to distinguish NSSI from other common forms of self-inflicted pain. NSSI is different from

the stereotypical and habitual self-injurious behaviors seen in the spectrum disorders and is also distinct from severe forms of body mutilation, such as limb amputations seen in individuals suffering from psychotic disorders (Favazza, 2009; Klonsky, 2007; Nock & Favazza, 2009). NSSI is different from socially sanctioned body modifications such as tattoos and piercings because NSSI is not done for the purpose of decoration or individualizing oneself, and is considered by nature to be socially inappropriate (Nock & Favazza, 2009). Additionally, NSSI does not include more benign and socially accepted habits like nail biting or picking at scabs (American Psychiatric Association, 2013). The functions, discussed later in greater detail, are key features that distinguish NSSI from the aforementioned behaviors. For the purpose of the current study, NSSI refers to repetitive and low-lethality skin desecration, including cutting, stabbing, burning, scratching, pinching, and self-hitting.

There has been a push in the professional community to make NSSI a disorder in its own right (Muehlenkamp, 2005). Nonsuicidal self-injury is included in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM–5*; American Psychiatric Association [APA], 2013) Section 3 disorders, which are characterized as conditions requiring further research before consideration as official diagnoses. According to the *DSM-5* (APA, 2013), the main diagnostic feature of NSSI is engaging in repetitious self-inflicted injury to the surface of one's body in order to obtain some form of desired relief or response. Over the course of a year, the individual has engaged in self-inflicted injury on five or more days, usually resulting in visible skin desecration, such as bruising or bleeding. The individual engages in the behavior in the absence of suicidal intent, and not for purposes that are socially sanctioned, such as body piercing or tattooing. The

intentional self-injury is associated with interpersonal difficulties, or negative feelings or thoughts, which occur in the time frame immediately prior to the act. A preoccupation exists with the self-injury that is difficult to control, even when it is not acted upon, and the behavior or consequences cause clinically significant distress or interfere in interpersonal, academic, or other important areas of functioning. Although these diagnostic criteria are in the *DSM-5*, Section 3 disorders need further research before consideration as formal disorders; therefore a diagnosis of NSSI is not formally recognized (APA, 2013).

Background of the Problem

By definition, NSSI is performed with the absence of suicidal intent, however, research supports the presence of a co-occurring relationship between NSSI and suicide attempts (Jacobson & Gould, 2007). Individuals who engage in NSSI have a high rate of attempts, placing them at an increased risk for completing suicide (Klonsky, 2014). The interpersonal-psychological theory of suicidal behavior posits that suicide attempts and completions involve a three-way interaction between low levels of belonging, high levels of perceived burdensomeness to others, and a high fearlessness of physical threat (Joiner & Silva, 2012). Joiner (2005) explains that individuals innately lack the ability to engage in suicidal behaviors due to fear of death and fear of physical pain. One explanation for the correlation between NSSI and suicide is individuals who repeatedly engage in NSSI become desensitized to the fear and pain, thus acquiring the capability to complete lethal self-injury (Klonsky, May, & Glenn, 2013).

Nock and colleagues (2006) found that among adolescent psychiatric inpatients, 70% of those engaging in NSSI had a lifetime prevalence of at least one suicide attempt.

Further statistical analyses found that number of suicide attempts was positively correlated with a longer history of NSSI, greater number of NSSI methods used, and the absence of pain during NSSI episodes. It is possible that over time adolescents became desensitized to the fear and pain of self-injury, perhaps working their way up to more lethal forms of self-injury. Additionally, more than half of the adolescents from the study met criteria for an internalizing disorder, such as depression, anxiety, and posttraumatic stress disorder, suggesting the relationship between NSSI and suicide attempts is mediated by heightened emotional distress. Findings from Nock and colleagues (2006) support the interpersonal-psychological theory of suicide behavior, and attempt to explain the connection between adolescent NSSI and suicide attempts.

NSSI not only threatens the physical safety of the individual, but their emotional and psychological safety, as well. NSSI is associated with numerous interpersonal difficulties and psychological maladjustments that lead to an increased risk of developing psychopathology (Taylor, Peterson, & Fischer, 2012). Individuals who engage in NSSI are more likely to present with clinical symptomology, such as anxiety and depression (Klonsky & Olino, 2008). In a clinical sample of adolescents who engaged in NSSI, Nock and colleagues (2006) found that more than half of the participants met criteria for internalizing disorders, externalizing disorders and substance use disorders.

According to Conterio and Lader (1998), “many self-injurers suffer from frequent bouts of very severe depression. Yet-paradoxically-they may also lose touch with the despair at the root of the depression, as self-injury develops into a strategy for blotting feelings out of their conscious awareness” (p. 172). Contrary to popular belief that it is an attention-seeking behavior, reducing negative emotions is cited as most common reason

for engaging in NSSI (Klonsky, 2007; Taylor et al., 2012). Self-injurers report engaging in NSSI to relieve unpleasant emotions, including anxiety, guilt, anger, loneliness, and self-hatred (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007). A statistical analysis of self-injurers found that individuals endorsed high levels of intrapersonal motives and low levels of interpersonal motives for engaging in NSSI (Klonsky & Olino, 2008). Given its comorbidity with other psychological conditions, and its ability to provide relief, NSSI could actually be considered a maladaptive coping skill (Muehlenkamp, 2005).

Individuals can differ substantially in their desire to stop self-injuring (Klonsky, 2014). Many individuals make repeated efforts to resist NSSI urges (Klonsky & Glenn, 2008). However, there are individuals who justify using NSSI as a coping strategy and express no desire to stop their behavior (Conterio & Lader, 1998; Klonsky, 2014). The reluctance to stop self-injuring may result from perceived benefits of NSSI, such as inducing desired feelings or alleviating negative symptoms (Brown & Kimball, 2013). If an individual perceives benefits from NSSI, they are likely opposed to stopping on their own or seeking treatment (Conterio & Lader, 1998). Self-injurers who do not see their behavior as problematic often meet therapeutic interventions with great resistance (Conterio & Lader, 1998; Straiton, Roen, Dieserud, & Hjelmeland, 2013).

NSSI is not unique to clinical settings; individuals in community settings also engage in NSSI (Baetens, Claes, Muehlenkamp, Grietens, & Onghena, 2011; Klonsky, 2011; Muehlenkamp, 2005; Whitlock et al., 2006). Klonsky (2011) sampled 439 adults throughout the United States through random digit dialing and found a lifetime prevalence of NSSI to be 5.9%, with 2.7% reporting five or more NSSI incidents. The average age of onset was 16 years, indicating that NSSI is a problem that starts at a

pivotal and relatively young age. This is consistent with other findings that NSSI typically begins in adolescence (Whitlock et al., 2006). Whitlock and colleagues (2006) surveyed 2,875 students from two major northeastern universities on NSSI behaviors. Out of this rather large sample size, 17% reported engaging in self-harm at some point in their lives, with an average age of onset between 15 and 16 years old. An alarming finding was the low rate of help-seeking behaviors within the NSSI population. Forty percent of all the individuals who endorsed NSSI reported that no one was aware of their behavior. Confounding the problem of treatment resistance, NSSI begins in adolescence and can continue well into adulthood, which implies a poor prognosis.

The majority of individuals who engage in NSSI do not seek professional help (APA, 2013; Brown & Kimball, 2013; Hawton, Rodham, Evans, & Harriss, 2009). The lack of help-seeking behaviors may result from the perceived stigma of NSSI (Long, Manktelow, & Tracey, 2013). Feelings of shame or fear of being harshly judged likely contribute to the tendency to keep NSSI a secret (Laye-Gindhu & Schonert-Reichl, 2005). A qualitative study by Fortune, Sinclair, and Hawton (2008) found that community adolescents in the United Kingdom believed the stigma of NSSI impeded prevention efforts and was directly related to lack of willingness to seek treatment.

A qualitative study by Brown and Kimball (2013) explored the lived experience of self-harm in a community sample of adults. A major theme that emerged from the study was seeking professional help for self-injury was not beneficial. Even in the absence of judgmental responses, participants still believed that talking with a professional was not helpful to them. Participants assumed that professionals did not understand NSSI and did not want to understand NSSI. Findings from the study

emphasize the need for professionals to become more educated about NSSI and subsequent issues. Participants reported an overall frustration with professionals' lack of training in relation to NSSI behaviors. Furthermore, participants believed that assuming the role of educating their doctors and therapists was burdensome to treatment. The findings highlight the deficits in systematic research and subsequent treatment of NSSI and suggest a greater need to understand the functions of and motives for engaging in NSSI. As a result, clinicians can more effectively approach clients from a position of informed, non-judgmental expertise.

Statement of the Problem

NSSI is a phenomenon worth studying, as it is associated with a myriad of mental disorders and comes with the threat of more serious and potentially fatal self-inflicted behaviors (Nock et al., 2006). A strong body of research shows that NSSI is a problematic behavior, which begins in adolescence and is used to regulate affect (Di Pierro, Sarno, Gallucci, & Madeddu, 2014; Laye-Gindhu & Schonert-Reichl, 2005; You, Lin, & Leung, 2013). While there is an abundance of research on the affect regulation function of NSSI in adolescence, the majority of existing research is quantitative, resulting in a dearth of qualitative literature. In the current study, the deep personal nature of NSSI and associated emotionality was explored qualitatively through conducting phenomenological interviews. Phenomenological interviews allowed adolescents to describe their experiences with NSSI in their own words, adding to the existing literature by clarifying their emotional experience of NSSI and identifying areas for future research.

Purpose of the Current Study

The purpose of the current study was to explore the affective experience of adolescents who engage in nonsuicidal self-injury, as told in their own words. The primary research question the study sought to investigate was: *What is the lived experience of adolescents who self-harm?* It should be noted that the term self-harm was used purposefully in the research question, and was also used when directly addressing participants. Using the term self-harm, as opposed to NSSI, showed sensitivity towards participants by using terminology they understood, rather than confusing clinical terminology. The terms NSSI and self-injury were used consistently throughout the literature review, while self-harm was used in the semi-structured interview, informed consent, recruitment poster, and explanation of research.

Semi-structured interviews inquired about feeling states before, during, and after episodes of self-harm, how participants handle emotionally challenging situations, emotions that are difficult to express, and how participants perceive their relationship with parents or caregivers. Interviewing adolescents who engage in NSSI gave a picture of the participants' identities, emotionality, familial relationships, and conflict styles. It is this researcher's belief that the aforementioned traits contributed to the propensity for engaging in NSSI. The following literature review seeks to identify prevalence and demographic correlates of NSSI, functions of NSSI, and theories of affect regulation.

Chapter Two: Literature Review

Prevalence and Demographic Correlates

NSSI is a behavior that begins in adolescence, with an average age of onset between 13 and 16 years of age (Klonsky, 2011; Rodham & Hawton, 2009; Skegg, 2005). NSSI may manifest in childhood or adolescence as a relatively harmless accident (Conterio & Lader, 1998). "Some teenage self-injurers say they accidentally cut themselves, then were surprised when they were flooded by feelings of relief" (Conterio & Lader, 1998, p.22). Often times, the behavior has a contagion effect, with impressionable adolescents initiating NSSI after learning about it from their friends (Heilbron & Prinstein, 2008; You, Lin, Fu, & Leung, 2013). While children and adolescents might learn to initiate NSSI from their friends, peer pressure has little to do with repetitive NSSI (Hollander, 2008). NSSI is likely continued because the individual is in some way benefiting from the behavior (Nock, 2009). Klonsky and Muehlenkamp (2007) find that the majority of individuals who engage in NSSI only do so a handful of times, while a smaller proportion proceed to habitual NSSI.

Studies documenting age of onset find that 5.1% to 24% of individuals who endorse NSSI report initiating the behavior prior to age 11 (Heath, Toset, & Beetam, 2006; Ross & Heath, 2002; Whitlock et al., 2006). While there is limited research on NSSI in children, it is believed that approximately one percent of five to ten-year-olds engage in NSSI (Meltzer, Gatward, Goodman, & Ford, 2001). Self-injuring children under the age of ten are more likely to have a mental health diagnosis, namely an anxiety disorder, and have more often experienced multiple traumatic life events (Meltzer et al., 2001). Children under the age of 12 who endorse NSSI experience greater sleep

disturbances, including nightmares and difficulty staying asleep throughout the night (Singareddy et al., 2013). In the absence of treatment, younger self-injurers have a poorer prognosis due in part to the potential for NSSI to become more deeply engrained over time (Conterio & Lader, 1998).

The trajectory path of NSSI appears to peak in late adolescence and young adulthood, although research has shown it can continue well into adulthood (Barrocas, Hankin, Young, & Abela, 2012; Klonsky & Muehlenkamp, 2007; Klonsky, 2011; Young, van Beinum, Sweeting, & West; 2007). Lifetime prevalence of NSSI varies from 13% to 23.2% among adolescent populations (Jacobson & Gould, 2007) and 11.68% to 17% in young adult populations (Heath, Toset, Nedecheva, & Charlebois, 2008; Whitlock et al., 2006). The prevalence of NSSI is much higher in clinical samples than community samples, occurring in approximately 20% of adult psychiatric inpatients and 40-80% of adolescent psychiatric inpatients (Klonsky & Muehlenkamp, 2007). Although hospital admissions for NSSI have been documented to be the highest between 20 and 29 years of age, research that examines age at hospital admission fails to provide age of onset for the behavior (APA, 2013). According to Rodham and Hawton (2009), young adults between the ages of 18 and 25 are at the greatest risk for engaging in NSSI, which is somewhat consistent with existing research that identifies adolescents and young adults at the greatest risk (Klonsky & Muehlenkamp, 2007).

Estimated prevalence rates are likely subject to underreporting due to the stigma associated with NSSI and subsequent tendency to keep the behavior private (Brown & Kimball, 2013;Whitlock et al., 2006). Fear of being judged or being seen as “crazy,” or even fear of being institutionalized are all possible reasons for underreporting NSSI, and

refraining from help-seeking behaviors (Conterio & Lader, 1998; Brown and Kimball, 2013). While exact statistics are inconclusive, it can be agreed upon that NSSI is a serious problem that often begins in adolescence, impacting healthy development into adulthood (Klonsky, 2011).

NSSI is a worldwide phenomenon, occurring not only in North America, but also among populations in South America (Gonzalez-Forteza, Alvarez-Ruiz, Saldana-Hernandez, & Carreno-Garcia, 2005), Europe (Claes, Luyckx, & Bijttebier, 2014; Plener, Libal, Keller, Fegert, & Muehlenkamp, 2009), Asia (Matsumoto, Azekawa, Yamaguchi, Asami, & Iseki, 2004), Australia (de Kloet et al., 2011), and New Zealand (Lucassen et al., 2011). There is an abundance of literature on adolescent NSSI in North America, the United Kingdom, and Australia, although it is unclear whether NSSI is more prevalent in these nations, or merely more researched (Hawton et al., 2012; Muehlenkamp, Claes, Havertape, & Plener, 2012). Prevalence rates are similar among western cultures, with an estimated 25.6% of German adolescents and 23.2% of American adolescents endorsing NSSI (Plener et al., 2009). Consistent with these results, Claes, Luyckx, & Bijttebier (2014) found that 26.5% of Flemish adolescents engage in NSSI. While far less research has been conducted on South American populations, Thyssen and van Camp (2014) posit that the prevalence of NSSI in Latin America is similar to rates found in the United States and Europe. The authors attribute the lack of research on NSSI in Latin American populations to "the gap between academic professionals, practitioners, and inhabitant population, the language of the publications, and the confusion between terminology and research traditions" (Thyssen & van Camp, 2014; p. 152).

NSSI was once thought to occur exclusively in females with Borderline Personality Disorder (Muehlenkamp, 2005). Current research supports that NSSI is no longer synonymous with a diagnosis of Borderline Personality Disorder, and is also quite frequently performed by males (Claes et al., 2014; Heath et al., 2008; Klonsky, Oltmanns, & Turkheimer, 2003; Klonsky, 2011). A substantial amount of research actually supports equivalent ratios of NSSI among males and females (Briere & Gil, 1998; Klonsky et al., 2003; Swannell, Martin, Page, Hasking, & John, 2014).

Hawton and Harriss (2008) found an overall gender ratio of 1.5 females to every male who engages in NSSI. Interestingly, the authors found a wide variation in the gender ratio across different age groups. For instance, while the average ratio was 1.5 females to every male, at age 13 the ratio was 17.6 females to every male. The gender gap steadily narrowed throughout the life span, and reversed after age 50, with more males than females engaging in NSSI. The authors attributed the disproportionate gender ratio in early adolescence to puberty, which occurs at a younger age in females, and is marked by fluctuating hormones, susceptibility to mood disturbances, and increased interpersonal difficulty. Although research on the gender distribution of NSSI yields mixed results, it is no longer believed to occur solely among females.

The previously held belief that NSSI is unique to females likely stems from earlier research conducted among predominately female psychiatric inpatient samples (Graff & Mallin, 1967; Swannell et al., 2014). One possible explanation for the heavily weighted female samples is the predominance of inpatients diagnosed with borderline personality disorder (BPD). BPD is more common among females and includes the diagnostic criteria of self-mutilation (Swannell, et al., 2014). Additionally, females are

more likely to engage in help-seeking behaviors, increasing their representation on the clinical radar (Conterio & Lader, 1998). While prevalence rates appear relatively consistent across gender, methods of NSSI seem slightly more gender specific. Laye-Gindhu and Schonert-Reichl (2005) found that males endorsed more self-hitting while females report more skin cutting. Whitlock and colleagues (2011) also found that women were more likely to engage in scratching and cutting, and men more likely to report punching objects with the intention of self-injury. Consistent with these findings, Klonsky (2011) found that among adults with a lifetime history of NSSI, women were more likely than men to report cutting behaviors.

NSSI appears to have a high comorbidity with other self-destructive behaviors including disordered eating (Claes, Norre, Van Assche, & Bijttebier, 2014). One out of five British college students with disordered eating reports a history of NSSI (Wright, Bewick, Barkham, House, & Hill, 2009). Among a sample of female outpatients with disordered eating, 33% endorsed NSSI, naming severe cutting and hitting oneself as the most common methods (Claes, Norre, Van Assche, & Bijttebier, 2014). Participants identified suppressing/avoiding negative emotions as the most significant function of NSSI. Emotional dysregulation is one possible explanation for the link between disordered eating and NSSI (Ross, Heath, & Toste, 2009). Difficulties in experiencing and regulating emotions are thought to be pivotal risk factors for developing both disordered eating and NSSI (Muehlenkamp, Peat, Claes, & Smits, 2012).

Substance abuse is another self-destructive behavior common among individuals who engage in NSSI (Klonsky, 2011). Binge-drinking and heavy alcohol consumption in the United States peaks in 15 to 24 -year-olds (SAMHSA, 2010), an age group that is also

susceptible to high engagement in NSSI (Klonsky & Muehlenkamp, 2007; Rodham & Hawton, 2009). One in five episodes of NSSI are thought to occur while under the influence of alcohol, and one in eight while under the influence of illegal drugs (Madge et al., 2008). Children and adolescents who use drugs and alcohol are nearly three times more likely to engage in NSSI than their clean and sober peers (Stewart, Baiden, Theall-Honey, & den Dunnen, 2014).

Both substance abuse and NSSI have been conceptualized as maladaptive coping skills, used to control or avoid negative emotions (Ogle & Clements, 2008). The ability to provide a quick fix to ones problems likely contributes to the continuation of these behaviors, despite an abundance of negative consequences (Chapman, Gratz, & Brown, 2006). Additionally, being under the influence of drugs and alcohol impairs judgment and inhibits impulse control, resulting in behaviors that might not otherwise be performed if substances were not involved (Dvorak et al., 2014).

Models of NSSI

High prevalence rates, safety concerns, and correlation with a multitude of problematic behaviors, have contributed to an influx in research exploring why individuals engage in NSSI (Prinstein, Guerry, Browne, & Rancourt, 2009). Although earlier research on NSSI was largely theoretical, a recent influx in empirical data has identified multiple functions of NSSI (Klonsky, 2007; Klonsky & Muehlenkamp, 2007). According to Klonsky and Muehlenkamp (2007), “It is important to note that different functions are not mutually exclusive; they can and often do co-occur in individuals who self-injure” (p.1049). Even with a degree of overlap, identifying functions of NSSI allows for a clearer conceptualization and attempts to make sense of an otherwise

counterintuitive behavior. The following section identifies some of the commonly researched models of NSSI, including anti-dissociation, anti-suicide, interpersonal-influence, self-punishment, and affect regulation.

Anti-Dissociation Model

The anti-dissociation model of NSSI posits that self-injury is a method used to interrupt a dissociative episode (Klonsky, 2007). Dissociation is a trauma-related symptom that represents a disturbance in the usually integrated functions of consciousness, memory, identity, or perception (Siegel, 1999). Dissociation can range from typical daydreaming to more extreme pathology found in dissociative identity disorder (Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003). Dissociation often occurs as a result of a traumatic experience in which the physical pain and emotional intensity of actually experiencing the traumatic event would be too painful to endure (Conterio & Lader, 1998). In order to preserve the psyche, dissociation sets in, leaving the individual feeling detached, surreal, and emotionally numb (Strong, 1998).

While dissociation has adaptive functions, extreme dissociation can lead to a disintegrating mind, evoking a sense of panic in the dissociating individual (Strong, 1998). NSSI allows the individual to regain a sense of self through generating strong emotional and physical sensations (Klonsky, 2007). Extreme dissociation can be likened to feeling dead or unreal, and NSSI provides the feeling of being jolted back into reality (Strong, 1998). Eliciting physical pain allows self-injurers to feel more in touch with their bodies (Klonsky, 2007), as NSSI regulates the degree of physical sensation and provides reassurance about feeling alive (Connors, 1996). In a study looking at the role of blood in NSSI, approximately half of the participants revealed that it was important to see blood

during an NSSI episode, and strongly endorsed the function, "makes me feel real" (Glenn & Klonsky, 2010, p.469).

> I feel so unreal in those states, like I'm disappearing, Josie continues. Sometimes I even have difficulty recognizing things and am unsure of who I am. I often get trancelike, far away. With the pain, cutting and burning bring me back into sharp focus. I'm back in my body and fully aware again, with a calmness and peace that makes me love the pain and find the blood beautiful. I am in control again. (Strong, 1998, p. 40)

A study by Rallis, Deming, Glenn, and Nock (2012) found that increased self-reports of dissociation and emptiness were correlated with an elevated presence and frequency of NSSI. Eighty-six adolescents, aged 12-19, completed self-report measures on childhood abuse, feelings of dissociation and emptiness, and NSSI behaviors. Results indicated that NSSI was performed in order to generate feelings, and reduce dissociation and emptiness. Of the various forms of child abuse, emotional and sexual abuses were most strongly correlated with dissociation, emptiness, and NSSI. Findings support the anti-dissociation model, suggesting that NSSI is used as a means to alleviate trauma symptoms, namely dissociation.

Similarly, Cyr and colleagues (2005) found elevated levels of NSSI and dissociation among female adolescents who were victims of child sexual abuse. Female participants, aged 13-17, were recruited through child protective services after substantiated claims of child sexual abuse. A self-report inventory was administered in order to measure the degree of NSSI behaviors. Participants were divided into three categories based on self-harming behaviors: low self-harm, those who reported either no

self-harm or one method of self-harm; moderate self-harm, those who reported two or three different behaviors; and high self-harm, those who reported engaging in more than three self-harming behaviors. Roughly half of the adolescents fell into the low self-harm group, 28.2% into the moderate group and 18.1% into the high group.

The authors found a significantly elevated level of dissociation among adolescents who engaged in NSSI, suggesting that dissociative experiences could be a mediating factor between child sexual abuse and NSSI. While only 5% of the participants in the low and moderate NSSI group presented with clinical levels of dissociation, 37% of participants in the high NSSI group presented with clinical levels of dissociation. It should also be noted that a decline in the level of dissociation was significantly related to a decline in NSSI behaviors.

