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Walden University

College of Psychology and Community Services

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Nicoletta Weide

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Walden University
2022

Abstract

The Connection Between Positive Coping Skills and Cutting for Young Adults in Adolescence

by

Nicoletta Weide

MPhil, Walden University, 2019

MHS, Nova Southeastern University, 2017

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services

Walden University

July 2022

Abstract

According to recent studies, the instances of non-suicidal self-injury (NSSI) in adolescents have sharply risen in recent years. Cutting is the most prevalent form of NSSI in adolescence which leads to scarring, social stigma, and an increased risk of suicide. NSSI and cutting are considered maladaptive coping skills. The purpose of this general qualitative study is to explore how positive coping skills and self-regulation impacted their instances of cutting. Self-regulation theory was used to analyze if having positive alternative skills was enough to regulate the behavior and have an impact on their instances of cutting. This general qualitative research study utilized interviews of eight individuals with past cutting experiences during adolescence to gather information on effective alternative coping strategies. The results of this study showed that individuals had to learn positive skills through self-discovery and that each of these skills was very individualized. These skills were not present at the onset of cutting, but once the participants were able to gain these skills, they were able to self-regulate and lower their instances of cutting. Adolescents may benefit from the results of this study as they can be given positive coping skills earlier in childhood to lessen the instances of cutting and improve self-regulation.

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Chapter 1: Introduction to the Study

Introduction

Non-suicidal self-injury (NSSI) in adolescents is a growing public health concern. NSSI is the act of deliberately injuring oneself through various means without suicidal intent (Emery et al., 2016). In the United States, self-inflicted injuries in adolescents are becoming a more common occurrence. The rise in self-harm rates in adolescents is troubling as it has risen to over 60% within the past decade (Hall & Place, 2010; Morgan et al., 2017). This rise can be seen within the literature, reports from the media, and with the instances of emergency room visits for self-harm increasing (Cutler et al., 2015; Scherr et. al., 2019).

The onset of NSSI most often starts in early adolescence between the ages of 12 and 14 years old. For children that start NSSI before the age of 12, their injuries tend to be more severe and will include a greater frequency of self-injury, increased hospital visits, and suicidal ideation and planning (Ammerman et al., 2018). The most common form of NSSI for adolescents is cutting (Cipriano et al., 2017). Additional forms of NSSI can include scratching, burning, biting, head-banging, and hitting oneself (Roley-Roberts et al., 2016). NSSI behaviors are typically a coping response that is commonly associated with high stress, negative family dynamics, trauma, or abuse (Morales et al., 2018).

Coping strategies refer to the psychological knowledge, skills, and strategies that people use to deal with stressful situations and emotions (de la Feunte et al., 2020). These coping strategies can be either positive or negative. NSSI exists largely as a negative way

to cope with stress, trauma, abuse, mental health concerns, and emotional regulation (Morales et al., 2018). Self-regulation is a positive, conscious effort and impulse control to guide one's behaviors which includes coping strategies (Gillebaart, 2018). Since NSSI is a negative coping strategy, it is imperative to find positive strategies that can replace it for adolescents dealing with stressful situations.

To best understand the potential for NSSI positive coping strategies, it is important to understand the history of NSSI and cutting. After understanding the background of NSSI, it is important to outline statements to illustrate the problem and purpose for this research that will lead to the research questions being addressed. The theoretical framework and nature of the study as well as illustrating the assumptions, scope, limitations, and challenges provide structure to the proposed research.

Background

Based on the data collected from the Centers for Disease Control and Prevention (CDC, 2019), the number of emergency room visits for self-harm increased from 2010 to 2017 by a rate of 47% (25.7 to 38.0 NSSI injuries per 10,000 adolescents). Many of those who partake in NSSI do not have suicidal intent (Wu & Liu, 2019). While engaging in NSSI is often without suicidal intent, adolescents are more than likely to have one or more suicide attempts if they have previously engaged in NSSI (Stanford et al., 2017). NSSI is a very complex issue due to all the varying reasons behind self-harm behaviors (Hawton et al., 2012; Minor et al., 2016; Swannell et al., 2014).

Emergency room visits for self-inflicted injuries have continued to increase and cutting is the most common form of self-inflicted injury (Cutler et al., 2015). Cutting is a type of NSSI that is becoming more prevalent and common among adolescents (Morales et al., 2018). The issue with cutting is that it often leads to physical injuries requiring medical attention, scarring, and lasting social stigma. Cutting, as a self-harm attempt, can also lead to a greater risk of suicide (Cutler et al, 2015; Emery et al., 2016). Adolescents who cut may recognize that they are not coping well and use cutting as a tool for emotional regulation (Wu & Liu, 2019).

Adolescents who deliberately self-harm often use it as a coping strategy when faced with stress, abuse, trauma and to regulate emotions such as fear or sadness (Andover & Morris, 2014). An individual engages in self-regulation to guide one's behavior which can be positive or negative skills. Cutting is a short-term negative coping skill or strategy that often feels better at the moment. Cutting has many lasting physical and mental health difficulties and is highly stigmatized and often misunderstood which may result in prejudice or discrimination (Staniland et al., 2020).

Cutting actions are influential on a young adults' development and lived experiences (Mitten et al., 2015). These actions can develop traumatic response patterns that also impact the individual's physical and mental health. When an individual cuts, this often results in extensive skin scarring (Lewis et al., 2019). These scars are permanent and may require treatment and reconstructive surgery to repair some of the scarred areas once they have healed. The scars can also be stigmatizing and traumatizing (Mitchell et

al., 2019). These scars also can be in highly visible areas of the body that can cause the individual to feel self-conscience and ashamed. The body alteration from scaring impacts social relations, social activities, and occupational functioning (Jayarajah & Samarasekera, 2017).

A thorough literature review on NSSI and cutting indicated what a growing concern it has become in recent years (Morgan et al., 2017). Researchers who focused on both cutting and alternative positive coping skills with self-regulation were scarce (Hall & Place, 2010; Le Breton, 2018; Mikolajczak et al., 2009). While authors focused on actual self-harming behaviors (Morgan et al., 2017), self-regulation theory (Modecki et al., 2017), or coping skills (Zila & Kiselica, 2011) there were only a few that covered the use of self-regulation and alternative coping strategies regarding the number cutting instances in adolescents (Modecki et al., 2017; Muehlenkamp et al., 2008).

Problem Statement

Clare (2014) noted in their research on self-harm, that there was a lack of effective alternative coping skills given by mental health professionals that could meet the needs of the individual. Additionally, the Mayo Clinic (2018) suggested that there are little to no evidence-based established methods for treating self-injuring behavior. With NSSI sharply rising in recent years, it is imperative to find alternative positive coping strategies for these adolescents (Cutler et al., 2015).

Individuals who engage in cutting are at risk for physical, mental, and emotional difficulties along with increased suicide risk (Mitten et al., 2015). These difficulties

include personality disorders, anxiety, depression, and substance abuse. Many adolescents who cut themselves increase their self