Matsumoto and colleagues (2004) explored the relationship between dissociative symptoms and NSSI in a sample of female Japanese outpatients. Participants, aged 15-34 years, with a history of NSSI were matched to psychiatric controls without a history of NSSI, and to a group of normative controls (no NSSI and no psychiatric symptoms). Participants were given the adolescent version of the Dissociative Experience Scale (A-DES; Bernstein & Putnam, 1986), an instrument used to screen for dissociative disorders. Results showed a positive correlation between NSSI and dissociative symptoms, with the NSSI group scoring significantly higher on the A-DES than either of the control groups. Additionally, the study found that a history of child sexual abuse was more frequent in the NSSI group than either control group. This study further supports the belief that NSSI is not unique to Western culture; NSSI appears to be a more universal response to symptoms brought on by enduring traumatic events.

Exposure to childhood maltreatment might be an environmental risk factor for developing NSSI, and attempts to explain the anti-dissociation model of NSSI (Lang & Sharma-Patel, 2011). It is important to note that NSSI is not synonymous with child sexual abuse or other forms of maltreatment; an individual without an abuse history may display NSSI behaviors. Noteworthy, research on NSSI and child sexual abuse yields mixed results (Klonsky & Moyer, 2008). A meta-analysis by Klonsky and Moyer (2008) found only a modest relationship between child sexual abuse and NSSI.

While research has not conclusively shown a cause and effect relationship between NSSI and traumatic events, it is likely that dissociation, a trauma-related symptom, serves as a mediator between the two phenomena (Smith, Kouros, & Meuret, 2014). In exploring the connection between NSSI and childhood trauma, Connors (1996) conceptualized NSSI as a ‘‘fundamentally adaptive and life-preserving coping mechanism’’ (p. 199). A review of the existing research suggests that NSSI plays a role in coping with trauma symptoms, namely ending dissociative episodes (Cyr, McDuff, Wright, Theriault, & Cinq-Mars, 2005; Rallis, Deming, Glenn, and Nock, 2012). Given the research, it is plausible that traumatic events play a role in the development and maintenance of NSSI (Smith et al., 2014).

Anti-Suicide Model

The anti-suicide model posits that NSSI is a means of withstanding powerful urges to commit suicide (Klonsky, 2007). This model has roots in psychoanalytic theory, describing self-injury as a replacement behavior for suicide (Suyemoto, 1998). As stated by Waska (1998), “Psychoanalytic theory proposes that all human behavior has meaning. Specifically, self-destructive acts can be understood as resulting from and symbolizing

certain intrapsychic phantasies involving wishes, fears, and compromises" (p.19). Menninger (1938) argued against the notion that cutting and other forms of NSSI were merely botched suicide attempts. He believed the act of self-injuring was a compromise between the Freudian concepts of life instinct and death instinct; an ongoing war between survival and aggressive impulses (Strong, 1998). NSSI sacrifices a part of the body in order to preserve the whole; avoiding complete destruction, yet satisfying urges through acting upon destructive impulses (Suyemoto, 1998).

According to Conterio and Lader (1998), NSSI "is usually a *life-sustaining* act, a mechanism to cope with stress, relieve inexpressible feelings, and gain attention" (p. 29). Those who engage in NSSI often report it is for the purpose of fighting off suicidal ideations; a safety raft as opposed to an exit strategy (Conterio & Lader, 1998). Additionally, the majority of behaviors associated with NSSI result in superficial wounds, which are highly unlikely to result in fatality (APA, 2013; Conterio & Lader, 1998). However, as stated previously, some self-injurers report hurting themselves more severely than intended (Whitlock et al., 2006).

> There is no hazy line, says Lindsay, a fifteen-year-old cutter. If I'm suicidal I want to die, I have lost all hope. When I'm self-injuring, I want to relieve emotional pain and keep on living. Suicide is a permanent exit. Self-injury helps me get through the moment. (Strong, 1998; p.32)

Literature has supported the notion that NSSI is used as a form of anti-suicide, in that it actually generates feelings of being alive (Hollander, 2008; Conterio & Lader, 1998; Simpson, 1980). Much like Lindsay, the young woman quoted above, quite a few individuals report using NSSI as a means to prevent suicide (Favazza, 1996). Klonsky

and Glenn (2009) found anti-suicide to be the third most cited cause of NSSI in a sample of undergraduate students. This subset of individuals appears to be struggling with suicidal preoccupations and emotional vulnerability, therefore turning to NSSI as a means of averting suicide (Hollander, 2008). Less than 1% of individuals report the desire to die as the precipitating reason for NSSI (Rodham, Hawton, & Evans, 2004). Furthermore, only a small percentage of individuals who engage in NSSI have actually completed suicide (de Moore & Robertson, 1996).

Interpersonal-Influence Model

The interpersonal-influence model theorizes that NSSI is used as a means to acquire a desired response from others (Klonsky, 2007). As stated by Klonsky (2007):

> An individual might self-injure to elicit affection from a significant other or loved one, or to elicit reinforcing responses from authority figures or peers in correctional, clinical, or school settings. One who self-injures for these reasons may or may not be aware of the reinforcement provided by others' reactions to the self-injury. (p. 229)

From this perspective, NSSI is viewed as a cry for help, or a means to communicate to others when less dramatic efforts have failed (Klonsky, 2007). Research has shown that NSSI is positively correlated with symptoms of alexithymia, characterized by a marked inability to identify and verbalize emotions, suggesting that the behavior is used to physically express emotions that words are incapable of doing (Borrill, Fox, Flynn, & Roger, 2009; Garish & Wilson, 2010; Gratz, 2006).

Nock and Prinstein (2004) studied NSSI in a sample of psychiatric adolescent inpatients. Participants were given the Functional Assessment of Self-Mutilation (FASM;

Lloyd, Kelley, & Hope, 1997), a self-report inventory measuring methods, frequency, and functions of NSSI. Findings supported the structural validity and reliability of the interpersonal-influence model of NSSI. Nock and Prinstein (2004) found that NSSI is often used to manipulate the environment, either through social positive reinforcement or social negative reinforcement.

With underpinnings in behavioral psychology, Nock and Pristein's (2004) theory posits that NSSI is performed to either increase the likelihood of an environmental response or decrease the likelihood of an environmental response. The social positive reinforcement function postulates that NSSI is used to elicit a response from others, such as attention, or insight into the self-injurer's psychological pain (Nock & Prinstein, 2004). The social negative reinforcement function posits that NSSI is used to get out of interpersonal task demands, such as avoiding punishment or other undesired activities, like going to school (Nock & Prinstein, 2004). Although findings from the study support the interpersonal-influence model of NSSI, the majority of adolescents self-injured for affect-regulation purposes, supporting the belief that NSSI can serve multiple concurrent functions (Conterio & Lader, 1998; Klonsky, 2007; Klonsky & Muehlenkamp, 2007; Nock & Prinstein, 2004; Suyemoto, 1998). The findings of this study specific to affect regulation will be discussed later on in greater detail.

Hilt, Nock, Lloyd-Richardson, and Prinstein (2008) longitudinally examined perceptions of relationships with parents among a community sample of self-injuring adolescents. The purpose of the of the study was to test the social positive reinforcement theory by examining whether 10-14 year-olds perceived increases in relationship quality with their mothers and fathers after engaging in NSSI. Adolescents were asked to answer

questions about NSSI behaviors, and were then administered the Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987), a 25-item self-report inventory measuring quality of relationships with parents. The IPPA was administered in the beginning of the research study (Time 1) and again 11 months later (Time 2). The study found that participants who engaged in NSSI reported an increase in positive relationship quality with their fathers from Time 1 to Time 2. Individuals perceived NSSI as being associated with positive changes in interpersonal relationships, suggesting that the behavior is used to elicit social support from others.

Lloyd-Richardson, Perrine, Dierker, and Kelley (2007) explored motivations for engaging in NSSI among a community sample of high school students residing in the southern and Midwestern United States. The Functional Assessment of Self-Mutilation (FASM; Lloyd et al., 1997) was used to measure the frequency and functions of NSSI. Those endorsing NSSI reported an average of nearly five NSSI motives, with 19-31% citing interpersonal motives. The most commonly endorsed reasons for NSSI were to try "to get a reaction from someone" and "to get control of a situation." Findings from the study suggest that community adolescents use NSSI to influence individuals in their environments.

Self-Punishment Model

The self-punishment model posits that NSSI is an expression of derogation towards the self, performed because the individual believes they deserve to be in pain (Klonsky, 2007; Wilkinson, 2013). Individuals who engage in NSSI report higher levels of hostility towards themselves, possibly contributing to the tendency to self-punish (Brittlebank, et al., 1990; Simeon, 1992; Hillbrand, 1995). Penn and colleagues (2003)

explored NSSI in a sample of incarcerated adolescents and found that 60% cited self-punishment as a reason for their behavior. Adolescents who endorsed NSSI presented with more severe state anger than their non self-injuring counterparts.

Inbar and colleagues (2013) asked participants to think about a situation in which they felt a strong sense of guilt, then directed them to self-administer electric shocks. Compared to control conditions where participants recalled sad events or neutral events, participants who recalled events that made them feel guilty administered significantly stronger shocks. Results suggest that recalling guilt-inducing events leads to an increased tendency to self-injure. Findings from the study are consistent with existing theories that self-inflicted physical pain is used to compensate for misbehavior (Tanaka, Yagi, Komiya, Mifune, & Ohtsubo, 2014). It is possible that self-injury fulfills urges to self-punish whilst simultaneously reducing feelings of guilt.

Research has shown a link between NSSI and shame, a self-conscious emotion characterized by "disruption in behavior and confusion in thought" (Chapman et al., 2006, p. 378). Shame is associated with the urge to cringe, crawl in a hole, and avoid thinking about the source of shame at all cost (Chapman et al., 2006). Shame is highly correlated with other self-destructive behaviors such as disordered eating and substance abuse (Meehan, O'Connor, Berry, & Weiss, 1996; Randles & Tracy, 2013;Troop, Allan, Serpell, & Treasure, 2008). Individuals prone to shame avoid experiencing and processing intense painful emotions, increasing the likelihood of engaging in NSSI (Chapman et al., 2006).

A laboratory study by Tanaka and colleagues (2014) found that shame proneness is positively correlated with non-physical self-punishment. Japanese undergraduates were

administered the Test of Self-Conscious Affect (TOSCA), a standardized measurement of proneness to guilt and shame. Participants then took part in a fixed laboratory experiment, in which they unknowingly allocated a large portion of money to themselves, leaving their assigned partners with a grossly unfair portion of the funds. Self-punishment was measured by participants' willingness to relinquish a portion of their money, knowing it would not be reallocated to their partners. In other words, giving up money would not result in an even distribution of funds, and thus would not be rewarding by nature of being fair or doing the right thing for the sake of their partner. The amount of money that participants relinquished was significantly correlated to their shame proneness scores on the TOSCA, suggesting that shame-prone individuals self-punish to compensate for perceived wrongdoings.

Schoenleber, Berenbaum, and Motl (2014) found that elevations in shame-proneness were correlated with more frequent NSSI episodes. Participants who endorsed shame-related functions of NSSI endorsed a significantly greater aversion to shame and an overall aversion to negative affect. Results suggest that individuals prone to shame self-injure as a means of down-regulating shame, further supporting the self-punishment model of NSSI. According to the authors "the self-punishment model additionally suggests that NSSI is motivated by punishment-deservingness, or the belief that one deserves to suffer" (p.205).

Affect Regulation Model

The emotional profile of a self-injurer is one of chronic negative affect, specifically self-dissatisfaction (Victor & Klonsky, 2013). Those who engage in NSSI experience more frequent and more intense negative emotions, including depression, anxiety, and anger (Selby et al, 2012). There appears to be a pronounced self-directed aspect to the negative emotion among individuals who engage in NSSI (Klonsky, 2014; Victor & Klonsky, 2013). Intense self-directed negative emotions, including self-derogation, self-directed anger, self-criticism, and low self-esteem, might be the best psychological identifiers of those who self-injure (Klonsky, 2014). Given the degree of negative emotion, it can be assumed that self-injurers suffer from significantly greater emotional dysregulation.

The affect regulation model of NSSI posits that self-injury is a behavior used to relieve intolerable affective states (Klonsky, 2007). As stated by Bresin (2014), "NSSI is a response to intense, frequent, negative affect that is difficult to control" (p. 56). Individuals who engage in NSSI are thought to be more angry, hostile, and irritable than their non self-injuring counterparts (Linehan, 1993). A diminished ability to tolerate negative and ambivalent emotions along with inadequate coping mechanisms to self-soothe may lead to maladaptive coping strategies such as NSSI (Linehan, 1993).

Through her extensive work with Borderline Personality Disorder, Linehan (1993) identified NSSI as a means to regulate one's mood, alleviating intolerable levels of distress. Invalidating environments in early childhood lead to inadequate coping strategies for dealing with psychological distress. Individuals raised in invalidating environments were never taught appropriate coping skills, leading them to believe that they must display extreme behaviors in order to have their problems recognized (Linehan

& Schmidt, 1995). “Individuals from these environments and/or with biological dispositions for emotional instability are less able to manage their affect and are therefore prone to use self-injury as a maladaptive affect-regulation strategy” (Klonsky, 2007; p. 229). In the face of extreme emotional and interpersonal difficulties, NSSI provides an escape from an otherwise intolerable state of being (Linehan, 1993).

Nock (2010) has explored the maintenance of NSSI behaviors through the lens of behavioral psychology:

> A functional approach proposes that behaviors are caused by the events that immediately precede and follow them. This perspective, which is rooted in the tradition of behavioral psychology, has generated major advances in the understanding, assessment, and treatment of a wide range of mental disorder and clinical behavior problems (p. 348).

Nock’s (2010) four-function model conceptualizing the maintenance of NSSI behaviors is comprised of a combination of positive reinforcement, negative reinforcement, intrapersonal factors, and interpersonal factors.

Intrapersonal negative reinforcement refers to situations in which NSSI is followed by a decrease in negative thoughts or feelings. Intrapersonal positive reinforcement refers to an increase in desired thoughts or feelings following an NSSI episode. Interpersonal positive reinforcement refers to situations in which NSSI results in the presence of a desired social outcome. Finally, interpersonal negative reinforcement refers to a situation where NSSI results in a decrease or cessation of a social outcome. The current study will predominately focus on intrapersonal factors related to adolescents

who engage in NSSI, although participants will also be asked about relationships with their parents.

Taylor and colleagues (2012) suggest that individuals are motivated to perform NSSI for intrapersonal reasons. Participants reported frequent use of NSSI to increase desired affect and decrease undesired affect. In comparison to individuals with only a history of self-injury, those who currently engaged in NSSI reported greater levels of intrapersonal negative reinforcement motives, intrapersonal positive reinforcement motives, and past week negative affect. In sum, those with current NSSI behaviors endorsed more affect regulation motives and more prominent negative affect than individuals with only a history of NSSI. Additionally, the authors found that individuals who endorsed NSSI demonstrated higher levels of impulsivity and negative urgency.

Negative urgency, a marker of impulsivity, is the tendency to react to stressful situations in a rash manner (Whiteside & Lynam, 2001). Individuals with high levels of negative urgency are typically high in neuroticism, and low in conscientiousness and agreeableness (Settles, et al, 2012). Settles and colleagues (2012) note that individuals high in negative urgency endorse frequently depressed moods and low self esteem, and tend to have difficulty getting along with others. Taylor, Peterson, and Fischer (2012) revealed that individuals with a history of NSSI demonstrated higher levels of negative urgency and impulsivity than individuals who with no history of NSSI, suggesting that NSSI is used impulsively to relieve stress.

Favazza and Conterio (1988) found NSSI to be a form of morbid self-help, which offers reprieve from unpleasant symptoms including “severe anxiety, intense anger, depression, hallucinations, perceived external or internal flaws, racing thoughts and

rapidly fluctuating emotions, boredom and stimulus deprivation, and feelings of loneliness, emptiness, and insecurity" (p. 27). High levels of negative affect further support the conceptualization that NSSI serves to regulate and cope with distressing emotions. Given the significant level of emotional pain reported by these individuals, there appears to be a need for more effective copings skills to manage distressing symptoms while subsequently replacing NSSI behaviors.

Summary of NSSI Models

Research suggests there are multiple purposes for engaging in NSSI, including anti-dissociation, anti-suicide, interpersonal influence, self-punishment, and affect regulation (Chapman et al., 2006; Conterio & Lader, 1998; Klonsky, 2007; Lloyd-Richardson et al., 2007; Nock & Prinstein, 2004; Strong, 1998; Suyemoto, 1998). According to Klonsky (2007) the multiple functions of NSSI can be interpreted as differences among subgroups of self-injurers, evolution of functions over time, overlap among functional models, and the possibility that multiple functions of NSSI exist concurrently among individuals. While there are multiple models, which attempt to explain NSSI, the affect regulation model appears to have the most empirical support (Klonsky, 2007).

An argument can be made that affect regulation is at minimum, indirectly related to most models of NSSI. For example, self-punishment is associated with feelings of shame, and the belief that one deserves to be punished, both of which are highly indicative of negative affect (Chapman et al., 2006). Engaging in self-inflicted injury because one feels they deserve to be punished is an extreme act of self-derogation, a clinical issue common among those suffering from anxiety and depression (Cramerus,

1989). Dissociative episodes that necessitate bodily harm to cease, are indicative of pathological fear, helplessness, and horror (Smith et al., 2014), and outside of psychotic disorders, one does not typically have suicidal urges because they are feeling "well." While affect regulation might not be the direct purpose for all acts of NSSI, it can be argued that an underlying affective disturbance is prevalent in many individuals who self-injure (Conterio & Lader, 1998). The remainder of the literature review will identify definitions and theories of affect regulation and attempt to synthesize research among adolescent populations. For the purpose of this research, the terms affect regulation and emotion regulation, are used interchangeably.

Affect Regulation

Emotion has been described as "a subjective reaction to a salient event, characterized by physiological, experiential, and overt behavior change" (Sroufe, 1996, p. 15). Emotions involve an evaluation of meaning, and typically emerge when something important is in the balance (Gross, 2002; Siegel, 1999). Emotions can come about automatically, exampled by a fear reaction to hearing menacing footsteps at two o'clock in the morning (Gross, 2002; Sutton & Altarriba, 2011). Emotions can also come about more deliberately after thorough consideration, exampled by becoming saddened after not being invited to socialize with a group of friends (Gross, 2002). Emotions catalyze behavioral and physiological reactions that influence the way in which one responds to challenging situations, events, and stimuli (Gross, 2002; Gross & John, 2003).

Emotions can be of great service, as in the aforementioned example of hearing footsteps in the middle of the night. "This rapid perception of potential threat and danger is evolutionarily significant and supports a variety of coping strategies such as fight or

flight responses" (Sutton & Altarriba, 2011, p. 736). A fear reaction causes a surge in adrenaline and a heightened level of alertness needed to respond to the threat of a potential intruder (Mezzacappa, Katkin, & Palmer, 1999). Without the fear reaction, one might be physically and emotionally unequipped to deal with a seemingly dangerous situation. In other situations, emotions can be undermining, and are capable of doing more harm than good. In the example of not being invited to socialize, reacting with a violent display of anger, an over-the-top response, would likely result in many more evenings of not being invited to socialize. When emotions fall out of line with a given situation, individuals attempt to modify their responses in order to have their needs met, a process referred to as emotion regulation, or affect regulation (Augustine & Larsen, 2015).

Gross (1998) defines affect regulation as "the processes by which individuals influence what emotions they have, when they have them, and how they experience and express these emotions" (p. 275). Most individuals wish to feel happy, therefore affect regulation strategies often serve to reduce negative feelings and increase positive feelings (Augustine & Larsen, 2015). However, affect regulation is a complex process that involves increasing, decreasing, and maintaining both positive and negative emotions (Gross, 2002). Research suggests that individuals exert a considerable amount of effort into regulating their emotional experiences (Gross & John, 2003). Managing one's emotions requires the ability to effectively identify and label feelings, the capacity to modify feelings as necessary, and the knowledge and motivation to develop effective regulation strategies (Grewal, Brackett, & Salovey, 2006).

The ability to regulate emotions is an adaptive strategy that has implications for one's social, physical and mental wellbeing (Gross, 2002). As stated by Gross (2002), "How we regulate our emotions matters: Our wellbeing is inextricably linked to our emotions" (p. 281). Appropriate affect regulation entails being able to evoke, control or inhibit emotional states that are the most applicable to the immediate task at hand (Gross, 2002). For example, when a tearful friend confides in you that they are breaking up with their lover, it would be appropriate to display empathic feelings, even if you find their lover to be a jerk and are actually pleased that they are parting ways. If your end goal in this situation is to be a supportive friend, then suppressing positive emotion and controlling the urge to jump for joy would be the necessary reaction.

Gross (1998) posits that on the most simplistic of levels, affect regulation efforts can be classified as response focused or antecedent focused. Response focused efforts refer to attempts made by an individual to regulate emotions that they are already experiencing (Gross, 1998). An example of this would include suppressing feelings of anger, or going for a bike ride to alleviate anxiety. Antecedent focused efforts refer to situations in which an individual attempts to control emotions that they could potentially experience in the future (Gross, 1998). An example of an antecedent-focused effort would entail avoiding a person whom is known to induce unpleasant feelings. The majority of the research on affect regulation and NSSI suggests the behavior is a response-focused effort, as it is often used to alleviate negative affect, or release unbearable levels of tension (Klonsky, 2007).

Research supports a biological basis for affect regulation involving the prefontal cortex and amygdala (Siegel, 1999; Squire et al., 2008). The prefrontal cortex is

responsible for carrying out more complex behavior, such as decision making, impulse control, and moderating social behavior (Blakemore & Robbins, 2012). This brain region plays a central role in the cognitive control needed to emotionally appraise thoughts and coordinate them into willful actions (Squire et al., 2008). The prefrontal cortex is interconnected with the limbic system, which is implicated in mediating emotion, motivation, and goal-directed behavior (Siegel, 1999; Squire et al., 2008). According to Siegel (1999), "Limbic structures permit the integration of a wide range of basic mental processes, such as the appraisal of meaning, the process of social experience (called "social cognition"), and the regulation of emotion" (p. 10).

The amygdala, part of the limbic system, has a primary role in generating, processing, and regulating emotions (Banks, Eddy, Angstadt, Nathan, & Phan, 2007; Siegel, 1999). Research shows that the amygdala-prefrontal cortex interaction is a pivotal neural mechanism that underlies emotion regulation (Banks et al., 2007; Kong et al. 2013), and lesions in these brain regions result in emotion dysregulation (Sanchez-Navarro, Martinez-Selva, & Roman, 2005). The prefrontal cortex modulates hyperactivity in the amygdala, with successful affect regulation showing increased activity in the prefrontal cortex and decreased activity in the amygdala (Banks et al., 2007; Hartley & Phelps, 2010). The strength of coupling between the prefrontal cortex and the amygdala is positively correlated with the effectiveness of affect regulation, such that stronger connectivity is associated with less intense negative affect (Banks et al., 2007). Functional MRI studies suggest that hyperactivity in the amygdala is indicative of negatively valenced emotional experiences (Davis et al., 2014).

Hyperactivity in the amygdala is thought to be part of the disturbed neural circuitry underlying the heightened emotional reactivity and emotion regulation deficits seen in borderline personality disorder (Goodman et al., 2014). A functional MRI study used picture stimuli to induce negative affect in participants with borderline personality disorder (Niedtfeld, Schulze, Kirsch, Herpertz, Bohus, & Schmahl, 2010). Negatively charged pictures resulted in stronger amygdala activity in participants with borderline personality disorder as compared to healthy controls. Additionally, participants with high symptom severity and deficits in affect regulation showed hyperactivity in the amygdala. When participants were administered a thermal pain stimuli, there was a notable decrease in amygdala activation, suggesting that pain causes an attentional shift away from negatively valenced emotions. Findings have implications for self-injury, in that NSSI might actually give the sensation of feeling good by decreasing amygdala activity, and subsequently reducing negative affect.

Although research on brain activity and NSSI is scarce, it has been found that NSSI behaviors are associated with hyper-reactivity of the amygdala (Niedtfeld et al., 2010). A functional MRI study found that in response to emotionally latent pictures, adolescents with NSSI demonstrated a significantly stronger brain response in the amygdala than their non self-injuring peers (Plener, Bubalo, Fladung, Ludolph, & Lule, 2012). Findings are consistent with existing research showing amygdala hyperactivity in subjects with NSSI (Niedfeld et al., 2010).

The overarching negative affect in self-injuring adolescents (Klonsky, 2014; Selby et al, 2012; Victor & Klonsky, 2013) dovetails nicely with current research on amygdala hyperactivity. Furthermore, the prefrontal cortex, a brain region implicated in

affect regulation and the ability to exercise good judgment, does not fully develop until age 25, placing adolescents are at a biological disadvantage in terms of being able to successfully modulate affect (Walsh, 2014). It may be possible that individuals with altered neural-circuitry have a biological vulnerability to using NSSI as a means to regulate affect. Despite research suggesting a link between disrupted neural-circuitry and NSSI (Niedtfeld et al., 2010; Plener et al., 2012), there is no agreed upon pharmacological treatment for NSSI (Sandman, 2009).

In sum, affect regulation involves the intentional control of feelings in order to achieve a desired outcome, with an emphasis on regulating one's affect in an adaptive manner (Dahl, 2001). As stated by Dahl (2001), "Typically this modulation involves some inhibition, delay, or intentional change of emotional expression or behavior to conform with learned social rules, to meet long-term goals, or to avoid future negative consequences" (p.60). The skill set needed for successful affect regulation reflects adult levels of social maturity and the ability to demonstrate responsible behavior across emotionally challenging circumstances. Proper affect regulation equips individuals with the skill set to navigate powerful and unpleasant feelings that arise in everyday situations. Given the preponderance of evidence pointing to the affect regulation function of NSSI, it appears necessary to expand upon the concept of affect regulation. The following section will explore affect regulation from Schore's modern attachment theory and Linehan's dialectical behavioral therapy paradigm.

Affect Regulation and Modern Attachment Theory

According to Siegel (1999), "Attachment serves as a crucial way in which the self becomes regulated" (p. 240). Modern attachment theory expands upon earlier works of

Bowlby and Ainsworth, integrating attachment theory and neuroscience in attempt to explain the role of affect regulation in human development (Schore & Schore, 2008). Attachment theory focuses on the role of relationships between infant and caregiver in the earliest stages of life, and how those relationships shape basic survival functions throughout the lifespan (Schore & Schore, 2008). Attachment processes, motivated by safety, are at the core of human experience (Slade, 2014). Attachment theory emphasizes the importance of physical safety, as well as the safety that comes through relationships (Slade, 2014). As stated by Slade "relationships, after all, are a basic remedy for fear-of loss, of annihilation, of psychic emptiness-and offer us the deepest expression of our humanity" (pp. 254-255).

While attachment theory believes that infants are motivated to form attachments for safety purposes, the new paradigm for attachment focuses on affect regulation (Schore, 1994). "Modern attachment theory focuses on the nonverbal communication of affective states and the relational regulation of the infant's developing brain/mind/body" (Schore & Newton, 2013, p. 87). Achieving emotional regulation is contingent upon successful social interactions (Siegel, 1999). From the modern attachment perspective, the essential task during the first year of life is the creation of a secure attachment bond between infant and primary caregiver, which is fostered through auditory vocalizations and visual and tactile exchanges (Schore, 2003). Visual experience in particular plays a pivotal role in an infant's emotional and social development (Schore, 2003). According to Schore (2003) early attachment functions are comprised of predominately visual mechanisms, which have the capacity to elicit positive feelings.

Given that visual experience is central to emotional and social development, affect regulation begins with sustained mutual gaze between caregiver and infant (Schore, 2003). The infant's preoccupation with the caregiver's face inducts the pair into an intense mutual gaze, which serves as a powerful means of interpersonal communication (Schore, 2003, Spitz, 1958). As mutual gazes increase the caregiver-infant dyad engages in a process called affective mirroring (Schore, 2003). Affective mirroring is demonstrated by the caregiver responding to the infant's affective displays with affective displays of their own. When an infant looks at his/her mother, the mother responds with an exaggerated smile, which the infant then reciprocates. As the infant laughs, the mother relaxes her smile, causing the infant to look away. As the infant looks away, the mother returns to a neutral facial expression and watches the infant for cues. As stated by Schore (2003) affective mirroring is the process of "moment-by-moment matching of affective direction in which both partners increase together their degree of engagement and facially expressed positive affect" (p. 8).

In early development, the participation of caregivers is critical in enabling the infant to shift from negative hyperarousal to positive affect (Schore, 2003). Infants have the ability to regulate low-level negative affect, but as affect states increase in intensity, infants rely on the caregiver's mutual gaze, motherese tone, gentle touch, and physical gestures to modulate their affect (Schore, 2003). When caregivers are in states of dysregulated hyperarousal or hypoarousal they are less attuned to the infant's emotional communications, and cannot act as a regulator of their infants' affective states (Schore & Newton, 2013).

Prolonged negative affect states in infants are thought to be a pivotal risk factor for developing psychopathology (Schore, 2003). Infants who sustain critical and prolonged sympathetic nervous system arousal develop dissociative hypoarousal as a means to regulate affect, which can lead to pathological levels of dissociation (Schore & Newton, 2013). Furthermore, infants who are not regulated by their caregivers are at an increased risk for forming a disorganized attachment style (Schore, 2003), which is implicated in the development of internalizing disorders, externalizing disorders, and personality disorders (Sroufe, Duggal, Weinfield, & Carlson, 2000). Resiliency is measured through the ability for infants and caregivers to shift between states of negative and positive affect. According to Malatesta-Magai (1991), "the process of reexperiencing positive affect following negative experience may teach a child that negativity can be endured and conquered" (p.218).

> The baby becomes attached to the modulating caregiver who expands opportunities for positive affect and minimizes negative affect. In other words, the affect state underlies and motivates attachment, and the central adaptive function of attachment dynamics is to interactively generate and maintain optimal levels of positive states and vitality affects. (Schore, 2003, pp. 11-12).

Schore and Schore (2008) postulate "that individual development arises out of the relationship between the brain/mind/body of both infant and caregiver held within a culture and environment that supports or threatens it" (p.10). One of the key concepts of modern attachment theory is the role of the right brain hemisphere in regulating emotion (Schore, 1994). Attachment communications are essential to the structural development of the right brain, which is involved in processing emotion, modulating affect, and self-

regulation (Schore & Schore, 2008). The infant's visual exchanges with the caregiver stimulates the developing brain, as the right hemisphere is dominant in the processing of visual and emotional information, and for the recognition of affect states in the caregiver. (Emde, 1988). "The dyadic relations between child and caregivers within the first years of life can have direct and enduring effects on the child's brain development and behavior" (Leckman & March, 2011; p. 334).

Affect Regulation and Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) is one of the leading modalities in the conceptualization and treatment of emotional dysregulation (Neacsiu, Eberle, Kramer, Wiesmann, & Linehan, 2014). Emotional dysregulation is categorized by the marked reactivity of mood, which can lead to more severe affective disturbances including depression, irritability, and anxiety (Marganska, Gallagher, & Miranda, 2013). DBT views maladaptive behavior as either a result of dysregulated emotions or a failed attempt to modify emotions (Neacsiu, Eberle, Kramer, Wiesmann, & Linehan, 2014). DBT was developed by Dr. Marsha Linehan to address Borderline Personality Disorder (BPD), which one of the major characterizations is extreme affect dysregulation (McMain, Korman, & Dimeff 2001). DBT blends cognitive behavioral treatment approaches with Buddhist concepts of mindfulness and acceptance (McMain et al., 2001). It is worth noting that to date, BPD is the only formal diagnosis that includes self-mutilation in its diagnostic criteria (APA, 2013*)*.

DBT assumes that emotions are prompted by internal or external events, and function to organize and motivate action (McMain et al., 2001). Emotions are conceptualized systemically, and not just from the individual's lived experience. Emotion

is a survival mechanism encompassing behavioral reactions, but also biochemical changes in the brain, as well as physiological changes in the body (McMain et al., 2001). Emotions allow an individual to prepare both psychologically and physiologically to environmental stimuli, and appraise the personal significance of stimuli (McMain et al., 2001). As stated by McMain and colleagues (2001), emotions can be validating in that they "affirm one's perceptions and interpretations of events. For example, the recognition of an actual environmental threat affirms the experience of 'terror' and the emotion of fear." (p. 185). Being able to accurately identify an emotional response allows the individual to trust his or her own voice and is critical in the development of effective emotion regulation (Linehan, 1993).

Emotional dysregulation is thought to result from an interaction between biological irregularities and invalidating environments (Linehan, 1993). Biological irregularities result in emotional vulnerability; categorized by exaggerated sensitivity to emotional triggers, heightened emotional intensity, and a slow return to emotional baseline (Linehan, 1993). High sensitivity is identified by hasty reactions and low tolerance for emotional stimuli; individuals described as being quick to fly off the handle (Linehan, 1993). Individuals with emotional sensitivity are more likely to be triggered by seemingly benign situations. In other words, events that do not take aback most people are likely to draw an elevated reaction from an emotionally vulnerable individual.

Emotional intensity, another characteristic of emotional vulnerability, refers to the extremeness in reaction to emotionally triggering stimuli (Linehan, 1993). These individuals are often labeled dramatic, as their reactions appear to be out of proportion for the situation. What might result in guilt for most is met with a deep, resonating shame

by the emotionally vulnerable. Finally, return to emotional baseline refers to the amount of time it takes to regroup and move past an emotional reaction (Linehan, 1993). Those who display emotional vulnerability typically have longer lasting emotional reactions (Linehan, 1993).

According to Linehan (1993), the greater the emotional vulnerability the more important it is to be successful at modulating affect states. Emotional vulnerability stems from a biological predisposition, and can be exacerbated by environmental circumstances. Environment can contribute to the development of emotional regulation deficits in situations where the child is already predisposed to being sensitive (Linehan, 1993). An emotionally sensitive child is often not well received in their environment, as their behavior is characterized as being reactive and extreme. Over time, those around the emotionally sensitive child grow annoyed with the emotional outbursts and either ignore the child, or punish the child for being seemingly over reactive. The sensitive child is made to feel that their emotions are bad or wrong because they are constantly being ignored or punished for their emotional expression (Linehan, 1993). The lack of emotional validation in the environment leads to significant disruptions in the ability to self-regulate emotions (Linehan, 1993).

Invalidating environments minimize, dismiss, ignore, or even punish the child for their cognitive and emotional expressions (Harned, Banawan, & Lynch, 2006). “An invalidating environment is one that chronically and pervasively invalidates an individual’s internal experiences and self-generated behavior” (Harned, Banawan, & Lynch, 2006; p. 70). According to Linehan (1993), the two primary characteristics of invalidation are 1) communicating to the individual that their experiences are wrong and

2) attributing one's experiences to individual character defects. For example, a crying child might be told that they are ridiculous for getting upset. This statement sends the message that the child's reaction is both inappropriate and indicative of a character flaw. Invalidating environments communicate to the child that negative emotions will not be tolerated; lending them to believe that experiencing and expressing any kind of unpleasant feeling is inherently bad (Linehan, 1993). Furthermore, invalidating environments do not teach children how to "tolerate distress or to form realistic goals and expectations" (Linehan, 1993, p. 51).

Summary of Affect Regulation Theories

Both modern attachment theory and dialectical behavioral therapy note the influence of early environment, specifically caregivers, on the acquisition of affect regulation. The development of affect regulation begins at an early age, and although adolescence is marked with rapidly fluctuating emotions, basic affect regulation skills are usually acquired by this stage of development (Schore, 2003). There can be very negative long-term consequences to the wellbeing of individuals, adolescents in particular, who have failed to appropriately develop affect regulation skills (Dahl, 2001). How individuals are able to regulate their emotions is of particular importance, as emotional disturbances appear to be at the core of many psychological disorders (Kring & Sloan, 2010). In fact, over 85% of the disorders specified in the *DSM-5* involve substantial difficulties in the expression and experience of emotions (Kring & Sloan, 2010).

As stated previously, there appears to be an underlying affective disturbance among individuals who engage in NSSI, and a preponderance of research points to NSSI as a maladaptive affect regulation strategy (Klonsky, 2014; Selby et al, 2012; Victor &

Klonsky, 2013). Given that NSSI has been 1) established as an affect regulation strategy, and 2) is overrepresented in the adolescent population, the remainder of the literature review will explore adolescent populations who engage in NSSI for affect regulation purposes.

Adolescent NSSI and Affect Regulation

In regards to prevalence and age at onset, it appears that adolescence is the most vulnerable demographic group for NSSI (You, Lin, & Leung, 2013). Adolescence is an age when rapid changes in biological, social, cognitive, and emotional spheres take place (Lerner & Steinberg, 2009). During adolescent development, negative affect is more common, as it is an age linked to biological changes, increased need for autonomy, and problem behaviors such as defiance, low self-esteem, and bouts of anger (Berger, 2009; Silk, Steinberg, & Morris, 2003). During adolescence, unstable peer relationships are prevalent, and a decrease in the level of parental support is readily perceived (Furman & Collins, 2009; Furman & Buhrmester, 1992). Quirk, Wier, Martin and Christian (2014) found that perceived parental rejection was positively correlated with NSSI, suggesting that dysfunctional relationships with caregivers negatively impact the ability to self-regulate affect.

Ross and Heath (2002) explored NSSI behaviors in a community sample of 440 adolescents. Adolescents who engaged in NSSI reported significantly more depressive symptomology and greater anxiety in comparison to their non self-injuring counterparts. The majority of adolescents who engaged in NSSI endorsed language such as “lonely” “sad” and “alone” to describe how they felt prior to episodes of NSSI. Given the elevated level of negative affect immediately prior to engaging in the behavior, it is likely that

NSSI functions as a means to control distressing feelings of tension and sadness within the adolescent population. Given the results, it appears that research efforts should focus on exploring and managing negative affect.

Laye-Gindhu and Schonert-Reichl (2005) examined underlying functions of NSSI behaviors in a community sample of adolescents. More than four hundred adolescents who were attending public high school in Canada completed questionnaires assessing for NSSI, psychological adjustment, health behaviors, suicide history, and social desirability. A 29-item self-report inventory was used to assess motivations and functions of NSSI, including self-anger, interpersonal anger, tension/distress and boredom. Participants were asked to reflect on their NSSI behaviors and indicate the veracity of the statements on a 4-point Likert scale.

An overwhelming percentage of motivations for engaging in NSSI focused on affect regulation. Results found that more than 50% of the adolescent participants identified depression, loneliness, anger, and inadequacy as reasons for engaging in NSSI. Participants endorsed a number of emotional states that they experienced prior to, during, and after engaging in NSSI episodes. It was found that participants experienced unbearable negative affect (anger, depression, loneliness, and frustration) prior to engaging in episodes of NSSI. There was a decrease in negative affect both during and after engaging in episodes of NSSI, supporting the affect regulation function of NSSI. Paradoxically, participants experienced shame, guilt and disgust with their NSSI behaviors. This finding is worth noting because it shows that adolescents were willing to engage in a physically harmful behavior in order to decrease negative affect despite the fact that it made them feel badly about themselves. While a decrease in negative affect

was reported during and after NSSI episodes, positive feelings increased only slightly during NSSI episodes.

DiPerro and colleagues (2014) also measured affect states before and after episodes of NSSI in a community sample of adolescents in Northern Italy. Affect states were grouped into four categories: positive high-arousal affects (happy); positive low-arousal affects (relieved); negative high-arousal affects (nervous, anxious, angry at self, angry at others); and negative low-arousal affects (bored, sad, guilty). The most commonly reported affect states reported before and after NSSI episodes were negative high-arousal affect states and negative low-arousal affect states. Linear regressions showed that negative high-arousal affect states before engaging in a NSSI episode predicted increases in relief, boredom, sadness and guilt after a NSSI episode. Oddly enough, linear regressions showed that experiencing negative high-level arousal states such as anxiety and anger before an NSSI episode actually predicted increased feelings of anxiety and anger after a NSSI episode.

These results partially support the affect regulation function of NSSI, suggesting that NSSI may be performed with the intention of reducing acute negative feelings. It is possible that engaging in NSSI provides mixed results and is not always effective in reducing intense and unpleasant affect states. It is also possible that adolescents are being intermittently reinforced by the affect regulation function of NSSI, as it appears to be effective at times, in reducing such negative high-arousal affect states.

Lloyd-Richardson, Perrine, Dierker, and Kelley (2007) used the Functional Assessment of Self-Mutilation to assess NSSI behavior in a sample of community adolescents residing in the southern and midwestern United States (FASM; Lloyd et al.,

1997). Results showed that adolescents reported high rates of NSSI in order to manage internal emotions. One of the most common reasons for NSSI was "to stop bad feelings." Rather alarming is the fact that the sample used in the study was non-clinical, indicating that NSSI might be a relatively normal affect regulation strategy among the general adolescent population.

You, Lin, and Leung (2013) explored functions of NSSI among Chinese adolescents over a six-month span. Participants aged 12 to 18 years, were recruited from eight high schools in Hong Kong. The researchers classified seven NSSI behaviors into two types: moderate/severe (self-cutting and burning) and minor (self-biting, punching, scratching, inserting objects and banging). At Wave 1 of the study, participants were asked how often they had engaged in each of the seven NSSI behaviors over the past year. At the Wave 2 assessment, participants were asked how often they had engaged in the same seven NSSI behaviors over the past six months. The frequency of NSSI behaviors was rated on a 4-point Likert scale, ranging from "never" to "six times or more." Participants who endorsed engaging in one or more NSSI behaviors were asked to complete an additional assessment on the functions of their NSSI. Functions of NSSI behaviors were assessed through an adapted version of the FASM (Lloyd et al., 1997). To further clarify the affect regulation function of NSSI, the researchers replaced the original FASM item " to stop bad feelings" with several emotion-specific items such as "to get rid of depression" and "to relieve stress." The items were rated on a 7-point Likert scale ranging from "not at all like me" to "like me very much."

Exploratory factory analyses found affect regulation to be the most frequently endorsed function of NSSI, followed by social influence and social avoidance.

Specifically, reducing depression, anxiety, stress, senses of hopelessness and helplessness, getting rid of unwanted thoughts or memories and feeling relax comprised the affect regulation function in the study. There were no differences on the mean endorsement of NSSI functions between moderate/severe self-injurers and minor self-injurers, suggesting that self-injurers did not choose NSSI methods to serve different purposes. Upon examining the six-month stability of NSSI functions between Wave 1 and Wave 2, it was found that functions of NSSI varied over time within the individual adolescents. These findings suggests that functions of NSSI might be less stable in adolescent populations, therefore regular assessment of the functions of NSSI would be beneficial when working with adolescent self-injurers. The findings from this study support the affect regulation function of NSSI. Again, the sample used was non-clinical, suggesting that NSSI is not exclusive to clinical samples. Additionally, the sample used was from China, adding further support that NSSI is a more universal strategy used to regulate negative affect states.

There is a strong body of research showing that NSSI is a problematic behavior used by adolescents as a means to regulate affect (Di Pierro, Sarno, Gallucci, & Madeddu, 2014; Laye-Gindhu & Schonert-Reichl, 2005; Lloyd-Richardson et al., 2007; You, Lin, & Leung, 2013). The following study contributes to the existing literature on affect regulation by exploring the affective experience of adolescents who engage in NSSI. The majority of existing research on adolescent NSSI employs quantitative methods, leaving a vacuum for qualitative research. Given the lack of qualitative research on adolescent NSSI, the following study used semi-structured interviews to inquire about feeling states before, during and after episodes of NSSI, and perceived relationships with

parents. Semi-structured phenomenological interviews allowed adolescents to discuss self-injury in their own words, contributing to the existing research, and potentially generating new hypotheses about the affective experience of adolescent self-injury.

Chapter Three: Methods

Qualitative Research

It is not possible to fully understand human actions without first understanding the personal meaning assigned to these actions (Marshall & Rossman, 2011). The purpose of the current research is to describe the lived experience of NSSI as accurately as possible from the perspective of adolescents experiencing it. Qualitative research is a fitting method to explore the phenomenon of NSSI due to the deep, personal nature, and intensity of emotions involved. In-depth knowledge about the emotions and values that encompass NSSI were explored using phenomenological interviews, which allowed participants to convey what self-injury means to them on a deeply personal level. As previously stated, individuals who engage in nonsuicidal self-injury feel misunderstood, judged and unheard. The very nature of NSSI is isolating, as it is typically performed alone, kept a secret, and carries a stigma of shame. Allowing individuals the space to describe their emotional experience with NSSI provided rich descriptions and contributed to a deeper understanding of NSSI. In addition, the study provided the capacity to be a healing opportunity, as phenomenological research allowed participants to be heard, without imposing judgments or assumptions about their feelings and individual experiences.

Phenomenological Research

The methodology chosen for this research was descriptive phenomenology. Phenomenological research exemplifies lived experience and provides rich descriptions of how individuals experience certain phenomena (Marshall & Rossman, 2011). Phenomenology is a qualitative research method grounded in the works of German

Philosopher, Edmund Husserl (Giorgi & Giorgi, 2008). Founded at roughly the same time as modern psychology, phenomenology and psychology are complimentary, both with underpinnings in the study of consciousness. In building the foundation for phenomenology, Husserl attempted to identify the process for which objects and events come through one's consciousness, and eventually developed a method for conducting this process.

The objective behind phenomenology was to legitimize the foundations of knowledge so it could withstand scrutiny from skeptics (Giorgi & Giorgi, 2008). The school of thought behind phenomenology is in opposition to positivism, which assumes that truth only exists in scientific knowledge, backed by rigorous empirical evidence. Husserl's antipositivist approach assumes that legitimate and useful information about a phenomenon can be gathered outside the confines of an experimental laboratory. Qualitative research occurs in a naturalistic setting, and phenomenological research in particular, explores the lived experience of an individual in relation to a particular phenomenon.

Although phenomenology was being developed in the beginning of the twentieth century, it was not until 1970 that Amedeo Giorgi was credited with pioneering a scientific methodology conducive to psychological research (Giorgi & Giorgi, 2003). The phenomenological method has aided the discipline of psychology a great deal in its ability to derive information about human experience in psychologically significant ways. Evidence from phenomenological research is obtained through first-person accounts of lived experience (Moustakas, 1994). "The aim of the researcher is to describe as accurately as possible the phenomenon, refraining from any pre-given framework, but

remaining true to the facts" (Groenewald, 2004, p. 5). Phenomenological research aims to understand and shed light on the experiences of individuals in everyday life.

Statement of the Research Problem and Question

The research problem. The decision to study adolescents was made after reviewing the literature, which strongly suggests that NSSI is a behavior that begins in adolescence. NSSI is a problem that is associated with a myriad of mental disorders including depression, disordered eating, anxiety disorders, and borderline personality disorder, and comes with the threat of more serious and potentially fatal self-inflicted behaviors (Nock et al., 2006). It is a behavior that is poorly understood by parents, teachers, friends, and mental health providers. A strong body of research shows that NSSI is a problematic behavior, which begins in adolescence and is used to regulate affect (Di Pierro, Sarno, Gallucci, & Madeddu, 2014; Laye-Gindhu & Schonert-Reichl, 2005; Lloyd-Richardson et al., 2007; You, Lin, & Leung, 2013). Although there is a wealth of information on adolescent NSSI and affect regulation, the majority of existing research uses quantitative methodology. There is currently a dearth of literature in clinical psychology describing the affective experience of adolescents who engage in NSSI as told in their own words.

The research question. The primary research question the study sought to investigate was: *What is the lived experience of adolescents who engage in NSSI?* The focus was on the adolescent's affective experience of NSSI. Interviewing adolescents who engage in NSSI provided insight into the emotional state associated with this painful phenomenon. Generating additional knowledge on the affective experience of adolescents who self-injure has important social and clinical implications in reducing the stigma of

NSSI and identifying traits that appear to be common among adolescent self-injurers. Identifying common characteristics among adolescent self-injurers may potentially lead to prevention measures and developments in effective treatment strategies. Phenomenological semi-structured interviews were held with the participants in order to answer the research question, "What is the lived experience of adolescents who self-harm?" This question was intended to be as open-ended as possible in order to refrain from introducing biases and increase the possibility of obtaining responses rich in description. To stimulate further discussion and open up the nuances of the primary research question, a semi-structured interview was used (Appendix A). It is worth noting that phenomenological methodology refrains from making assumptions about what the participants will reveal, therefore specific hypotheses were not identified.

Participants

The study sample consisted of six adolescent participants, aged 14 to 17, who acknowledged engaging in NSSI. About qualitative research, Hycner (1999, p. 156) asserts, "the phenomenon dictates the method (not vice-versa) including even the type of participants." The volunteers were recruited through purposive sampling from an outpatient facility in Southern California. In purposive sampling, participants are selected based on a specific characteristic that is known about them (Groenewald, 2004). In the current study, participants were chosen based on their age and identified experience with NSSI.

Criteria for Inclusion

In order to qualify for the study, participants were required to meet criteria for the proposed NSSI diagnosis found in the *Diagnostic and Statistical Manual of Mental*

Disorders (5th ed.; *DSM-5*; APA, 2013). The main diagnostic feature of NSSI is engaging in self-inflicted injury in order to obtain some form of desired relief or response. Over the course of a year, the individual has engaged in self-inflicted injury on five or more days, usually resulting in visible skin desecration, such as bruising or bleeding. The individual engages in the behavior in the absence of suicidal intent, and not for purposes that are socially sanctioned, such as body piercing or tattooing. The intentional self-injury is associated with interpersonal difficulties, or negative feelings or thoughts, which occur in the time frame immediately prior to the act.

The participants, five females and one male, obtained parental consent to participate in the research, and were enrolled in psychotherapy at the time of their phenomenological interview. The requirement for receiving psychotherapy was an important safeguard for the participants because of the negative affect and physically harmful behaviors involved in NSSI. Requiring participants to be receiving psychotherapy assured they had a place to process any thoughts or feelings that might have come up during the interview. Additionally, it is possible that participants who were enrolled in psychotherapy demonstrated unique insights as a result of having experience with processing emotions, family relationships, and self-injury behaviors.

Criteria for Exclusion

Due to the sensitive nature of the phenomenon being studied, participants were not eligible for the study if they had made a suicide attempt or suicide plan within 60 days of their phenomenological interview.

Recruitment Procedures

The outpatient facility provided written permission for the research to be conducted and for the recruitment of participants **(**Appendix D**)**. Upon receiving approval from the Institutional Review Board, this researcher spoke with the clinical staff of the outpatient facility, and provided an overview of the research. Inclusion and exclusion criteria were reviewed with the clinicians so they were able to refer participants who met requirements to participate in the study. In addition, clinicians were given the following instructions: "Please do not refer anyone to the research that you, in your professional opinion, feel is suicidal or does not have the emotional capacity to discuss their experiences with NSSI; Do not refer anyone whose parent is unaware of their history of NSSI, as parental consent is required for their participation and to be screened for potential participation." Additional recruitment took place by posting flyers at the outpatient setting and having counselors make announcements during therapy groups and individual sessions. Flyers had the researcher's contact information, both email and phone number, and clinicians provided the researcher's contact information to any potential participants who expressed interest in the research. A copy of the recruitment flyer is located in Appendix F.

Screening Process

Potential participants were screened through specific questions (Appendix C) to assure they met requirement for participation. The participants were all under the age of 18, therefore, parents were provided with an explanation of the research (Appendix E) and signed an informed consent (Appendix B) giving permission for their children to be screened and interviewed. The researcher provided each participant with the written

overview of research as well as the informed consent prior to the initial meeting via email. Participants and parents were asked to familiarize themselves with the documents prior to the screening so they had time to reflect upon any questions they might have had about the research.

Procedure

Both parents were required to consent to their child's participation in the research. A meeting was scheduled with each potential participant to explain the research and screen for participation. The screening was conducted with only the participant present, and took place in person, due to the sensitive nature of inquiring about potential suicidal behaviors. Upon completing the screening process, eligible participants stayed for the semi-structured interview. Adequate time was given for participants to ask questions. All participants who were screened met criteria and subsequently participated in the study.

Data Collection

Phenomenological research begins with a detailed description of an experience, obtained through interviews (Giorgi & Giorgi, 2003). This study used semi-structured interviews to identify perceptions and explore the insights, emotions, and attitudes of participants. Semi-structured interviews were conducted, based on open-ended interview questions (Appendix A) that allowed participants to richly describe their lived experience of NSSI. According to Giorgi and Giorgi (2003), "the purpose of the interview is to have the participant describe in as faithful and detailed a manner an experience of a situation that the investigator is seeking" (p. 251). The interviews were open-ended, ranging in length from 30 to 90 minutes, and audio taped using a digital voice recorder. Following

each interview, this researcher transcribed the audio recordings. The transcribed interviews served as the raw data.

Data Analysis

Prior to reading the transcriptions, it was important to adopt the phenomenological attitude of the epoche, or bracketing. In phenomenological research, the epoche, a Greek word meaning, "to stay away from or abstain," involves bracketing the researchers own biases and assumptions about the phenomenon (Moustakas, 1994). "In the Epoche, we set aside our prejudgments, biases, and preconceived ideas about things" (Moustakas, 1994, p. 85). The attitude of the epoche allows the phenomenon to be viewed for what it is, as closely as possible to how it is experienced by the participants, without biases or preconceived notions from the researcher. As stated by Hycner (1999), "the transcriptions, are approached with an openness to whatever meanings emerged" (p. 280). Bringing awareness to potential biases this researcher had about the phenomenon was a measure used to help assure that the data remained as objective as possible.

A specific method used to analyze the phenomenological data was reading for a sense of the whole (Giorgi & Giorgi, 2003; Hycner, 1999). "Once in written form, data are openly read first without the research focus in mind in order to grasp the participant's expression and meaning in the broadest context" (Wertz, 2005, p. 172). Each transcript was read in entirety, a number of times to obtain a sense of the whole interview. In addition, this researcher listened to the audio-recorded interviews a number of times in order to pick up on any nuances, and get a full flavor for each participant. The

phenomenological perspective is holistic; therefore it is a necessary to capture the full essence of each transcription (Giorgi & Giorgi, 2008).

The next step in the data analysis was delineating units of general meaning, which was a rigorous process of going over each word of the transcript in order to identify meaning units (Hycner, 1999). According to Hycner (1999), meaning units are words or phrases in the transcript "which express a unique and coherent meaning (irrespective of the research question) clearly differentiated from that which precedes or follows" (p. 282). The transcript was thoroughly and rigorously read, and slash marks were used to separate each unit of meaning. A list of the general meaning units were recorded.

The next step of analysis involved delineating units of meaning relevant to the research question (Hycner, 1999). Once the list of general meaning units was generated, it was reviewed to determine which meaning units were relevant to the research question, "what is the lived experience of adolescents who engage in nonsuicidal self-injury?" If the meaning unit appeared to be related to the research question, it was recorded as being a relevant meaning unit. All relevant meaning units were recorded, and any statements irrelevant to the research question or clearly redundant to those previously listed were not recorded. After developing a list of non-redundant units of relevant meaning, the next step was clustering together the remaining units of relevant meaning in order to identify emerging themes (Groenewald, 2004). This process was repeated for each participant interview. Themes among each participant were then compared and contrasted to one another in order to look for themes consistent across all of the participants.

Ethical Considerations

The informed consent document identified the purpose of the research, procedures, perceived risks and benefits, the voluntary basis specifying the right to stop research at anytime, and the procedures used to protect confidentiality. Participation in the study was completely voluntary and the participants were repeatedly made aware that they were able to end their participation in the study at any time without risk or harm. The signed informed consent forms will be kept for seven years in a sealed envelope and stored in a locked cabinet, to which only this researcher will have access. After seven years have elapsed, the signed informed consent forms will be shredded and thrown away.

As one measure to protect anonymity, participants were asked to pick a pseudonym to go by in the research. Allowing participants to pick their own pseudonym demonstrated a sense of safety by protecting anonymity, and gave participants a feeling of being invested in the research. Any identifying information was concealed, altered or omitted from the data analysis at the discretion of this researcher.

It was clearly explained that while discussing their experience with NSSI might have therapeutic elements, the researcher would not be providing therapy and participating in the research should not be done in lieu of therapy. It was also explained the content of the interview would be completely confidential. Only the date and time of their interviews were provided to clinicians. The purpose of notifying clinicians was a safeguard to assure that participants had a venue to process any emotions that might have come up during the interview. Participants were made aware that should they choose to

withdrawal from the study, it would in no way impact the treatment they were receiving at the facility.

It is worth noting that this researcher has more than five years of experience conducting clinical interviews with adolescents who self-harm. Although the scope of the research did not involve providing therapy, this researcher used therapeutic judgment when interviewing participants in order to build rapport, and monitor for signs and symptoms of distress. Using therapeutic judgment was an ethical safeguard to protect participants from experiencing undue distress.

The collected information is stored in a Microsoft Word document maintained on a password protected flash memory data storage device, and a second backup flash memory data storage device, as to avoid inadvertent data loss. The hardcopies of the transcripts will be kept in a sealed envelope for seven years, and stored in a locked cabinet, to which only this researcher will have access. After seven years have elapsed, the hard copies will be shredded and properly discarded.

Chapter Four: Results

Participant Descriptions

Six participants, five females and one male, were interviewed for the research study, using a semi-structured phenomenological interview. The participants ranged in age from 14-17, with a mean age of 15.83. Of the sample, four participants identified as Caucasian, one participant identified as Mexican-Caucasian, and one participant identified as Russian.

Allie

Allie was a 16-year-old, soft-spoken, Caucasian female, who had been self-harming since she was 14 years old. She identified cutting as her preferred method of self-harm, and gave the reason, "I feel like I deserve it." When asked if the intention of cutting was to end her life, Allie shook her head with conviction, and firmly said, "no." In a twelve-month period, Allie had cut herself on more than 20 occasions, and stated that on average, she cut "about twice a month." Despite negative consequences, namely arguments with her parents and being placed on various restrictions, Allie continued to cut herself. The last time she engaged in self-cutting was "a couple weeks" prior to the interview.

Allie demonstrated good insight into her cutting behaviors, and described her experiences using therapeutic language. She referred to her conflict style as "avoidant," acknowledged that she was "self-sabotaging," and identified fighting with her parents as "very triggering." Allie had been attending individual and group therapy for approximately one year in order to address self-harm and depressed mood, and was referred to the study by her individual therapist, whom she was meeting with weekly.

Allie reported that her individual therapist was the "only person" she felt comfortable talking to about cutting.

John Doe

John Doe was an outspoken, 16-year-old Caucasian male, referred to the study by his drug and alcohol counselor. In three years, John Doe had attended numerous outpatient psychotherapy programs to address self-harm, substance abuse, anxiety, and depression. John Doe was engaging, and appeared at ease during the interview, evidenced by spontaneous speech, sustained eye contact, and frequent joking with this interviewer. Although he required little prompting to elaborate upon his lived experience with self-harm, John Doe was somewhat distractible, readily went off on tangents, and used sweeping narratives when responding to interview questions. In spite of seemingly circumstantial speech, John Doe provided rich interview data.

John Doe began cutting his forearms at age 13, a behavior introduced to him by friends. He identified cutting as "a stress reliever," that he used "once every few weeks or months" when having an exceptionally bad day. Despite engaging in the behavior on an, at-minimum, monthly basis, John Doe considered the frequency of his cutting to be "little to not at all." Several years prior to his interview, he was cutting multiple times throughout each day. John Doe attributed his lull in cutting behavior to active participation in therapy, which aided him greatly in managing his level of distress. His most recent cutting episode occurred three weeks prior to the interview, and was triggered by relapsing on inhalants, and subsequently getting into trouble with his parents. In spite of negative consequences for engaging in self-harm, including conflict

with friends and family, John Doe continued to cut his forearms when feeling overwhelmed with anxiety and depression.

Beatrice

Beatrice was a 17-year-old Caucasian female, adopted from Russia at age six, along with her twin sister. She had pressured speech, used excessive profanity, and became side tracked frequently; "I get off topic a lot," she acknowledged. Despite frequent derailments, Beatrice provided rich responses and appeared at ease talking about her experiences with self-harm. She learned about self-harm from friends, and had been engaging in the behavior since age 14. Beatrice identified "coping and attention" as the main reasons for engaging in self-harm. When Beatrice was cutting for attention she felt physical pain; however, when she was cutting to cope with negative emotionality, she did not. While her preferred method was cutting, Beatrice occasionally gave herself eraser burns because, "It doesn't leave as bad of scars as cutting."

Despite losing friends as a result of her behavior, Beatrice continued to cut or burn herself when she needed to alleviate tension. Beatrice most often cut at night, as nighttime was when she found her thoughts racing and was in need of a release. In the year prior to her interview, Beatrice cut herself on more than 30 occasions. At the time of her interview, she was cutting "three to four times a month," an improvement from her previous "daily" self-harm. Beatrice enjoyed the look of her own blood, and when she didn't make herself bleed, she felt that somehow she had "failed." Beatrice had been attending individual and group therapy to address self-harm, depression, and conflict with her parents, and was referred to the study by her individual therapist.

Daisy

Daisy was a 16-year-old Caucasian female, referred to the study by her group therapist. She was eloquent, and spoke thoughtfully and deliberately when articulating her experience with self-harm. Daisy began self-harming when she was a freshman in high school, around the same time that she "came out" as homosexual to her parents. She identified with the self-punishment function of self-harm. "I felt like I needed to be punished for doing things wrong, or just being wrong in general," she explained. At the time of the interview Daisy had been in remission from self-harm for six months, after completing a two-month stint in a residential treatment facility.

At age 14, Daisy began compulsively cutting her arms with razors, punching her head with her fists, and burning her skin with cigarettes. When asked how many times in the past year she engaged in self-harm, Daisy responded "Like, as in one day?" She clarified that until very recently, she had been cutting herself almost every night before going to bed. She explained, "I feel like it's more private, and things kind of come out when it's dark." After cutting, Daisy would wrap her arms, to prevent blood from getting on her sheets, and she would go to sleep. She enjoyed "the sting," and the physical pain of cutting, and continued to engage in the behavior despite the shame it brought her, and the torment it caused her mother and sister.

Rocky Balboa

Rocky Balboa was an expressive, 14-year-old female, of Mexican and Caucasian descent. She had been engaging in self-harm for three years in order to distract herself from depression. Much like the other participants, Rocky demonstrated good insight into her behaviors and used therapeutic language to describe her experience with self-harm.

Despite her young age, Rocky Balboa was eloquent in articulating her thoughts and provided very rich interview data. At age 11, Rocky Balboa started feeling depressed, and subsequently took apart a pencil sharpener and began slicing her legs and forearms. “I just kind of figured, well that’s what all the people in movies and online do, and they seem to always end up getting better, so there must be something to it,” she explained.

Self-harm was only a temporary distraction from depression, but every couple of weeks, Rocky Balboa would cut her arms, legs, and lower stomach with razor blades. Although she identified cutting as her preferred method of self-harm, Rocky also experimented with self-burning, “For about a month, I burned a bit, but I didn’t necessarily like that too much. It caused more pain than distraction, I guess.” Rocky Balboa engaged in self-harm more times than she could count, and became “fond of” the stinging feeling that came from cutting herself. At the time of her interview Rocky Balboa had “47-days free from self-harm,” an accomplishment which brought her great pride. Rocky attributed her abstinence from self-harm to participation in a 12-week intensive outpatient group therapy, which she was attending to address anxiety, depression, and self-harm. Rocky was referred to the study by her individual therapist, whom she was meeting with weekly.

Nicole

Nicole was a thoughtful, 16-year-old Caucasian female who had been engaging in self-harm since age 10. She was polite, made good eye contact, and was eager to discuss her experiences with self-harm. She identified her preferred methods as “cutting and burning.” Although the intention of self-harm was not to end her life, Nicole often thought about suicide while engaging in the act. She endorsed multiple functions of self-

harm, including self-punishment, relieving tension, distracting herself from emotional pain, and avoiding suicide. More often than not, Nicole did not feel physical pain while burning or cutting. She stated, “There were certain times where, this is kind of morbid, but if I went deep enough I could just barely start to feel it.” Nicole described the frequency of her self-harm as progressive in that it started as an isolated event and gradually became a daily act. “As the weeks and months went by, it got to be everyday, sometimes twice a day,” she said. Nicole was able to abstain from cutting and burning for nearly two years, before relapsing and engaging in multiple cutting episodes a month prior to her interview.

Nicole explained that she prefers to keep to herself, and identified her activities of choice as “reading” and “watching movies.” Instead of attending traditional high school, she had been on independent study since her freshman year. “I just couldn’t handle school, especially after all the bullying,” she explained. Both a psychologist and a psychiatrist were treating Nicole, as she endorsed hallucinations and paranoid delusions consistent with a psychotic disorder. Additionally, Nicole was attending intensive outpatient group therapy to address anxiety, depression, and self-harm behaviors. At the time of the interview, Nicole was in the process of being admitted to a partial hospitalization program in order to rule out schizoaffective disorder.

Themes

Nine central themes emerged as significant in the current study. This researcher identified themes when at least half of the participants provided similar responses that were significant to the research question. Subthemes were identified when responses were particularly salient and fell under the umbrella of a central theme.

Theme One: Identification with an Alternative to the Dominant Culture

One of the central themes that emerged from the phenomenological interviews was identification with an alternative to the dominant culture. Participants either identified with a subgroup that fell outside of the dominant culture, or they adopted an attitude that went against the grain of what they believed to be *normal*. In one way or another, the participants all considered themselves to be outsiders.

For John Doe, identifying with an alternative to the dominant culture manifested in the presence of an overarching defiance and rebellion. Although polite with age-appropriate manners, John Doe verbalized a resistance towards authority and societal norms. He made multiple references to America being comprised of "greedy bastards," and felt resentful that there was an implicit expectation for him to be happy. "Why waste my time just so society can think I'm a happy guy like the rest of them?" he shrugged. John Doe felt that "human instinct is to question everything you're told." He added, "It's a good thing. It helps me not bend to what society wants."

For Beatrice, an alternative to the dominant culture meant identifying as Russian. She was born and raised in a Russian orphanage before being adopted by American parents and relocating to Southern California at six-years old. She proudly identified as Russian, and voiced a particular disdain towards "stereotypical Americans." Beatrice reported that she would often get mistook for being Caucasian, which she found highly offensive. She explained, "Caucasians or whites are more from America. The stereotype of being Caucasian or white is like snobby, arrogant people. So I don't like when people call me that. I like Russian. Like, I'm Russian. I'm from Russia."

Daisy's identification with the non-dominant culture manifested in her sexual orientation. She identified as homosexual, and was still coming to terms with the struggles of being a gay teenager in a culture that was not entirely accepting of her lifestyle. "I don't know I am still kind of upset about the fact of me being gay," recalled Daisy. "I'm still like, kind of there's days where I'm like, 'It's cool. Don't worry about it. And just do your own thing and it will be okay.' Then there is other days where I'm just kind of like, 'Ugh! This is such bullshit. Why does it have to be like this?' For a while I would think, 'If I was straight, like my buddy Maggie, I could be like normal and I could do all the things she's doing, and I would have the relationship she has with her family.' But that doesn't really work that way, you know?"

For Rocky Balboa, identification with an alternative to the dominant culture manifested in her feeling like an outcast, having been the victim of bullying since elementary school. "The friends that I had from seventh to eighth, they started off okay, but eventually their jokes got meaner," she recalled. "I didn't understand their humor and it like got to the point where like, I dyed my hair red, all red, so one girl called me 'period head,' and another girl called me 'rag head.' I think around the end of eighth grade, one girl would push me down on the concrete of our gym area. She would take my shoelaces and run around until I chased her to get it back, and stuff. And at the time, they would always come back and be nice to me afterwards, so at the time I was just kind of like, well that's not right, but they're still my friends I guess." By the end of freshman year, Rocky had started a home school program, and completely detached from any semblance of a standard high school experience.

Nicole's identification with the non-dominant culture manifested in her mental health diagnosis. Nicole strongly identified with a diagnosis of Schizoaffective Disorder, a mental illness seen in about .3% of the population (APA, 2013). She reported having visual, auditory, and tactile hallucinations, and described, "Bugs crawling on me, and hands around my neck, and just breath on my face, and it's not cool." In addition to psychotic symptoms, Nicole also reported experiencing a fairly debilitating depression. Even though she had the tendency to keep to herself, her symptomatology made her feel even more isolated from her peers. She explained, "Why can't I be normal? I mean, I don't even know what normal is. What's normal? For the longest time I didn't know that hearing voices wasn't normal. It's happened as long as I can remember. So, yeah. I don't remember life without them. I don't know if I ever had life without them."

Theme Two: Inhibition of Affect

The inhibition of affect was a central theme that emerged from the interviews. All six participants described situations in which they masked their emotions and felt uncomfortable expressing them. While all of the participants expressed difficulty with the "negative" emotions, namely sadness and anger, more than half of the participants also struggled with positive emotions like happiness or love. Difficulty expressing negative emotionality and difficulty expressing positive emotionality were identified as subthemes.

Subtheme One: Difficulty Expressing Negative Emotionality

When asked which emotions were easy for her to express, Allie laughed and said, "Happiness. That's it. Not really anything else is easy to express." She further added, "I don't like to express myself, but I guess mostly bad emotions." She reported difficulty

showing “sadness and depression,” and referred to these as the aforementioned “bad emotions.” In addition to sadness and depression, Allie stated, “Anger is easier to express, but it’s still not something I like doing.”

John Doe reported difficulty expressing “sadness, anger, grief, depression,” which he labeled “all of the negative emotions.” He verbalized, “I just kind of tell myself to get over it, and if I cant get over it, then just don’t show it.” John Doe emphasized his difficulty expressing anger, labeling it “an unnecessary emotion,” which he “very rarely” expressed. He believed it was a better use of his time to focus on fixing the problem rather than getting angry, stating, “Being angry doesn’t do anything for you. It doesn’t make use or change anything. It’s just temporary relief.”

Beatrice acknowledged that she “stuffs” her feelings “a lot,” and explained that one of the reasons why she would cut was to suppress emotional pain through inflicting physical pain. “I hate emotional pain because I can’t live with it,” she said. Beatrice learned from her mother that crying was a sign of weakness, therefore, she reported feeling uncomfortable appearing visibly sad in the presence of others. Beatrice reported that anger was also difficult for her to express. When asked to elaborate, she responded, “I hate anger. I can’t do it. When I show it, I try to stop it right away. I hate when people are angry, so like whatever I hate I try not to do.”

Daisy also voiced an aversion to experiencing and showing anger. For Daisy, anger embodied a loss of control and misuse of power over others. She explained, “You aren’t thinking very straight and you may say or do something that when you’re in a normal state of mind, you wouldn’t really do that. I always kind of think about that and I didn’t like that I had that power over people. When you’re angry, and you are with

someone who really cares about you, whether it's family or a friend or whatever, and you say or do something that could really affect them, and I don't want to do that."

Rocky Balboa reported difficulty with "vulnerable" emotions, namely sadness. She explained, "You can't be vulnerable 'cause you'll get hurt, bullied and stuff like that." Rocky expressed an aversion to crying and being "publicly sad" because crying shows weakness. "I didn't even cry when my grandfather died," she states. "I mean, I was sad about it, but I didn't cry."

Nicole reported that "anxiety and depression" were extremely "difficult to handle." For the majority of her life, Nicole suppressed her feelings, and had only recently started opening up about her struggles. She verbalized, "I was not a happy person, but I hid it very well. My mom keeps saying that I deserve an Oscar. But, it was hard. It was very tiring."

Subtheme Two: Difficulty Expressing Positive Emotionality

In addition to "negative" emotions, John Doe expressed difficulty with "true happiness or joy." In regards to happiness, John Doe verbalized, "It's really hard to express for me. I feel it sometimes I don't know why I cant show it." Much like his account of anger, John Doe rationalized his inability to express happiness, and stated that he does "just fine without it." Happiness is not an emotion that "comes naturally" to him, nor did he feel like "making an effort to figure it out." When asked if there were any emotions that came naturally, John Doe laughed and responded, "Boredom."

Beatrice also had a difficult time expressing positive emotions, such as "caring, love, and anything in between." She explained, "Emotions like caring, like for people that I love. It's hard to express caring for some reason. If I don't like you very much, I

can totally fake it. And if I'm faking it, I can totally do it, but it's true, then somehow it's hard for me." Despite a proclivity for masking her feelings, Beatrice believed that if she didn't hide how she felt, "life would be better because then people would know."

Daisy struggled with the concept of romantic love, "I have kind of a hard time with love, but not like a family kind of love, more like a romantic kind of love." Upon further exploration, Daisy said, "I am still kind of upset about the fact of me being gay." In addition to coming to terms with her sexuality, Daisy's resistance towards romantic love also stemmed from a fear of "getting hurt."

Nicole denied having ever experienced happiness. "I don't know what it is," she claimed. "I just watch other people around me to fake it." It was difficult for Nicole to express any kind of positive emotionality because "anxiety takes over" whenever she would start feeling "hopeful." She laughed and said, "I've been called a party pooper by many people." Nicole questioned whether she actually knew what love was, and although she reported feeling "close" with her parents, she remained "unsure" if she actually loved them.

Theme Three: Difficulty Managing Conflict

Difficulty managing conflict was another theme that emerged from the interviews. Overall, participants struggled with conflict and voiced intolerance for being able to contain their feelings when others were upset with them. Subthemes of conflict avoidant and conflict as a trigger for self-harm were also identified.

Subtheme One: Conflict Avoidant

Allie identified with an "avoidant" conflict style, which lead her to "stuff" her feelings. When faced with conflict, Allie reported the tendency to withdraw and then

perseverate on the circumstances, which caused her to become “even more depressed.” Allie explained that during conflict, the other person would obviously know she was upset, but she still refused to tell them. She added, “I don’t like talking to people like that. It’s uncomfortable.”

John Doe voiced an aversion to conflict and his typical response was to shut down and not talk. His response to conflict was fairly consistent across settings and people. “I’d say with all people I shut down and don’t talk,” he said. He reported being avoidant, and instead of processing or dealing with conflict, John Doe would “go do some pills or cut or whatever.”

“I don’t like conflict,” said Beatrice. When asked how she handled conflict, she responded, “I try to escape.” Beatrice explained, “but if someone’s yelling at me, I will like hide myself and push back all my feelings so I wont get so upset and lash out at them.” Beatrice recounted the last time she had conflict with her sister, “I just started breaking down. I had to go to my room for like five minutes and I was crying so bad.” Despite her tendency to avoid conflict, Beatrice reported an ongoing state of conflict with her mother, sister, and peers at school.

Daisy was also conflict avoidant, and managed conflict with the silent treatment. When she came out to her parents as gay, there began a three month long, “silent conflict” in which they did not speak to one another. “My sister would talk to them and talk to me, but we’d never all talked together,” she explained. At that time, her family did not eat dinner together, and when they were in the same room together, her parents would leave. Daisy stated that while she tends to avoid conflict, she also doesn’t “look for drama, or anything.” She added, “I’m not that kind of kid.”

Nicole also identified with an avoidant conflict style. “Well mostly I try to stay away from it, but I’m not that great with people yelling at me,” she stated. Nicole explained that during conflict, she would become anxious and tearful. When she was upset with somebody, she would hide it “pretty well,” and reported that there was “not a single person” with whom she would feel comfortable addressing conflict.

Subtheme Two: Conflict as a Trigger for Self-Harm

Allie identified that parental conflict was the biggest trigger for her self-harm episodes. “I argue with my parents a lot, so that’s very triggering for me, ” she stated. Although Allie initially described her relationship with both her mother and father as “good,” she went on to say that she argued fairly often with both parents and believed they were too hard on her. Allie felt that nothing she did was ever “good enough” for her parents. “They make me feel like crap all the time,” Allie stated. “I feel like they expect so much more than what I’m doing.” She further added, “The majority of the time I feel like cutting, it’s triggered by my relationship with them.” Because arguing with her parents was a trigger for engaging in self-harm, Allie would not talk to her parents about her cutting behaviors.

John Doe’s last self-harm episode was triggered by parental conflict, after his mother and father discovered he had relapsed on inhalants. Because he had been very recently discharged from an inpatient drug and alcohol program, John Doe’s relapse was a source of contention for his parents. He explained, “When they left my room that night, and told me to go to bed, I cut almost immediately after they left.”

Daisy acknowledged that parental conflict was a big trigger for self-harm. “When I first started actually, I was coming out to my parents,” she explained. “I guess that’s a conflict. And that didn’t turn out too well.”

Rocky Balboa reported that she struggled with managing conflict, and would become “really, really defensive and really upset and angry.” She added, “And afterwards if I can, when I see, like, that I’ve done something wrong and the other person is upset with me, I’ll try to make it better and be really nice to them. But if they’re not accepting that, I get really upset with myself and I withdraw, and that’s usually when I would end up cutting.”

Theme Four: Suicidality

Suicidality was a central theme that emerged from the phenomenological interviews. At some point in time all of the participants had experienced, at minimum, passive suicidal ideations. Furthermore, five out of the six participants made at least one suicide attempt, all of which were medication overdoses. Although suicidality was present in every participant, all six denied engaging in their preferred method of self-harm with the intention to end their lives. Suicide attempt by means of medication overdose has been identified as a subtheme.

Allie reported a lengthy history of passive suicidal ideations, in which she believed it would be easier to die, but adamantly denied plan, means, or intent to end her life. She had never attempted suicide, and denied fantasizing about specific suicide methods.

John Doe acknowledged frequent suicidal ideations, in which he imagined killing himself and rehearsed death scenarios in his head. Suicidal ideations were brought on by

stressful external events such as fighting with his parents or relapsing on drugs and alcohol. At the time of the interview, he adamantly denied plan, means, or intent to end his life.

Beatrice reported a history of chronic passive suicidal ideations in which she "wished" she were dead, but denied plan, means, and intent to end her life. She had no intention of "actively seek out" death, and stated, "I cant like bring myself to kill myself because I know, now, I know it would hurt so many people, but sometimes I wish I was in a car accident, and I would die at someone else's hand."

Daisy reported having experienced "many thoughts," of suicide in the past. She would often think about dying, which caused her a great deal of distress. She explained, "I really hated the way I thought because I would always think about dying, right? And I hated that so I thought, I don't know where this logic came from but I thought like, 'Oh If I hit my head, then I'll stop thinking that way.' It did not work that way, but that's what I did sometimes."

Rocky Balboa reported frequent thoughts of suicide during the course of her depression. She stated, "I don't necessarily want to be here, but I don't want to kill myself." Rocky acknowledged thinking about suicide while cutting, but exclaimed, "I'm definitely not going to die by cutting." At the time of the interview, she denied plan, means, or intent to end her life, and verbalized that the last time she had thought about suicide was "two months ago."

Nicole reported daily suicidal ideations in which she wished she were dead, but had no intention to follow through with the act. She identified self-harm as a means to avert suicide, and stated, "It was mostly just me trying to not kill myself." While cutting,

Nicole would tell herself, “Okay, I can do this, but I’m not gonna go super deep.” She denied feeling suicidal at the time of her interview, adding, “My parents would be so hurt. I have to stay here for my family.”

Subtheme One: Suicide Attempt by Means of Medication Overdose

John Doe had made two low-lethality suicide attempts, neither of which involved cutting. His first suicide attempt, approximately one year prior to his interview, was an “overdose on prescription Ritalin.” Although low in lethality, Ritalin toxicity induced “really, really scary auditory and visual hallucinations.” His most recent suicide attempt was approximately three months prior to his interview, in which he attempted to “overdose on alcohol,” an event which did not necessitate medical attention.

Beatrice had made two suicide attempts, with the most recent attempt occurring eighteen months prior to her interview. On both occasions, Beatrice tried to kill herself by overdosing on Tylenol. During her most recent attempt, Beatrice had taken “thirty-three 200-milligram Tylenol,” which resulted in a hospitalization where she was being monitored for “liver damage.” Once medically cleared, Beatrice was transferred to the local adolescent psychiatric unit where she was held for “about a week.”

Daisy had made one suicide attempt, “the day before Mother’s Day,” approximately nine months prior to her interview. “I overdosed on Benadryl,” she explained. “I guess Benadryl. It was Kirkland Signature brand for allergies.” Daisy meticulously counted out a high quantity of pills before taking them. She recollected, “And I fell, and then my sister found me, and then I went to the hospital. I guess I was hallucinating a lot or something.” After being medically cleared, Daisy spent the

following two months in a residential treatment facility where she was being treated for depression, self-harm, and suicidality.

Rocky Balboa made a low-lethality suicide attempt several months prior to her interview. She recalled, "I was taking my pill for the night and, I poured out too many in my hand, and went, 'well, why not?' and I just downed a couple." Rocky Balboa immediately regretted her decision, and told her father, who called the paramedics. Although she later learned that she wouldn't die from "six Trazodone," she still considered her previous act a suicide attempt. She explained, "I had the intention of going, 'Yeah I want to die. I'm going to do this to die.' But then I changed my mind."

Nicole attempted suicide during the summer before her freshman year in high school. She recalled, "I took a lot of pills. A lot. Pain pills and anti-anxiety pills. I took a total of like, 80 pills." Nicole's mother found her hyperventilating, and took her to the emergency room. Nicole was then transferred to an adolescent psychiatric hospital, where she was held for about a week.

Theme Five: Negative Emotionality

Another central theme that emerged from the interviews was the presence of negative emotionality, namely anxiety and depression. All six of the participants reported symptoms consistent with an ongoing state of depression, and four of the participants reported anxiety. In addition to ongoing states of anxiety and depression, negative emotionality was clearly present just prior to engaging in self-harm.

Subtheme One: Depression

Allie reported a constellation of symptoms consistent with depression. Despite verbalizing that she felt "good" at the time of the interview, Allie presented with an air of

sadness, evidenced by slumped posture, monotone voice, and flattened facial expression. She reported symptomatology consistent with depression, including recurrent suicidal ideations without a specific plan, and excessive guilt, which was evident by self-harming as a means of punishment. In the moments directly preceding self-harm Allie described her emotional state as "really, really like down," and acknowledged that she would cut herself at minimum, twice a month. Even though Allie wished she did not cut herself, she acknowledged that part of her was "okay" with her self-harm behavior.

John Doe reported experiencing depression since "around eighth grade," and began cutting and abusing marijuana shortly thereafter. In spite of being prescribed Prozac by a psychiatrist, John Doe still experienced "a lot of sadness." He stated, "It would seem like I'm not expressing anything at all. I would probably look bored and flat, but I was really sad." In the moments directly preceding a self-harm episode, John Doe experienced "depression" and "self-pity."

Beatrice also experienced frequent episodes of depression in which she felt "worthless, lonely, and hopeless." When asked about her depression, she responded, "There's a room, and there's all these beams of light, and you're all having fun and dancing. And that's how I usually am. And then the power goes out suddenly. And you have no idea why, and you're lost, and you have no idea where you're going, and it's just so dark that you feel like it's not going to end even though you know it's going to, because somehow the power always turns back on, eventually." In reference to her feeling state directly prior to engaging in self-harm, Beatrice reported, "I'm just feeling like sad but like it's more than just sad. It isn't really depressed but it's not sad. It's in

between there somewhere. I don't wanna' get depressed like I used to, so that's one reason I cut, 'cause I don't wanna' get *that* sad."

Eight months prior to the interview, Daisy was in the throes of a yearlong depression, which culminated in a serious suicide attempt and subsequent hospitalization. She described feeling so stuck in her depression, that she was "scared of getting better." She recalled, "I didn't remember what it was like to be really happy. And it didn't make sense to me. I was like, 'Well what about the friends I made while being sad? What if they don't like me because I'm happy now?' You know? And I don't know. I just think it's kind of funny how that works, but I think depression is definitely the most comfortable place to be in, for me." Daisy's self-harm subsided after undergoing inpatient treatment to address her underlying depression.

Rocky Balboa began cutting at age 11, explaining, "because that's when I started feeling depressed, and I didn't really know how to deal with it." Just prior to engaging in self-harm, she felt "extremely sad." When asked what her depression felt like, Rocky Balboa responded, "I just kind of feel mentally heavy. I'll just lay in bed and go, 'No. No, I'm not gonna' do this. Not gonna' do anything cause I can't do it. I can't do it. I can't do it. I don't want to do it.' I can't and I'm getting annoyed at myself because I'm a person, and a normal person *can* do this and *can* do that. And wow, you must be such a failure because you can't do this you are just laying in bed. So I lay there with a war inside my head."

As previously stated, Nicole strongly identified with a diagnosis of schizoaffective disorder, and reported psychotic symptoms in addition to major depression. Consistent with depressive symptomatology, Nicole endorsed suicidal

ideations, history of suicide attempts, worthlessness, insomnia, and sadness. She reported a constant state of hopelessness and acknowledged the tendency to be "very negative." Nicole was prescribed Zoloft and Remeron to help with depression, but when asked if her medication helped, she immediately responded, "Not at all."

Subtheme Two: Anxiety

Although John Doe did not have an ongoing state of anxiety, just prior to engaging in self-harm, he described feeling "built up," and reported "anxiety" and "tension." Anxiety was situational and brought on by fighting with his parents or getting in trouble at school.

Rocky Balboa reported constant, debilitating anxiety to the point of necessitating home schooling. She had been experiencing anxiety for as long as she could remember, stating, "I was in second grade thinking, okay, well which college do I want to go to? I want to go to an Ivy League college, so I have to get good grades." She describes her anxiety, "like a mother constantly nagging you." She further added, "It's really hard. And then there's social anxiety. It's not even like a monologue, it's just like, don't do *anything* because somebody's gonna' see you. Just look at you, and then everyone's gonna look at you, and you don't want that, 'cause it's terrifying."

Beatrice complained of "really bad anxiety," which she attributed to monthly hormonal changes. In reference to cutting, Beatrice repeatedly stated that she "needs to get rid of tension," which she felt in her "forearms and shoulders."

Nicole experienced constant anxiety, which was difficult to control and interfered with her ability to attend school and interact with peers. When asked how she felt in the moments preceding self-harm, she responded, "Very anxious. And I think I was very

anxious before whatever had happened, whether it be a fight or I was bullied or something. So I'd be anxious. That's how I'd feel before."

Theme Six: Feeling Numb

Feeling "numb" was another central theme that emerged from the interviews. Each participant experienced numbness, before, during, or immediately after self-harm episodes. While five out of the six participants referenced feeling numb in relation to self-harm, one of the participants endorsed an ongoing state of numbness.

When discussing how she felt just prior to engaging in self-harm, Allie stated, "Just like I don't feel anything at all. Pretty numb." Although Allie did not elaborate on the experience of feeling numb, she identified that it was "not a good thing."

John Doe verbalized, "During the cutting and about thirty seconds after, it's just all kind of numb." He added, "I'd get into that numb spot where I would just feel like cutting and my arm would be destroyed. My whole arm would be just like bleeding."

Just prior to engaging in self-harm, Beatrice reported feeling, "hyper and frustrated and kind of numb." While cutting, Beatrice also felt numb, stating, "And feeling nothing is almost worse than having emotional pain for me. I feel like I'm just blank, and I want to be unique." When asked if she experienced physical pain while engaging in self-harm, she responded, "When I do it for attention, yes. But when I do it 'cause I'm feeling numb, then no."

When asked about her emotional state just prior to engaging in self-harm, Daisy replied, "I think the best word would probably be like, numb, and spacey. I wouldn't really feel anything, but I wanted to. You know what I mean?" For Daisy, feeling numb was far worse than sadness or depression. "I feel like there is sad and kind of depressed,

and lonely, and then just kind of numb where you don't feel anything," she explained. "And when you get to that point, you know it's pretty bad. I think it's kind of like a warning sign that you should really do something to help yourself."

When asked how she felt directly prior to engaging in self-harm, Rocky Balboa responded, "Kind of numb I guess. Just like either extremely sad or extremely angry or upset to the point where I just don't necessarily feel anything. But it's more anger. Like instead of being neutral it's numb in a sad sense. If that makes any sense."

Nicole reported an ongoing state of numbness. In reference to emotions that are difficult for her to express, Nicole stated, "Most of the time anything is difficult. A lot of the time I just, I feel very numb." She elaborated with, "And a lot of the time I don't really know what to feel, and I don't even know if I'm feeling anything."

Theme Seven: Negative Internal Monologue

The presence of a negative internal monologue emerged from the interviews. Participants reported either verbalizing or thinking negative statements about themselves during the act of self-harm.

Allie engaged in self-harm because she believed that she "deserves it." Despite maintaining decent grades, keeping up with household chores, and working part-time at the local bowling alley, Allie continuously told herself that she was "never good enough."

While engaging in self-harm, John Doe was filled with "self-hatred," and would call himself "pathetic" and "whiny." He mocked, "Oh feel bad for me," in a baby voice, then yelled at himself to "get over it."

While self-harming, Beatrice was experiencing "conflict within" herself in the form of "bad voices." She stated, "It's not like I'm hearing things, but it's in my mind." While cutting, Beatrice would tell herself, "You must have something wrong with you." She added, "I've never felt like I'm worth it for anything."

Rocky Balboa described her internal monologue as "provoking and taunting." She added, "I'm offensive to myself. Like, the monologue in my head is, 'Cut deeper. You fucking suck.' And I would hear words in my head, 'Oh, you're stupid. You're such a bitch.' Stuff like that. Just kind of cause ever since I started feeling depressed and even more anxious and stuff I kind of thought, 'This is not how normal people are. The majority of people that I hang around aren't like this. Why am I like this? I shouldn't be like this.' Stuff like that."

"There was a lot of self-hatred involved" during Nicole's self-harm episodes. While self-harming, she would tell herself, "You're not normal. You're a freak. You're so fucking stupid. Why would you do this? You're not normal. You might as well just kill yourself."

Theme Eight: Self-Harm as a Temporary Coping Skill

Self-harm as a temporary coping skill was another central theme that emerged from the interviews. Participants described self-harm as a momentary distraction from emotional discomfort, which lasted anywhere from a few seconds to a few minutes.

Allie identified cutting as a "temporary distraction" from emotional pain. Just prior to cutting herself, Allie was either experiencing depression or emotional numbness. While self-harming Allie felt "good" and was able to "forget about everything." When asked to describe how she felt immediately following a self-harm episode, Allie

responded, “Good for about five minutes then I regret it. Like I just like kinda’ wish I didn’t do it, but at the same time I’m okay with it.”

John Doe identified cutting as a temporary, maladaptive coping skill, which he used only when “having an exceptionally bad day.” Cutting was a means to alleviate stress, albeit, a very short-term relief, as “it lasts about thirty seconds.” He described a typical cutting episode as “A rush of just like memories of cutting in the past and I’m like, yeah, this works. This feels relieving. It takes my mind off of whatever’s happening. And I get caught up in it, and before I know it my arm’s destroyed. It’s just distracting I guess. It’s something to think about other than what’s going on. It’s a way to escape.” Cutting provided relief just long enough for John Doe to get over the preceding emotional pain. John Doe’s negative affect returned to a lesser degree, as he became preoccupied with how to conceal his visible injuries. “ Now I have to think about how I am going to cover it up,” he says. “It’s a giant distraction. It’s a bad distraction, but it’s a distraction.”

At age 14, Beatrice began cutting herself because she was feeling “really emotional” and trying to “find something to help cope.” At age 17, she continued to engage in the behavior when she was in need of some relief. “Cutting makes me feel better in the moment,” Beatrice explained. “But later I know I’m going to feel worse.” After self-harming, Beatrice would feel “a little bit better,” because “cutting gets rid of weird tension.” She stated,” I’m happy for like a split second then I’m just defeated.”

While Daisy identified with the self-punishment function of self-harm, cutting also gave her “satisfaction and relief.” When asked how she felt while cutting, Daisy responded, “It wasn’t like a high, and it wasn’t like I was overcome with happiness. It felt like I needed it.”

When asked if cutting made Rocky Balboa less depressed, she responded, “No, it definitely didn’t. But it gave me some sort of, I guess distraction’s not quite the word for it, but its just kind of something else to focus on for a bit.” She further explained, “It just kind of gives you something else to focus on versus, ‘I’m really sad. I’m really sad. I’m really sad.’ ‘Cause then I need to take care of it or else someone is going to notice. It hurts so I have to do something about it.”

Nicole labeled cutting as a “distraction” that she would use when overwhelmed with anxiety and depression. “It was kind of a release for a while,” she explained. “I could focus on the pain of that and try not to focus on everything else around me.” When asked how long the release from self-harm lasted, Nicole responded, “Minutes. Minutes, yeah. But I got to the point where I was so done with everything, I was like, ‘If I can have a couple minutes, I’m gonna’ take it.’ You know?”

Theme Nine: Maternal Conflict

Maternal conflict was a central theme that emerged from the participant interviews. Not only did participants express feeling closer with their fathers, but they also emphasized the strained relationships with their mothers.

John Doe voiced feeling “apathetic” towards his mother. He reported that they didn’t have “much of a relationship,” and felt he was “just somebody who lives in her house.” He found his mother “uninteresting,” and was therefore “not interested in having a relationship with her.” When asked what they had in common, he dryly responded, “Blood. That’s about it.” When asked about his level of interaction with his mother, John Doe responded, “If you are outside of work, would you want to be casual friends with your boss when they are the ones who deal out the punishment and are constantly on

you? Like she's generally where the negative things are coming from when it comes to punishments and all that, like being grounded. She's just not a big ray of sunshine." John Doe reported having more in common with his father, stating, "We understand each other a lot more than I understand my mom. We have very similar brains."

Beatrice acknowledged having a significant amount of conflict with her mother. "She's hurt me so many times its ridiculous," Beatrice stated. "I don't even care anymore about her. That's sounds bad, but I don't care about her anymore." Of her father, Beatrice stated, "He's way more easy-going. I love easy-going people, so much. 'Cause like, I get along with them way better than people who are like, arrogant like my mom."

Rocky Balboa reported having conflict with her mother. "We butt heads a lot because we are really, really similar," she stated. "So we're both prideful and we both get hot-headed." When asked what kind of things she and her mother argued about, Rocky responded, "She would yell at me for not doing chores, or not doing my homework. Or why I wasn't showing her any tests to bring home? Or why did I have an attitude? Why was I looking at her like that? Why was I talking to her like that? Or why did I have that tone?" Of her relationship with her father, Rocky Balboa stated, "It's pretty good. It's always been pretty good because my dad is a pretty mellow person. I don't think I've ever really fought with my dad unless he's really, really stressed out."

Nicole verbalized that the only person she ever raised her voice with was her mother. She explained, "The major thing about my mom is she doesn't really understand anxiety. It's more like, she doesn't understand how I'm not able to do some simple things, and I'll just get really annoyed with her, and sometimes I'll yell." Nicole stated, "My mom yells over nothing. She gets really worked up and yells a lot. She has a temper.

My dad doesn't really have a temper." She added that she and her father "don't have conflict," calling their relationship, "just perfect."

Chapter Five: Discussion

The purpose of the current study was to explore the lived experience of adolescents who engage in nonsuicidal self-injury. Holding true to phenomenological research, hypotheses were not made prior to collecting data, as the methodology refrains from making assumptions about what participants will reveal. Rather, themes emerged from the participants' stories about what it means to be an adolescent who self-injures. According to Brown (2010), "Stories are just data with a soul." This researcher attempted to capture the soul, or essence of the participants' experiences through conducting phenomenological interviews.

The original terminology used in the introduction and literature review was NSSI, which has been defined as the intentional, self-inflicted destruction of body tissue without conscious suicidal intent and for purposes not socially sanctioned (International Society for the Study of Self-Injury, 2007). In an effort to be sensitive to the participants, their own language was adopted into the methods section, appendices, and results section. The terms cutting, burning, self-hitting, and self-harm are used interchangeably with NSSI throughout the following discussion section.

The discussion section will elaborate upon the identified themes, and attempt to make sense of the findings in relation to the existing research reviewed in chapter two. Some of the themes that emerged did not directly address the physical act of NSSI, but rather gave a picture of the participants' identities, emotionality, familial relationships, and conflict styles. It is this researcher's belief that the aforementioned traits contributed to the propensity for engaging in NSSI. After a discussion of the nine emerging themes,

implications for clinical practice, implications for future research, and limitations to the existing study will be identified.

The average age of onset among the sample was 12.67 years old, which was slightly lower than existing research, identifying age of onset between 13 and 16 years of age (Klonsky, 2011; Rodham & Hawton, 2009; Skegg, 2005). In line with the present study, younger age of onset for NSSI has been associated with higher rates of mental health disorders (Meltzer et al., 2001). Participants in the present study were recruited from an intensive outpatient program, where they were being treated for various mental health diagnoses. Of the sample, Nicole reported the youngest age of onset for NSSI, which was 10 years old. Research suggests that children under the age of 10 who engage in NSSI are more likely to have a mental health diagnosis, namely an anxiety disorder, and have more often experienced multiple traumatic life events (Meltzer et al., 2001), both of which Nicole reported.

Theme One: Identification with an Alternative to the Dominant Culture

Participants identified as outsiders, and felt disconnected with what they considered to be the dominant culture. John Doe voiced an overall resentment towards societal norms and expectations, Beatrice identified as Russian and resented Americans, Daisy was ashamed of her sexual orientation, Rocky Balboa was home schooled as a result of chronic bullying, and Nicole identified with having a serious, pervasive mental illness. Participants believed they were abnormal, and lacked a sense of universality with their same-age peers. Lack of belonging is thought to be one of three major factors contributing to suicide (Joiner & Silva, 2012), which is positively correlated with NSSI

(Klonsky, 2014). Because suicidality was a separate emerging theme, a more in-depth exploration will take place later in the discussion section.

Present findings are consistent with existing research, which suggests that individuals who lack peer connectedness have difficulty managing stressful events, and tend to adopt inappropriate behavioral responses (Yoo & Park, 2014). Feeling isolated and not having a support group could result in NSSI as a means to alleviate subsequent negative emotionality. This dovetails nicely with existing research stating that adolescents who engage in NSSI report feeling lonely, sad, and alone (Ross & Heath, 2002). Furthermore, engaging in NSSI could be reinforcing preexisting isolation through the act of identifying with an abnormal behavior that is often met with shame and judgment.

Adolescents are not only lonely as a result of being disconnected, but they are also missing out on the social benefits of belonging to a peer group. Positive peer groups have the potential to provide constructive feedback in response to inappropriate behaviors (such as NSSI) and model more socially acceptable responses to managing distress. The word positive has been used intentionally, as this researcher is well aware that peer groups have the potential for negatively influencing their members. In fact, the majority of participants in the present study learned about NSSI from their peers. Identifying with a positive peer group could increase the likelihood of adopting healthy habits and behaviors and decrease the likelihood of engaging in more maladaptive coping skills.

Findings are not meant to suggest that social conformity is a protective factor against self-injury. Instead, it is likely that having a decreased sense of belonging leads to isolation and shame proneness, both of which are positively correlated with NSSI

(Chapman et al., 2006). Increasing positive social support could reduce NSSI behaviors through feeling connected and having other people to rely on in times of need. A social support network could serve as a safe place to process any feelings of negative emotionality, as well as promote an overall sense of belongingness. For clarification, it is this researcher's subjective opinion that there is absolutely nothing wrong with being individualistic or having unique idiosyncrasies. Instead, it is merely suggested that isolating behaviors have the potential to be problematic and appear to be indirectly related to NSSI.

Theme Two: Inhibition of Affect

Participants in the current study voiced difficulty tolerating high intensity emotions, and struggled with basic affect regulation capabilities. Specifically, participants described an aversion to "negative emotions" such as sadness, anger, and anxiety, and attempted to suppress their emotions when all possible. They identified with the tendency to "stuff" or otherwise not acknowledge how they were feeling, and when stuffing became too difficult, participants turned to NSSI for temporary relief. NSSI appears to be a self-inflicted mechanism allowing the body to physically release feelings that were otherwise too difficult to consciously process. This finding is consistent with existing research suggesting that a diminished ability to tolerate negative emotionality can lead to self-harm, especially if the individual lacks appropriate coping skills (Linehan, 1993).

While most individuals do not enjoy feeling sad, angry, or anxious, participants voiced a particular aversion to experiencing the aforementioned emotions. Intolerance for negative emotionality, and the tendency towards suppression are both strong indicators of basic affect regulation deficits. This particular finding dovetails nicely with existing

research that links NSSI to alexithymia (Borrill, Fox, Flynn, & Roger, 2009; Garish & Wilson, 2010; Gratz, 2006). Managing one's emotions requires the ability to effectively identify and label feelings, and the capacity to modify feelings as necessary. Because individuals with alexithymia lack the ability to identify and label feelings, they are placed at a disadvantage for being able to regulate their emotions, likely resulting in avoidance through suppression or utilizing maladaptive coping strategies.

Interestingly, four out of the six participants expressed discomfort with positive emotions, such as love and happiness. The scope of the literature review did not cover the suppression of positive affect, however, there are some possible explanations for this particular finding. Inhibition of positive affect could be more reflective of the aforementioned alexithymia, and the inability to express emotions in general, including positive emotions. Another potential explanation for suppressed positive emotionality could be an over-identification with negative emotionality impeding the ability to experience positive emotions. One of the participants described feeling sad for so long that she was scared of what it might feel like to get better. While unpleasant, if sadness is the identified baseline emotion, it is likely more familiar, and in turn, more comfortable than experiencing happiness.

Another possible explanation for inhibition of positive affect is that participants were universally suppressing all emotions and lacked the ability to filter which emotions they were attempting to regulate. Therefore, when negative emotions were being suppressed, positive emotions were also being suppressed. Additionally, there could be a fear that expressing happiness would only cause them to feel even more depressed when the happiness subsides; almost as if they were waiting for the other shoe to drop.

Happiness might be looked at as a mere tease among looming depression and anxiety. Regardless of the reason, participants appeared to be denying reality by suppressing their emotions. In turning off their emotions, participants felt nothing, and became out of touch with what was going on in and around them. In other words, what became inhibited stayed inhibited.

Theme Three: Difficulty Managing Conflict

Participants voiced considerable difficulty with addressing and managing conflict. They clearly identified with an avoidant conflict style, marked by "shutting down," refusing to speak, and using "the silent treatment." While there is no supporting NSSI literature that specifically addresses conflict styles, this finding falls in line with the overall picture, in that adolescent self-harmers are avoidant, and lack the necessary skills to manage uncomfortable emotions and situations. NSSI itself is an avoidant behavior, which fails to address the underlying psychological issues that lead one to self-injure in the first place. It is not surprising that avoidant behaviors would spill over into other facets of the participants' lives. Furthermore, conflict is likely to bring about negative emotionality, which participants actively avoided.

The present study found that conflict was a major trigger for engaging in NSSI. This finding could be related to the interpersonal influence model of NSSI, which suggests that the behavior is used to acquire a desired response from others (Klonsky, 2007). It is possible that self-harm was used to communicate the level of discomfort participants were feeling in response to conflict. Because participants identified as being conflict avoidant, it is also possible that NSSI was used as a means to end conflict or elicit sympathy from the opposing party. While participants did not expressly

acknowledge the aforementioned motives, literature suggests that self-harmers might not be consciously aware of the secondary gains for their behavior (Klonsky, 2007). Furthermore, the finding that NSSI is triggered by conflict, supports existing research suggesting that the behavior is used to communicate what words cannot (Gratz, 2006).

Theme Four: Suicidality

Consistent with existing research linking NSSI to suicide (Jacobson & Gould, 2007; Klonsky, 2014; Nock et al., 2006), all six participants in the current study reported chronic suicidal ideations in which they believed it would be easier to die. Furthermore, five out of the six participants reported a history of at least one suicide attempt. Interestingly, all of the reported suicide attempts were enacted by means of medication overdose, and the primary NSSI method for all participants was cutting. None of the participants identified their suicide attempts as an act of NSSI, nor did they consider ingesting pills as a recognized method of inflicting NSSI. Findings further support that while NSSI is correlated with suicidality, the act itself is not performed with conscious suicidal intent.

The interpersonal-psychological theory of suicide behavior could attempt to explain the prominent suicidality in the current study. The theory posits that attempts and completions involve a three-way interaction between low levels of belonging, high levels of perceived burdensomeness to others, and a high fearlessness of physical threat (Joiner & Silva, 2012). Participants in the current study perceived low levels of belonging to an identified peer group. Existing literature found that repeatedly engaging in NSSI desensitizes individuals to fear and physical pain (Klonsky, May, & Glenn, 2013). Taken together, low levels of belonging and high fearlessness of physical threat suggests that

individuals who engage in NSSI are at increased risk for following through with more lethal acts of self-injury.

Even though suicidality was prominent, and participants denied engaging in NSSI with suicidal intent, the anti-suicide model of NSSI was not supported in this study. Only one participant directly identified cutting as a means to avert suicide, whereas all of the participants endorsed affect regulation and self-punishment functions. However, according to the existing literature, NSSI can serve multiple concomitant functions (Klonsky & Muehlenkamp, 2007). While the anti-suicide function was not specifically identified, it is still possible that engaging in NSSI indirectly averts suicide by means of reducing mounting anxiety and depression.

Theme Five: Negative Emotionality

Not surprisingly, participants reported an ongoing state of negative emotionality. All six of the participants endorsed depression, and four of the participants endorsed anxiety. This finding supports existing research suggesting that the typical profile of a self-injurer is one of chronic negative affect (Victor & Klonsky, 2013). When asked what they were experiencing just prior to engaging in self-harm, participants provided responses such as, “anxiety,” “tension,” “depression,” and “self-pity.” While participants endorsed chronic negative emotionality, they also reported poor distress tolerance, and an aversion to experiencing negative emotions. This suggests that adolescent self-harmers experience a constant state of intolerable affect. High levels of negative affect further support the conceptualization that NSSI serves to regulate and cope with distressing emotions

Participants identified with a diagnosis of a mood disorder, anxiety disorder, or both, which is consistent with researching linking NSSI to internalizing disorders (Klonsky & Olino, 2008; Nock et al., 2006; Ross & Heath, 2002). One of the participants identified with a diagnosis of schizoaffective disorder, depressive type, although she was yet to be formally diagnosed. Previous research has suggested that NSSI is used to offer reprieve from a wide range of symptoms, including hallucinations (Favazza & Conterio, 1988).

While current literature states that the typical self-injurer experiences frequent, intense anger and irritability (Linehan, 1993; Selby et al, 2012), participants in the current study had low levels of self-reported anger. Consistent with what they were reporting, participants did not present as exceptionally angry, hostile, or irritable. Rather, they presented as sad, and likely repressed. Low levels of reported anger could be explained by inhibition of affect, possible alexithymia, or an overall aversion to expressing emotions. It is possible that anger was directed inward, and therefore manifested in symptoms consistent with the reported depression.

Theme Six: Feeling Numb

Participants all described feelings of intolerable numbness, before, during, or immediately after engaging in NSSI. Because emotional numbing was significant across all participants, it was delineated as a separate theme from negative emotionality. Four of the participants identified numbness prior to NSSI, one participant described numbness during and immediately after NSSI, and one participant described an ongoing state of numbness in which she often felt "nothing." Feeling numb was described as worse than feeling anxious or depressed, which is interesting given the preference for suppressing

emotionality. Logic would follow that given the overarching resistance towards experiencing both negative and positive emotions, feeling numb would be an ideal state. However, the majority of participants described engaging in NSSI in order to alleviate numbness, which is consistent with existing research (Favazza & Conterio, 1988; Strong, 1998).

Much of the literature that addresses emotional numbing focuses on the anti-dissociation function of NSSI (Klonsky, 2007). It is unclear whether emotional numbing in the present study was a form of clinical dissociation. None of the participants named posttraumatic stress disorder (PTSD) when discussing their diagnoses, nor did they elaborate on the experience of emotional numbing. Granted, feeling numb is not necessarily synonymous with dissociation, nor does one necessitate a diagnosis of PTSD in order to experience emotional numbing. Regardless, the results were inconclusive as to whether adolescents were engaging in NSSI to alleviate feelings of dissociation. Additional information about emotional numbing is needed in order to distinguish whether participants were endorsing the anti-dissociative function of NSSI.

Theme Seven: Negative Internal Monologue

While in the act of NSSI, participants reported a negative internal monologue in which they made disparaging comments about their characters and repeatedly told themselves they had something wrong with them. The monologues were indicative of shame, a highly painful, self-focused emotion characterized by the belief that one is fundamentally damaged (Chapman et al., 2006). Consistent with the present findings, existing research suggests that shame-prone individuals avoid experiencing and processing intense painful emotions, therefore increasing the likelihood of NSSI

(Chapman et al., 2006). This dovetails with findings in the present study, suggesting that participants were conflict avoidant, and demonstrated an aversion to experiencing emotions.

It is possible that participants were avoiding their emotions because they were ashamed of what they were feeling, and in turn self-punished by engaging in NSSI. In fact, the majority of participants in the present study referenced the belief that they deserved to be in pain. For example, Daisy expressed that she engaged in NSSI because she felt she needed to be "punished for doing things wrong or just being wrong in general." Other participants cited self-punishment as a reason for self-harming, and made comments such as, "I feel like I deserve it." Recent research has linked shame proneness to the self-punishment function of NSSI, suggesting that individuals who engage in the behavior believe that they deserve to suffer (Schoenleber, Berenbaum, & Motl, 2014).

Theme Eight: Self-Harm as a Temporary Coping Skill

Findings from the present study support the affect regulation function of NSSI, which states that the behavior is used to relieve intolerable affective states (Klonsky, 2007). All six participants identified self-harm as a temporary coping skill, which helped alleviate negative emotionality. This finding is consistent with existing research that identifies affect regulation as the most endorsed function of NSSI (Klonsky, 2007; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Taylor et al., 2012). Just prior to engaging in self-harm, participants described intolerable feelings of anxiety, depression, and emotional numbing that briefly subsided with the commission of the act. Participants identified self-harm as a distraction, which provided something else to focus on besides the level of psychological pain that they were experiencing.

The finding that NSSI provided only temporary relief from negative emotionality is also consistent with existing research (Favazza, 2009). Participants reported that the relief lasted anywhere from a few seconds to a few minutes. It is possible that the relief was only temporary because NSSI created an additional host of problems leading back to negative emotionality. While participants described NSSI as relieving, they also described the fear of being caught, the stigma of engaging in NSSI, and the disappointment it caused their families and friends. Furthermore, there is something to be said about feeling better by means of hurting oneself. Beatrice described feeling sad that "cutting worked" in making her less depressed, likely reinforcing her preexisting belief that something was inherently wrong with her. Additionally, NSSI appeared to be a maladaptive coping skill in that it provided temporary relief, but did not address the root of the problem.

Theme Nine: Maternal Conflict

Participants voiced significant maternal conflict, and specifically identified that they had better relationships with their fathers than their mothers. Implications are two-fold in that participants not only lacked the nurturing maternal relationships which would otherwise provide an external source of comfort, but additionally, they were triggered to self-harm as a result of experiencing conflict. Findings are consistent with existing research, suggesting that perceived parental rejection is positively correlated with NSSI and indicative of the inability to self-regulate (Quirk, Wier, Martin, & Christian, 2014). Interestingly, research on attachment emphasizes the importance of the early caregiver relationship between mother and child on developing basic affect regulation capabilities (Schore, 2003; Siegel, 1999). It is possible that the relationships between the participants

and their mothers were always strained, subsequently resulting in dysregulated affect and underdeveloped affect regulation skills.

Participants reported significantly less conflict with their fathers and perceived the quality of the relationship with their fathers to be better. It is unclear as to why maternal conflict, but not paternal conflict was reported. This finding is somewhat consistent with existing research, which found that adolescent self-harmers perceived an increase in positive relationship quality with their fathers, but not their mothers (Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008). While causality cannot be inferred, perhaps tumultuous maternal relationships are a better characteristic of adolescents who self-harm.

Implications for Clinical Practice

Adolescents who engage in NSSI are avoidant and struggle with the ability to regulate affect. It is recommended that treatment of NSSI focus on addressing the underlying affective disturbances. Every adolescent in the study identified with a mental health diagnosis, namely anxiety and depression, and had used the behavior to alleviate negative emotionality. For Daisy, self-harm behaviors subsided upon receiving intensive inpatient treatment to address underlying depression and familial conflict. Because individuals do not heal in isolation, it is recommended that the family unit be incorporated into treatment. Additionally, it is recommended that family therapy address the significant amount of maternal discord, reported by participants.

Given the significant level of emotional pain reported by these individuals, there appears to be a need for more effective copings strategies to manage distressing symptoms while subsequently replacing NSSI behaviors. Because the adolescents were overwhelmingly avoidant, they would likely benefit from assertiveness training, which

could bolster self-esteem and address their avoidant conflict styles. Addressing conflict styles is of particular importance because conflict was specifically identified as a trigger for self-harm.

Due to the low levels of belonging identified by adolescents in the study, clinical treatment of NSSI might want to address basic social skills and monitor for potential deficits in interacting with others. Being able to identify with a peer group could reduce feelings of isolation, as well as increase the level of support available to adolescents. Group therapy is a good laboratory for adolescents, as they are able to practice interacting with peers, and work on giving and receiving feedback. Tools, coping skills, and social skills can be acquired during group therapy, and then taken outside of group and utilized in the outside world.

Implications for Future Research

One of the unique aspects of the current study is the use of a sample population that met criteria for the DSM-5 (APA, 2013) proposed nonsuicidal self-injury diagnosis. To this researcher's knowledge, few studies have explored NSSI among individuals who met the diagnostic criteria. Continuing to use the proposed diagnostic criteria in future research will give validity to the diagnosis. Having clearly defined diagnostic criteria for NSSI could prevent misdiagnoses, lead to clearer conceptualizations of the behavior, and guide more accurate treatment planning.

It is recommended that future research explore the concept of emotional numbing. Findings were inconclusive as to whether participants were experiencing clinical dissociation, alexithymia, or something more along the lines of blunted affect. Emotional numbing is worth further investigation as all participants spoke about it with the same

level of disgust and described it as being essentially intolerable. Despite their propensity to "stuff" their feelings and suppress both positive and negative affect, somehow feeling emotionally numb was still perceived as being worse. Countless studies and literature on NSSI reference the concept of emotional numbing (Conterio & Lader, 1998; Nock, 2010; Strong, 1998), however, it is still a largely unconceptualized variable. Much like depression can manifest in a myriad of symptoms and behaviors, it is possible that emotional numbing is equally as complex. Treatment planning would benefit from knowing exactly what it means to feel emotionally numb.

Suppression of positive affect was a particularly interesting finding that would benefit from additional research. While the existing literature supports higher levels of negative affect among individuals who engage in NSSI (Klonsky & Victor, 2013), to this researcher's knowledge, existing literature has not focused on the active suppression of positive emotionality. It is unclear whether participants believed that they did not deserve to be happy, or if they were inadvertently suppressing positive affect by nature of suppressing all emotions. Identifying reasons for suppressing positive affect could aid in more accurate treatment planning and clinical recommendations when working with adolescents who self-injure.

The presence of maternal conflict is a research area that warrants further attention. It would be interesting to see whether NSSI decreased if maternal relationships were to improve. Studies with larger sample sizes might look at whether adolescents who engage in NSSI report more maternal conflict, or if there are actually equal rates of maternal and paternal conflict. Longitudinal studies with large sample sizes could study parenting styles from an early age in order to determine if appropriate affect regulation skills were

developed during early attachment. Family therapy could address the systemic conflict, and parenting classes could teach more effective communication skills and model more nurturing parenting styles.

Limitations

The sample in the present study was purposive in that participants were selected based on their age and history with NSSI. Because the sample was purposive, it is recommended that caution be exercised when generalizing findings about demographic information to the general population. The sample was overwhelmingly female (five females and one male), which is somewhat inconsistent with the existing research. Research has identified more equivalent ratios of males and females engaging in NSSI (Briere & Gil, 1998; Klonsky et al., 2003; Swannell, Martin, Page, Hasking, & John, 2014). However, other studies have suggested variations in the gender ratio across different age groups, with significantly higher female ratios during adolescence (Hawton and Harriss, 2008). Additionally, the higher ratio of females in the current study could be more reflective of participant availability than of demographic correlates.

All of the participants were receiving mental health treatment; therefore it is possible that they would have reported problems with conflict, emotional expression, and relationships with their parents independent of self-harm behaviors. It is difficult to know whether the experiences reported were more indicative of adolescents who have mental health difficulties or whether experiences were unique to adolescents who engage in NSSI. Despite this potential limitation, having been in therapy, participants demonstrated unique insights into their behaviors and articulated their experiences quite well.

A major limitation of the present study is the lack of procedures to enhance validity. Triangulation was not employed, as phenomenological interviewing was the only method used to collect raw data. Additionally, this researcher collected, transcribed, and analyzed the data without assistance from an outside party. Furthermore, there was no respondent validation, as participants declined the second meeting to review the content of themes and provide feedback on this researcher's interpretations of their responses. This researcher is operating under good faith that interviews were transcribed accurately, and themes were identified with as little biases as possible.

Conclusion

The affect regulation function of NSSI was clearly supported in the present study, as adolescents demonstrated low distress tolerance, poor affect regulation skills, and utilized NSSI to obtain temporary emotional relief. Paradoxically, the profile of the adolescent self-injurer in the present study was one of chronic negative affect and a clear aversion to experiencing negative emotionality. It is possible that adolescent self-injurers are no more prone to negative emotionality, but because they avoid processing their emotions, negative affect continues to linger. Perhaps the most salient feature of the adolescent self-injurer is absolute avoidance. Adolescents suppressed both positive and negative emotionality, and actively avoided initiating, managing, or addressing conflict. NSSI in itself is an avoidant behavior, as it is a temporary solution, which fails to address the underlying depression and anxiety.

Previous literature has described the typical self-injurer as labile, irritable, and attention seeking (Linehan, 1993). Perhaps these qualities are more indicative of self-injurers with borderline personality disorder, than of self-injurers in general. Much in the

same way that not all individuals with depression have the same clinical presentation, the adolescent self-injurer appears to be just as clinically diverse. The present study found that the typical self-injurer was not *that* typical. The majority of participants in the present study were repressed and avoidant. They did not engage in overt acting out behaviors, nor did they present with borderline personality disorder pathology. Based on the clinical profile of adolescents in the present study, it is possible that there exists a population of seemingly stable adolescent self-injurers who are not garnering clinical attention, resulting in missed opportunities for early interventions.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Armsden, G. C., & Greenberg, M. T. (1987). The Inventory of Parent and Peer Attachment: Individual differences and their relationship to psychological well-being in adolescence. *Journal of Youth & Adolescence*, *16*, 427-454.

Augustine, A. A., & Hemenover, S. H. (2009). On the relative effectiveness of affect regulation strategies: A meta-analysis. *Cognition and Emotion, 23*(6), 1181-1220.

Augustine, A. A., & Larsen, R. J. (2015). Personality, affect, and affect regulation. In M. Mario, P. Shaver, L. Cooper, & R. Larsen (Eds.) *APA handbook of personality and social psychology, Volume 4: Personality processes and individual differences* (pp.147-165). Washington DC: American Psychological Association.

Baetens, I., Claes, L., Muehlenkamp, J., Grietens, H., & Onghena, P. (2011). Non-suicidal and suicidal self-injurious behavior among Flemish adolescents: A web-survey. *Archives of Suicide Ressearch, 15*(1), 56-67.

Banks, S. J., Eddy, K. T., Angstadt, M., Nathan, P. J., & Phan, K. L. (2007). Amygdala-frontal connectivity during emotion regulation. *Social Cognitive and Affective Neuroscience, 2*(4), 303-312.

Barrocas, A. L., Hankin, B. L., Young, J. L., & Abela, J. R. Z. (2012). Rates of nonsuicidal self- injury in youth: age, sex, and behavioral methods in a community sample. *Pediatrics, 130*(1), 39–45.

Bennum, I., & Phil, M. (1983). Depression and hostility in self-mutilation. *Suicide and Life-Threatening Behavior, 13,* 71–83.

Berger, K. S. (2009). *The developing person: Through childhood and adolescence* (8th ed.). New York, NY: Worth Publishers.

Bernstein E. & Putnam F. W. (1986). Development, reliability and validity of a dissociation scale. *Journal of Nervous and Mental Disease,174*(12)*,* 727–735.

Blakemore, S., & Robbins, T. W. (2012). Decision-making in the adolescent brain. *Nature Neuroscience, 15*(9), 1184-1191.

Bonanno, G. A. (2001). Emotion self-regulation. In G. A. Bonanno & T. J. Mayne (Eds.), *Emotions: Current issues and future directions* (pp. 251□285). New York: Guilford Press.

Borrill, J., Fox, P., Flynn, M., & Roger, D. (2009). Students who self-harm: Coping style, rumination and alexithymia. *Counselling Psychology Quarterly, 22*(4), 361-372.

Bresin, K. (2014). Five indices of emotional regulation in participants with a history of nonsuicidal self-injury: A daily diary study. *Behavior Therapy, 45*(1), 56-66.

Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry, 68*, 609-620.

Brittlebank, A. D., Cole, A., Hassanyeh, F., Kenny, M., Simpson, D., & Scott, J. (1990). Hostility, hopelessness and deliberate self-harm: A prospective follow-up study. *Acta Psychiatrica Scandinavica, 81*(3), 280-283.

Brown, B. (2010, June). Brene Brown: The power of vulnerability [Video file]. Retrieved from http://www.ted.com/talks/brene_brown_on_vulnerability?language=en#t-

Brown, T. B. & Kimball, T. (2013). Cutting to live: A phenomenology of self-harm. *Journal of Marital and Family Therapy, 39*(2), 195-208.

Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy, 44*(3), 371-394.

Claes, L., Norre, J., Van Assche, L., & Bijttebier, P. (2014). Non-suicidal self-injury (functions) in eating disorder: Associations with reactive and regulative temperament. *Personality and Individual Differences, 57*, 65-69.

Claes, L., Luyckx, K., & Bijttebier, P. (2014). Non-suicidal self-injury in adolescents: Prevalence and associates with identity formation above and beyond depression. *Personality and Individual Differences, 61-62*, 101-104.

Connors, R. (1996). Self-injury in trauma survivors: 1.Functions and meanings. *American Journal of Orthopsychiatry, 66*(2), 197–206

Conterio, K., & Lader, W. (1998). *Bodily harm: The breakthrough healing program for self-injurers.* New York, NY: Hyperion.

Cramerus, M. (1989). Self-derogation: Inner conflict and anxious vigilance. *Journal of Contemporary Psychology, 19*(1), 55-69.

Cyr, M., McDuff, P., Wright, J., Theriault, C., & Cinq-Mars, C. (2005). Clinical correlates and repetition of self-harming behaviors among female adolescent victims of sexual abuse. *Journal of Child Sexual Abuse, 14*(2), 49-68.

Dahl, R. E. (2001). Affect regulation, brain development, and behavioral/emotional health in adolescence. *CNS Spectrums, 6*(1), 60-72.

Davis, T. S., Mauss, I. B., Lumian, D., Troy, A. S., SHallcross, A. J., Zarolia, P., Ford, B. Q., & McRae, K. (2014). Emotional reactivity and emotion regulation among

adults with a history of self-harm: Laboratory self-report and functional MRI evidence. *Journal of Abnormal Psychology, 123*(3), 499-509.

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Di Pierro, R., Sarno, I., Gallucci, M., & Madeddu, F. (2014). Nonsuicidal self-injury as an affect-regulation strategy and the moderating role of impulsivity. *Child and Adolescent Mental Health,* doi: 10.1111/camh.12063.

Donegan, N. H., Sansilow, C. A., Blumberg, H. P., Fulbright, R. K., Lacadie, C., Skudlarski, P.,….Wexler, B. E. (2003). Amygdala hyperactivity in borderline personality disorder: Implications for emotional dysregulation. *Biological Psychiatry, 54*(11), 1284-1293.

Dvorak, R. D., Sargent, E. M., Kilwein, T. M., Stevenson, B. L., Kuvaas, N. J., & Williams, T. J. (2014). Alcohol use and alcohol-related consequences: Associations with emotion regulation difficulties. *American Journal of Drug & Alcohol Abuse, 40*(2), 125-130.

Emde, R. N. (1988). Developmental terminable and interminable. I. Innate and motivational factors from infancy. *International Journal of Psycho-Analysis, 69,* 23-42.

Favazza, A. R. (1996). *Bodies under siege: Self-mutilation and body modification in culture and psychiatry* (2nd ed.). Baltimore: John Hopkins University Press.

Favazza, A. R. (1998). The coming age of self-mutilation. *The Journal of nervous and mental disease, 186*(5), 259-268.

Favazza, A. R. (2009). A cultural understanding of nonsuicidal self-injury. In M. K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, assessment, and treatment* (pp. 19–35). Washington, DC: American Psychological Association.

Favazza, A. R., & Conterio, K. (1988). The plight of chronic self-mutilators. *Community Mental Health Journal, 24*(1), 22-30.

Fitzpatrick, D. (2012). *Sharp: A memoir.* New York, NY: HarperCollins Publishers.

Fortune, S., Sinclair, J., and Hawton, K. (2008). Adolescents' views on preventing self-harm: A large community study. *Social Psychiatry and Psychiatric Epidemiology, 43*(2), 96-104.

Furman, W., & Buhrmester, D. (1992). Age and sex differences in perceptions of networks of personal relationships. *Child Development*, *63*, 103–115.

Furman, W., & Collins, W. (2009). Adolescent romantic relationships and experiences. In K. H. Rubin, W. M. Bukowski & B. Laursen (Eds.), *Handbook of peer interactions, relationships, and groups* (pp. 341–360). New York, NY: Guilford Press.

Garish, J. A., & Stewart, M. (2010). Vulnerabilities to deliberate self-harm among adolescents: The role of alexithymia and victimization. *British Journal of Clinical Psychology, 49*(2), 151-162.

Giorgi, A., & Giorgi, B. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), Qualitative research in psychology: Expanding perspectives in methodology and design (pp. 243-273). Washington, DC: American Psychological Association.

Giorgi, A., & Giorgi, B. (2008). Phenomenology. In J. Smith (Ed.) *Qualitative psychology: A practical guide to research methods* (pp. 26-52). Los Angeles, CA: SAGE Publications.

Glenn, C. R., & Klonsky E. D. (2010). The role of seeing blood in non-suicidal self-injury. *Journal of Clinical Psychology, 66*(4), 466-473.

Goodman, M., Carpenter, D., Tang, C. Y., Goldstein, K. E., Avedon, J., Fernandez, N., ….Hazlett, E. A. (2014). Dialectical behavior therapy alters emotion regulation and amygdala activity in patients with borderline personality disorder. *Journal of Psychiatric Research, 57*, 108-116.

Gonzalez-Forteza, C., Alvarez-Ruiz, M., Saldana-Hernansez, A., & Carreno-Garcia, S. (2005). Prevalence of deliberate self-harm in teenage students in the state of Guanajuato, Mexico: 2003. *Social Behavior and Personality, 33*(8), 777-792.

Graff, H., & Mallin, R. (1967). The syndrome of the wrist cutter. *The American Journal of Psychiatry, 124*(1), 36-42.

Gratz, K. (2006). Risk factors for deliberate self-harm among female college students: The role and interaction of childhood maltreatment, emotional inexpressivity, and affect intensity/reactivity. *American Journal of Orthopsychiatry*, *76*(2), 238-250.

Grewal, D., Brackett, M., & Salovey, P. (2006). Emotional intelligence and the self-regulation of affect. In D. Snyder, J. Simpson, & J. Hughes (Eds.), *Emotion regulation in couples and families: Pathways to dysfunction and health* (pp. 37-55). Washington, DC: American Psychological Association.

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1), 1-26.

Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2*(3), 271-299.

Gross, J. J. (2002). Emotion regulation: Affective, cognitive, and social consequences. *Psychophysiology, 39*(3), 281-291.

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology,85*(2), 348-362.

Hamza, C. A. & Willoughby, T. (2014). A longitudinal person-centered examination of nonsuicidal self-injury among university students. *Journal of Youth and Adolescence, 43*(4), 671-685.

Harned, M. S., Banawan, S. F., & Lynch, T. R. (2006). Dialectical behavioral therapy: An emotion-focused treatment for borderline personality disorder. *Journal of Contemporary Psychotherapy, 36*, 67-75.

Hartley, C. A., & Phelps, E. A. (2010). Changing fear: The neural circuitry of emotion regulation. *Neuropsychopharmacology, 35*(1)*,* 136–146.

Hawton, K., Bergen, H., Kapur, N., Cooper, J., Steeg, S., Ness, J., & Waters, K. (2012). Repetition of self-harm and suicide following self-harm in children and adolescents: Findings from the Multicentre Study of Self-Harm in England. *Journal of Child Psychology and Psychiatry, 53*(12), 1212-1219.

Hawton, K., & Harriss, L. (2008). The changing gender ratio in occurrence of deliberate self-harm across the life-cycle. *Crisis, 29*(1), 4-10.

Hawton, K., Rodham, K., Evans, E., & Harriss, L. (2009). Adolescents who self-harm: A comparison of those who go to hospital and those who do not. *Child and Adolescent Mental Health, 14*(1), 24-30.

Heath, N., Toste, J., & Beettam, E. (2006). "I am not well-equipped": High school teachers' perceptions of self-injury. *Canadian Journal of School Psychology, 21*(1-2), 73-92.

Heath, N. L., Toste, J. R., Nedecheva, T., & Charlebois, A. (2008). An examination of nonsuicidal self-injury among college students. *Journal of Mental Health Counseling, 30*(2), 137-156.

Heilbron, N., & Prinstein, M. J. (2008). Peer influence and adolescent nonsuicidal self-injury: a theoretical review of mechanisms and moderators. *Applied and Preventive Psychology, 12*(4), 169–177.

Hess, E. H. (1975). The role of pupil size in communication. *Scientific American, 235*, 110-119.

Hillbrand, M. (1995). Aggression against self and aggression against others in violent psychiatric patients. *Journal of Consulting and Clinical Psychology, 63*(4), 668-671.

Hilt, L. M., Nock, M. K., Lloyd-Richardson, E. E., & Prinstein, M. J. (2008). Longitudinal study of nonsuicidal self-injury among young adolescents: Rates, correlates, and preliminary test of an interpersonal model. *The Journal of Early Adolescence, 28*(3), 455-469.

Hollander, M. (2008). *Helping teens who cut: Understanding and ending self-injury.* New York, NY: The Guilford Press.

Hycner, R. H. (1999). Some guidelines for the phenomenological analysis of interview data. In A. Bryman & R. .G. Burgess (Eds.), Qualitative research (Vol. 3, pp. 143-164). London: Sage.

Inbar, Y., Pizarro, D. A., Gilovich, T., & Ariely, D. (2013). Moral masochism: On the connection between guilt and self-punishment. *Emotion, 13*(1)*,* 14–18.

International Society for the Study of Self-Injury (ISSS): 2007 [http://www.isssweb.org/]

Jacobson, C. M., & Gould, M. (2007). The epidemiology and phenomenology of non-suicidal self-injurious behavior among adolescents: A critical review of the literature. *Archives of Suicide Research, 11*(2), 129-147.

Joiner, T. E., 2005. *Why People Die by Suicide.* Harvard University Press, Cambridge MA.

Joiner, T. E., & Silva, C. (2012). Why people die by suicide: Further development and tests of the interpersonal-psychological theory of suicidal behavior. In P. R. Shaver & M. Mikulincer (Eds.), *The social psychology of existential concerns* (pp. 325-336). Washington, DC: American Psychological Association.

de Kloet, L., Starling, J., Hainsworth, C., Berntsen, E., Chapman, L., & Hancock, K. (2011). Risk factors for self-harm in children and adolescents admitted to a mental health inpatient unit. *Australian and New Zealand Journal of Psychiatry, 45*(9), 749-755.

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27*(2), 226-239.

Klonsky, E. D. (2011). Non-suicidal self-injury in United States adults: prevalence, sociodemographics, topography and functions. *Psychological Medicine, 41*(9), 1981-1986.

Klonsky, D. (2014). *Non-Suicidal Self-Injury: Description, Motivations, and Relationship to Suicide*. [podcast] Suicide Prevention Branch's Research Highlights Podcast Series. Available at: http://www.sprc.org/training-institute/samhsa-webinars [Accessed 12 Sep. 2014].

Klonsky, E. D. & Glenn, C. R. (2008). Resisting urges to self-injure. *Behavioural and Cognitive Psychotherapy, 36*(2), 211-220.

Klonsky, E. D. & Glenn, C. R. (2009). Assessing the functions of non-suicidal self-injury: psychometric properties of the inventory of statements about self-injury (ISAS). *Journal of Psychopathology and Behavioral Assessment,31*(3), 215-219.

Klonsky, E., D., May, A. M., & Glenn, C. R. (2013). The relationship between nonsuicidal self-injury and attempted suicide: Converging evidence from four samples. *Journal of Abnormal Psychology, 122*(1), 231-237.

Klonsky, E. D. & Moyer, A. (2008). Child sexual abuse and non-suicidal self-injury: Meta analysis. *The British Journal of Psychiatry, 192*(3), 166-170.

Klonsky, E. D. & Muehlenkamp, J. J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology, 63*(11), 1045-1056.

Klonsky, E. D. & Olino, T. M. (2008). Identifying clinically distinct subgroups of self-injurers among young adults: A latent class analysis. *Journal of Consulting and Clinical Psychology, 76*(1), 22-27.

Klonsky, D. E., Oltmanns, T. F., & Turkheimer, E. (2003). Deliberate self-harm in a nonclinical population: Prevalence and psychological correlates. *American Journal of Psychiatry, 160,* 1501–1508.

Kong, L., Chen, K., Tang, Y., Wu, F., Driesen, N., Womer, F., ... Wang, F. (2013). Functional connectivity between the amygdala and prefrontal cortex in medication-naïve individuals with major depressive disorder. *Journal of Psychiatry & Neuroscience, 38*(6), 417-422.

Kreitman, N. (1977). *Parasuicide.* New York, NY: Wiley.

Kring, A. M., & Sloan, D. M. (2010). *Emotion regulation and psychopathology: A transdiagnostic approach to etiology and treatment.* New York, NY: Guilford Press.

Lang, C. M. & Sharma-Patel, K. (2011). The relation between childhood maltreatment and self-injury: A review of the literature on conceptualization and intervention. *Trauma, Violence, & Abuse, 12*(1), 23-37.

Laukkanen, E., Rissanen, M. L., Tolmunen, T., Kylma, J., & Hintikka, J. (2013). Adoelscent self-cutting elsewhere than on the arms reveals more serious psychiatric symptoms. *European Child & Adolescent Psychiatry, 22*(8), 501-510.

Laye- Gindhu, A., & Schonert-Reichl, K. A. (2005). Nonsuicidal self-harm among community adolescents: Understanding the ‘whats’ and ‘whys’ of self-harm. *Journal of Youth and Adolescence, 34*(5), 447-457.

Leckman, J. F., & March, J. S. (2011). Editorial: Developmental neuroscience comes of age. *Journal of Child Psychology and Psychiatry, 52*, 333–338.

Lerner, R. M., & Steinberg, L. (2009). *Handbook of adolescent psychology.* New York, NY: Wiley.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guildford Press.

Linehan, M. M., & Schmidt, H. (1995). The dialectics of effective treatment of borderline personality disorder. In W.T. O'Donohue & T. William (Eds.). *Theories of behavior therapy: Exploring behavior change* (pp. 553-584). Washington DC: American Psychological Association.

Lloyd, E. E., Kelley, M. L., & Hope, T. (1997). Self-mutilation in a community sample of adolescents: Descriptive characteristics and provisional prevalence rates. In *Paper presented at the Annual meeting of the Society for Behavioral Medicine, New Orleans, LA.*

Lloyd-Richardson, E., Perrine, N., Dierker, L., & Kelley, M. (2007). Characteristics and functions of non-suicidal self-injury in a community sample of adolescents. *Psychological Medicine,37*(8), 1183-1192.

Long, M., Manktelow, R., & Tracey, A. (2013). We are all in this together: working towards a holistic understanding of self-harm. *Journal of Psychiatric and Mental Health Nursing, 20*(2), 105-113.

Lucassen, M. F. G., Merry, S. N., Robinson, E. M., Denny, S., Clark, T., Ameratunga, S., Crengle, S., & Rossen, F. V. (2011). Sexual attraction, depression, self-harm, suicidality and help-seeking behaviour in New Zealand secondary school students. *Australian and New Zealand Journal of Psychiatry, 45*(5), 376-383.

Madge, N., Hewitt, A., Hawton, K., Jan de Wilde, E., Corcoran, P., Fekete, S., van Heeringgen, K., De Leo, D., & Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: Comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study. *The Journal of Child Psychology and Psychiatry, 49*(6), 667-677.

Malatesta-Magai, C. (1991). Emotional socialization: Its role in personality and developmental psychopathology. In D. Cicchetti & S. L. Toth (Eds.), *Internalizing and externalizing expressions of dysfunction: Rochester symposium on developmental psychopathology* (pp. 203-224). Hillsdale, NJ: Erlbaum.

Marganska, A., Gallagher, M., & Miranda, R. (2013). Adult attachment, emotion dysregulation, and symptoms of depression and generalized anxiety disorder. *American Journal of Orthopsychiatry, 83*(1), 131-141.

Marshall, C., & Rossman, G. B. (2011). *Designing Qualitative Research* (5th ed.). Los Angeles, CA: SAGE Publications.

Matsumoto, T., Azekawa, T., Yamaguchi, A., Asami, T., & Iseki, E. (2004). Habitual self-mutilation in Japan. *Psychiatry and Clinical Neurosciences, 58*(2)*,* 191-198.

McMain, S., Korman, L. M., & Dimeff, L. (2001). Dialectical behavior therapy and the treatment of emotion dysregulation. *Journal of Clinical Psychology, 57*(2), 183-196.

Meehan, W., O'Connor, L. E., Berry, J. W., & Weiss, J. (1996). Guilt, shame, and depression in clients in recovery from addiction. *Journal of Psychoactive Drugs, 28*(2), 125-134.

Meltzer, H., Gatward, R., Goodman, R., & Ford, T. (2001). *Children and adolescents who try to harm, hurt or kill themselves. A report of further analysis from the national survey of the mental health of children and adolescents in Great Britain in 1999*. London: Office for National Statistics.

Menninger, K. A. (1938). *Man against himself.* New York, NY: Harcourt, Brace and Company.

Mezzacappa, E. S., Katkin, E. S., & Palmer, S. N. (1999). Epinephrine, arousal, and emotion: A new look at two-factor theory. *Cognition and Emotion, 13*(2), 181-199.

de Moore, G., & Robertson, A. (1996). Suicide in the 18 years of self-harm. British Journal of Psychiatry, 169, 489–494.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: SAGE Publications.

Muehlenkamp, J. J. (2005). Self-injurious behavior as a separate clinical syndrome. *American Journal of Orthopsychiatry, 75*(2), 324−333.

Muehlenkamp, J. J., Brausch, A., Quigley, K., & Whitlock, J. (2013). Interpersonal features and functions of nonsuicidal self-injury. *Suicide and Life-Threatening Behavior, 43*(1), 67-80.

Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(10), 1-9.

Muehlenkamp J. J., & Gutierrez P.M. (2007). Risk for suicide attempts among adolescents who engage in non-suicidal self-injury. *Archives of Suicide Research 11*(1), 69–82.

Muehlenkamp, J. J., Peat, C. M., Claes, L., & Smits, D. (2012). Self-injury and disordered eating: Expressing emotion Dysregulation through the body. *Suicide and Life-Threatening Behavior, 42*(4), 416-425.

Neacsiu, A. D., Eberle, J. W., Kramer, R., Wiesmann, T., & Linehan M. M. (2014). Dialectical behavior therapy skills for transdiagnostic emotion dysregulation: A pilot randomized controlled trial. *Behavior Research and Therapy,59*, 40-51.

Niedtfeld, I., Schulze, L., Kirsch, P., Herpertz, S. C., Bohus, M., & Schmahl, C. (2010). Affect regulation and pain in borderline personality disorder: A possible link to the understanding of self-injury. *Biological Psychiatry, 68*(4), 383-391.

Nock, M. K. (2009). New insights into the nature and functions of self-injury. *Association for Psychological Science, 18*(2), 78-83.

Nock, M. K. (2010). Self-injury. *Annual Review of Clinical Psychology, 6,* 339-363. Doi: 10.1146/annurev.clinpsy.121208.131258

Nock, M. K., & Favazza, A. R. (2009). Nonsuicidal self-injury: Definition and classification. In M. K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, assessment, and treatment* (pp. 9–18). Washington, DC: American Psychological Association.

Nock, M. K., Joiner, T. E., Gordon, K. H., Lloyd-Richardson, E., & Prinstein, M. J. (2006). Nonsuicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry Research, 144*(1), 65-72.

Nock, M. K, & Prinstein, M. J. (2004). A functional approach to the assessment of self-mutilative behavior. *Journal of Consulting and Clinical Psychology, 72*(5), 885-890.

Noll, J. G., Horowitz, L. A., Bonanno, G. A., Trickett, P. K., & Putnam, F. W. (2003). Revictimization and self-harm in females who experiences childhood sexual abuse: Results from a prospective study. *Journal of Interpersonal Violence, 18*(12), 1452-1471.

Ogle, R. L., & Clements, C. M., (2008). Deliberate self-harm and alcohol involvement in college-aged females: A controlled comparison in a nonclinical sample. *American Journal of Orthopsychiatry, 78*(4), 442-448.

Penn, J. V., Esposito, C. L., Schaeffer, L. E., Fritz, G. K., & Spirito, A. (2003). Suicide attempts and self-mutilative behavior in a juvenile correctional facility. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(7),762–769.

Plener, P. L., Bubalo, N., Fladung, A. K., Ludolph, A. G., & Lule, D. (2012). Prone to excitement: Adolescent females with non-suicidal self-injury (NSSI) show altered cortical pattern to emotional and NSS-related material. *Psychiatry Research: Neuroimaging, 203*(2-3), 146-152.

Plener, P. L., Libal, G., Keller, F., Fegert, J. M., & Muehlenkamp, J. J. (2009). An international comparison of adolescent non-suicidal self-injury (NSSI) and suicide attempts: Germany and the USA. *Psychological Medicine, 39*(9), 1549-1558.

Prinstein, M J., Guerry, J. D., Browne, C. B., & Rancourt, D. (2009). Interpersonal models of nonsuicidal self-injury. In M. K. Nock (Ed.), *Understanding*

nonsuicidal self-injury: Origins, assessment, and treatment (pp. 9–18). Washington, DC: American Psychological Association.

Quirk, S. W., Wier, D., Martin, S. M., and Christian, A. (2014). The influence of parental rejection on the development of maladaptive schemas, rumination, and motivations for self-injury. *Journal of Psychopathology and Behavioral Assessment.*

Rallis, B. A., Deming, C. A., Glenn, J., & Nock, M. K. (2012). What is the role of dissociation and emptiness in the occurrence of nonsuicidal self-injury? *Journal of Cognitive Psychotherapy,26*, 287-298.

Randles, D., & Tracy, J. L. (2013). Nonverbal displays of shame predict relapse and declining health in recovering alcoholics. *Clinical Psychological Science,1*(2), 149-155.

Rodham, K., & Hawton, K. (2009). Epidemiology and phenomenology of nonsuicidal self- injury. In M. K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, assessment, and treatment* (pp. 37-62). Washington, DC: American Psychological Association.

Rodham, K., Hawton, K., & Evans, E. (2004). Reasons for deliberate self-harm: Comparison of self-poisoners and self-cutters in a community sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 43,* 80–87.

Ross, S., & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence, 31*(1), 67-77.

Ross, S. Heath, N. L., & Toste, J. R. (2009). Non-suicidal self-injury and eating pathology in high school students. *American Journal of Orthopsychiatry, 79*(1), 83-92.

Sanchez-Navarro, J.P., Martinez-Selva, J.M., Roman, F. (2005). Emotional response in patients with frontal brain damage: effects of affective valence and information content. *Behavioral Neuroscience, 119*(1), 87–97.

Sandman, C. A. (2009). Psychopharmacologic treatment of nonsuicidal self-injury. In M. K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, assessment, and treatment* (pp. 19–35). Washington, DC: American Psychological Association.

Schoenleber, M., Berenbaum, H., & Motl, R. (2014). Shame-related functions of and motivations for self-injurious behavior. *Personality Disorders: Theory, Research, and Treatment, 5*(2), 204-211.

Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Schore, A. N. (2003). *Affect regulation and repair of the self.* New York, NY:W.W. Norton & Company.

Schore, A., R., & Newton, R. P. (2013). Using modern attachment theory to guide clinical assessments of early attachment relationships. In J. E. Bettmann, & D. D. Friedman (Eds.), *Attachment-based clinical work with children and adolescents.* (pp. 61-96) New York, NY: Springer.

Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal, 36*(1), 9-20.

Selby, E. A., Bender, T. W., Gordon, K. H., Nock, M. K., & Joiner, T. E. (2012). Non-suicidal self-injury (NSSI) disorder: A preliminary study. Personality Disorders, 3(2), 167–75.

Semrud-Klikeman, M., Fine, J. G., & Zhu, D. C. (2011). The role of the right hemisphere for processing of social interactions in normal adults using functional magnetic resonance imaging. *Neuropsychobiology, 64*(1), 47–51.

Settles, R. E., Fischer, S., Cyders, M. A., Combs, J. L., Gunn, R. L., & Smith, G. T. (2012). Negative urgency: A personality predictor of externalizing behavior characterized by neuroticism, low conscientiousness, and disagreeableness. *Journal of Abnormal Psychology, 121*(1), 160-172.

Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are.* New York, NY: The Guilford Press.

Silk, J. S., Steinberg, L., & Morris, A. S. (2003). Adolescents' emotion regulation in daily life: links to depressive symptoms and problem behavior. *Child Development, 74,* 1869–1880.

Simeon, D., Stanley, B., Frances, A., Mann, J. J., Winchel, R., & Stanley, M. (1992). Self-mutilation in personality disorders: Psychological and biological correlates. *American Journal of Psychiatry, 149,* 221−226.

Simpson, M. A. (1980). Self-mutilation as indirect self- destructive behavior. In N. L. Faberow (Ed.), *The many faces of suicide: Indirect self-destructive behavior* (pp. 257–283). New York: McGraw-Hill.

Singareddy, R., Krishnamurthy, V. B., Vgontzas, A. N., Fernandez-Mendoza, J., Calhoun, S. L., Shaffer, M. L., & Bixler, E. O. (2013). Subjective and objective sleep and self-harm behaviors in young children: A general population study. *Psychiatry Research, 209*(3), 549-553.

Skegg, K. (2005). Self-harm. Lancet, 366, 1471–1483.

Slade, A. (2014). Imagining fear: Attachment, threat, and psychic experience. *Psychoanalytic Dialogues, 24*(3), 253-266.

Smith, N. B., Kouros, C. D., & Meuret, A. E. (2014). The role of trauma symptoms in nonsuicidal self-injury. *Trauma, Violence, & Abuse, 15*(1), 41-56.

Spitz, R. A. (1958). On the genisis of superego components. *Psychoanalytic Study of the Child, 13*, 375-404.

Squire, L. R., Berg, D., Bloom, F. E., du Lac, S., Ghosh, A., & Spitzer, N. C. (2008). *Fundamental Neuroscience* (3rd ed.). Burlington, MA: Elsevier.

Sroufe, L. A. (1996). *Emotional development: The organization of emotional life in the early years.* New York: Cambridge University Press.

Sroufe, L. A., Duggal, S., Weinfield, N., & Carlson, E. (2000). Relationships, development, and psychopathology. In A. J. Sameroff, M. Lewis, & S. M. Miller (Eds.), *Handbook of developmental psychopathology (2nd ed.).* (pp. 1-17). New York, NY: Kluwer Academic/ Plenum Publishers

Stewart, S. L., Baiden, P., Theall-Honey, L., and den Dunnen, W. (2014). Deliberate self-harm among children in tertiary care residential treatment: Prevalence and Correlates. *Child Youth Care Forum, 43*(1), 63-81.

Straiton, M., Roen, K., Dieserud, G., & Hjelmeland, H. (2013). Pushing the boundaries: Understanding self-harm in non-clinical populations. *Archives of Psychiatric Nursing, 27*(2), 78-83.

Strong, M. (1998). *A bright red scream: Self-mutilation and the language of pain.* New York, NY: Penguin Group.

Substance Abuse and Mental Health Services Administration. Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings. Rockville, MD: SAMHSA, 2010.

Sutton, T. M., & Altarriba, J. (2011). The automatic activation and perception of emotion in word processing: Evidence from a modified dot probe paradigm. *Journal of Cognitive Psychology, 23*(6), 736-747.

Suyemoto, K. L. (1998). The functions of self-mutilation. *Clinical Psychology Review, 18*(5), 531-554.

Swannall, S. V., Martin, G. E., Page, A., Hasking, P., & St John, N. J. (2014). Prevalence of nonsuicidal self-injury in nonclinical samples: systematic review, meta-analysis and meta-regression. *Suicide and Life-Threatening Behavior, 44*(3), 273-303.

Tanaka, H., Yagi, A., Komiya, A., Mifune, N., & Ohtsubo, Y. (2014). Shame-Prone People Are More Likely to Punish Themselves: A Test of the Reputation-Maintenance Explanation for Self-Punishment. *Evolutionary Behavioral Sciences.*

Taylor, J., Peterson, C. M., & Fischer, S. (2012). Motivations for self-injury, affect, and impulsivity: A comparison of individuals with current self-injury to individuals with a history of self-injury. *Suicide and Life-Threatening Behavior, 42*(6), 602-613.

Thyssen, L. S. & van Camp, I. (2014). Non-suicidal self-injury in Latin America. *Salud Mental, 37*(2), 151-155.

Tice, D. M., Bratslavasky, E., & Baumeister, R. F. (2001). Emotional distress regulation takes precedence over impulse control: If you feel bad, do it! *Journal of Personality and Social Psychology, 80*(1), 53-67.

Troop, N.A., Allan, s., serpell, L. & Treasure, J.L. (2008). shame in women with a history of eating disorders. *European Eating Disorders Review, 16*(6), 480–488.

Victor, S. E., & Klonsky, E. D. (2013). Daily emotion in non-suicidal self-injury. *Journal of Clinical Psychology, 70*(4), 364-375.

Walsh, B. W. (2006). *Treating self-injury: A practical guide.* New York, NY: Guilford.

Walsh, D. (2014). *Why do they act that way? A survival guide to the adolescent brain for you and your teen.* New York, NY: Free Press.

Waska, R. T. (1998). Self-mutilation, substance abuse, and the psychoanalytic approach: Four cases. *American Journal of Psychotherapy, 52*(1), 18-27.

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 167-177.

Whiteside, S. P., & Lynam, D. R. (2001). The Five Factor Model and impulsivity: Using a structural model of personality to understand impulsivity. *Personality and Individual Differences, 30*(4), 669–689.

Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics, 117*(6), 1939-1948.

Whitlock, J., Muehlenkamp, J., & Eckenrode, J. (2008). Variation in nonsuicidal self-injury: Identification and features of latent classes in a college population of emerging adults. *Journal of Clinical Child & Adolescent Psychology, 37*(4), 725-735.

Whitlock, J., Muehlenkamp, J., Purington, A., Eckenrode, J., Barreira, P., Baral-Abrahms, G., Marchell, T., Kress, V., Girard, K., Chin, C., & Knox, K. (2011). Non-suicidal self-injury in a college population: General trends and sex differences. *Journal of American College Health, 59*(8), 691-698.

Wilkinson, P. (2013). Non-suicidal self-injury. *European Child & Adolescent Psychiatry, 22*(1), 75-79.

Wright, F., Bewick, B. M., Barkham, M., House, A. O., & Hill, A. J. (2009). Co-occurrence of self-reported disordered eating and self-harm in UK university students. *British Journal of Clinical Psychology, 48*(4), 397-410.

Yoo, G., & Park, J. (2014). The effects of the disconnection and rejection early maladaptive schemas on antisocial behavior and attitude in university students: The mediating role of peer attachment [In Korean]. *Korean Journal of Youth Studies*, *21*, 85-110.

Yoo, G., Park, J. H., & Jun, H. J. (2014). Early maladaptive schemas as predictors of interpersonal orientation and peer connectedness in university students. *Social Behavior and Personality, 42*(8), 1377-1394.

You, J., Lin, M. P., Fu, K., & Leung, F. (2013). The best friend and friendship group influence on adolescent nonsuicidal self-injury. *Journal of Abnormal Psychology, 41*(6), 993-1004.

You, J., Lin, M., & Leung, F. (2013). Functions of nonsuicidal self-injury among Chinese community adolescents. *Journal of Adolescence, 36*(4), 737-745.

Young, R., van Beinum, M., Sweeting, H., & West, P. (2007). Young people who self-harm. *British Journal of Psychiatry, 191*, 44-49.

Appendix A: Semi-structured Interview

Demographic Information

Pseudonym:

Age:

Gender:

Ethnicity:

Age at onset of self-harm behavior:

Preferred method of self-harm:

How often do you self-harm?

When was your last self-harm episode?

Interview Questions

1. How do you handle conflict?
2. How do you feel before engaging in self-harm?
3. How do you feel while self-harming?
4. How do you feel after engaging in self-harm?
5. What emotions are easy for you to express?
6. What emotions are difficult for you to express?
7. How is your relationship with your mother?
8. How is your relationship with your father?

Appendix B: Informed Consent

Informed Consent
Participant Assent and Parental Consent to Participate in Research

Participant Name_____

• I assent to be screened for participation in a research project investigating the experience of self-harm in adolescents. The screening will include a few questions about my self-harm as well as questions about my thoughts feelings, and behaviors. _____ (Participant Initial)

• I consent for my child to be screened for participation in a research project investigating the experience of self-harm in adolescents. The screening will include a few questions about their self-harm as well as questions about their thoughts feelings, and behaviors. _____ _____ (Parent Initials)

• If chosen, I assent to participate in a research project investigating the experience of self-harm in adolescents.

• I understand that Erin Holley is completing this research project in partial fulfillment of requirements for the PsyD degree in Clinical Psychology at Antioch University, under the direction of Dr. Steven Kadin, PhD, and that the information I provide may be included in a dissertation and/or other publications.

• I am aware that all data will be confidential and only my age, gender, ethnicity, and nature of my self-harm will be included. I am aware that I will be audio recorded during my interview. I am aware that my name will not appear in the dissertation an/or other publications.

• I am aware that I will be interviewed without my parent/legal guardian present in order to clarify the emotional content of my self-harm and how self-harm is significant for me.

• I am aware that the nature of the topic is such that reflection of my own self-harm may result in negative emotional reactions. I understand that the researcher has safety measures in place and I am encouraged to speak with my therapist about any negative reactions that might come up.

• I am aware that Erin will inform my therapist of ONLY the date and time of my interview, and the questions that will I will be asked to answer. I am aware that Erin will not disclose anything that I talk about during the clinical interview.

• I am aware there are limits to confidentiality in which Erin will have to break confidentiality including: child abuse, elder abuse, dependent adult abuse, if I communicate that I have suicidal plan and intent, and if I communicate a serious threat of physical violence against an identifiable person. I am aware that I can discuss these limits to confidentiality with Erin, and ask as many questions necessary to assure that I fully understand.

• I am aware that I may refuse to answer any questions and may withdraw my consent to participate at any time prior to the completion of the research project. A signed statement indicating my desire to discontinue participation will result in the removal of any data I have provided from this or any future studies.

Questions/Concerns: *If you have any additional questions about this study please feel free to contact me, Erin Holley, via phone XXX-XXX-XXXX, or email, XXXXXXX or Dr. Steve Kadin at XXX-XXX-XXXX, Ext. XXXX, or XXXXXX. If you have any questions about your rights as a research participant, you may contact Dr. Sharleen O'Brien, Chair of the Antioch University Santa Barbara Institutional Review Board, XXX-XXX-XXXX*

I have received a written explanation of the research project, and the research project and the procedures have been explained to me. I agree to participate in this screening and study. My participation is voluntary and I do not have to sign this form if I do not want to be part of this research project. I will receive a copy of this consent form for my records.

_____ _____
Date Signature of Participant

Appendix B Continued

I have received a written explanation of the research project, and the research project and the procedures have been explained to me. I agree to allow my child to participate in this screening and study. My child's participation is voluntary and I do not have to sign this form if I do not want them to be part of this research project. I will receive a copy of this consent form for my records.

_____	_____
Date	Signature of Parent/Guardian
_____	_____
Date	Signature of Parent/Guardian
_____	_____
Date	Erin Holley, M.A., Doctoral Candidate

Appendix C: Screening Form

How old are you?

Are you currently going to therapy?

In the last year, about how many times did you engage in self-harm?

What methods did you use to inflict self-harm?

What were some reasons for engaging in self-harm?

Have you ever had negative consequences for self-harming?

Was the intention of self-harming to end your life?

Are you currently having thoughts of suicide?

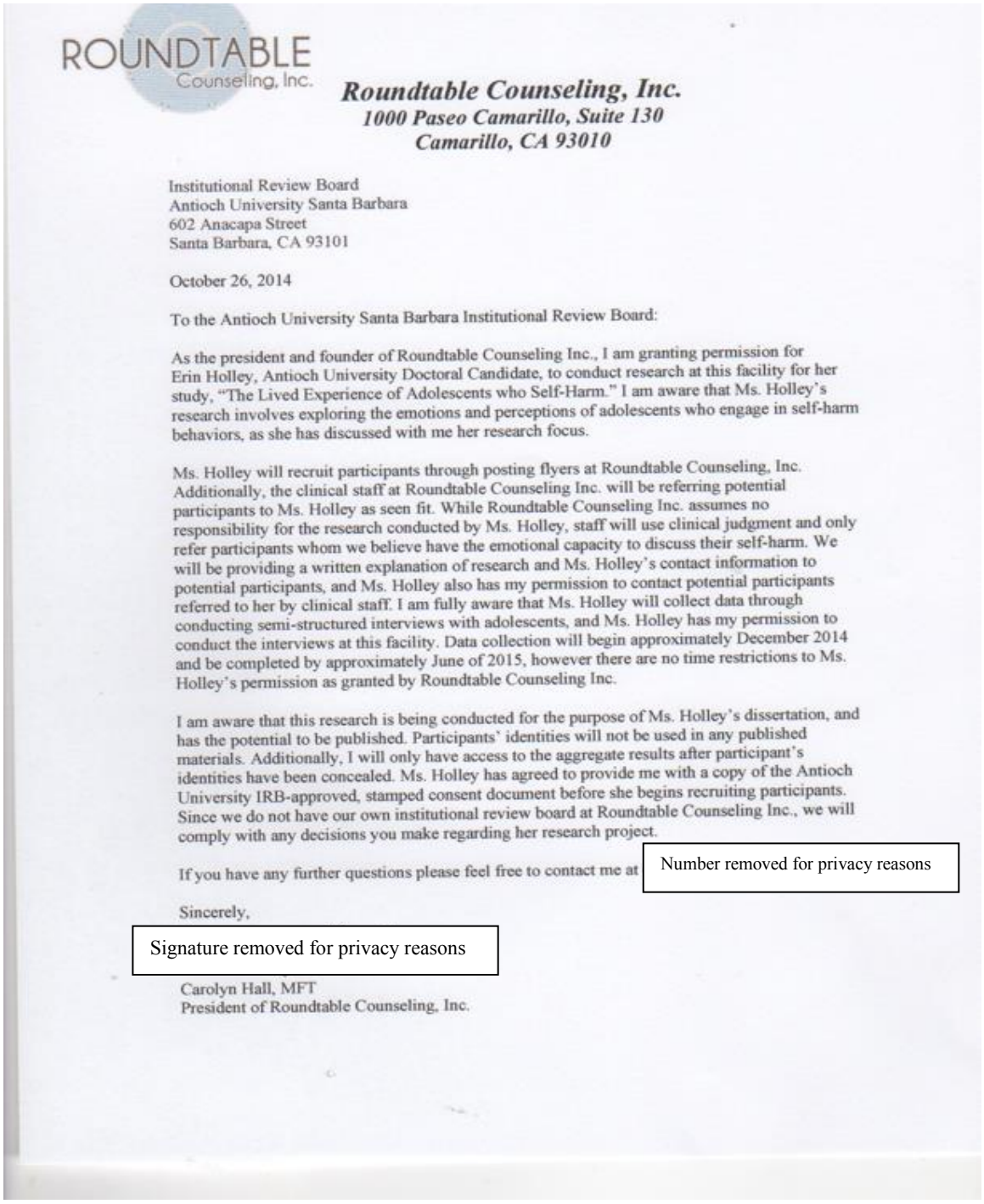
Have you had thoughts of suicide in the past?

If so, when did you have these thoughts?

Have you ever made a suicide attempt?

If so, when was your last suicide attempt?

Appendix D: Permission to Recruit from Roundtable Counseling Inc.



ROUNDTABLE Counseling, Inc.

Roundtable Counseling, Inc.
1000 Paseo Camarillo, Suite 130
Camarillo, CA 93010

Institutional Review Board
Antioch University Santa Barbara
602 Anacapa Street
Santa Barbara, CA 93101

October 26, 2014

To the Antioch University Santa Barbara Institutional Review Board:

As the president and founder of Roundtable Counseling Inc., I am granting permission for Erin Holley, Antioch University Doctoral Candidate, to conduct research at this facility for her study, "The Lived Experience of Adolescents who Self-Harm." I am aware that Ms. Holley's research involves exploring the emotions and perceptions of adolescents who engage in self-harm behaviors, as she has discussed with me her research focus.

Ms. Holley will recruit participants through posting flyers at Roundtable Counseling, Inc. Additionally, the clinical staff at Roundtable Counseling Inc. will be referring potential participants to Ms. Holley as seen fit. While Roundtable Counseling Inc. assumes no responsibility for the research conducted by Ms. Holley, staff will use clinical judgment and only refer participants whom we believe have the emotional capacity to discuss their self-harm. We will be providing a written explanation of research and Ms. Holley's contact information to potential participants, and Ms. Holley also has my permission to contact potential participants referred to her by clinical staff. I am fully aware that Ms. Holley will collect data through conducting semi-structured interviews with adolescents, and Ms. Holley has my permission to conduct the interviews at this facility. Data collection will begin approximately December 2014 and be completed by approximately June of 2015, however there are no time restrictions to Ms. Holley's permission as granted by Roundtable Counseling Inc.

I am aware that this research is being conducted for the purpose of Ms. Holley's dissertation, and has the potential to be published. Participants' identities will not be used in any published materials. Additionally, I will only have access to the aggregate results after participant's identities have been concealed. Ms. Holley has agreed to provide me with a copy of the Antioch University IRB-approved, stamped consent document before she begins recruiting participants. Since we do not have our own institutional review board at Roundtable Counseling Inc., we will comply with any decisions you make regarding her research project.

If you have any further questions please feel free to contact me at Number removed for privacy reasons

Sincerely,

Signature removed for privacy reasons

Carolyn Hall, MFT
President of Roundtable Counseling, Inc.

Appendix E: Explanation of Research

A STUDY OF ADOLESCENTS' EMOTIONAL EXPERIENCES WITH SELF-HARM

The person who is in charge of this research is Erin Holley, M.A. Erin has approximately seven years of experience working with teenagers and adolescents in a clinical capacity, and has been previously employed at Roundtable Counseling for approximately 3 ½ years, under the supervision of Carolyn Hall, MFT. Interviews will be conducted at a private location of your choice (Roundtable Counseling, participant's home, library, etc.).

Should your teen take part in this study?

This form tells you about the research study. You can decide if you want your child to take part in it. This form explains:

- Why this study is being done.
- What will happen during this study and what your child will need to do.
- Whether there is any chance your child might experience potential benefits from being in the study.
- The risks of having problems because your child is in this study.

Before you decide:

- Read this form
- Talk about this study with the person in charge of the study, Erin Holley, or your counselor/your child's counselor at Roundtable.
- You may have questions this form does not answer. You do not have to guess at things you don't understand. If you have questions, ask Erin.
- Take your time to think about it.

It is up to you. If you choose to let your child be in the study, then please sign the informed consent form.

Why is this research being done?

The purpose of this research study is to gain insight into the experience of self-harm from the adolescent's perspective. Self-harm can be a very scary, very difficult behavior to understand, especially from a parent's perspective. It is with great hope that inside information from your teen can shed light into this painful and often confusing behavior. One of the goals of this study is to interview your child about his/her feelings before, during, and after self-harm. Your teen will have one interview with Erin, lasting approximately 60-90 minutes. The interview will be audiotaped, transcribed, and destroyed upon completion of the study. During the interview, Erin will ask your teen a series of questions. If at anytime, your teen appears to be experiencing more than a mild amount of distress, Erin will stop the interview.

Appendix E (continued)

Why is your teen being asked to take part?
We are asking your teen to take part in this research study because he/she has engaged in self-harm in the past. We want to find out more about why this behavior occurs in their own words.

What will happen during the study?
Your teen will be asked to spend about 60-90 minutes answering questions about their self-harm behavior, general emotional state, and familial relationships. All of the information is 100% confidential, and your teen will be asked to pick a pseudonym to be referred to in the research.

How many other teens will take part?
About 6-8 adolescents (ages 14-18) will take part in this study.

What are the potential benefits to your teen if you let him/her take part in this study?
Your teen may benefit from sharing his/her experience with self-harm in his/her own words. Sometimes, being able to share one's story can be empowering. The interview will provide a place for your teen to be heard, without imposing judgments or assumptions about their feelings and individual experiences. It is possible that your teen may benefit from participating in research, which aims to promote a greater understanding of self-harm. Contributing to the research on self-harm may help in reducing the stigma and identifying factors that place adolescents at risk for engaging in self-harm. Identifying risk factors may potentially lead to prevention measures and developments in effective treatment strategies.

What are the risks if your teen takes part in this study?
Your teen may experience mild emotional distress during his/her interview. In some situations, discussing the act of self-harm can trigger acts of self-harm. Erin will be checking in with your teen throughout the interview for feelings of being triggered. Your teen has the right to discontinue the interview at any time without penalty and will be provided with follow-up information.

If your child has any of these problems, call Erin right away at (XXX) XXX-XXXX

One of the requirements for participating in the study is that your teen is currently receiving psychotherapy. If feelings are triggered throughout the interview, your teen is encouraged to process their feelings with their therapist.

Appendix F: Recruitment Poster

Participants Needed for a Study on Self-Harm

Are you an adolescent who has had experience with self-harming behavior?
Are you between the ages of 14 and 18?
Are you currently going to therapy?

If you are able to answer **YES** to all of these questions, you are needed for a study about the experience of self-harm in adolescents.

It involves participating in one interview, which will take approximately 60-90 minutes. All you need is consent from your parents to participate.

Participation is voluntary and confidential

If under 18 years of age, you will need your parent's permission to participate

If interested, please contact Erin Holley, Doctoral Candidate at Antioch University Santa Barbara, Department of Clinical Psychology at XXXXXXXX or (XXX) XXX-XXXX.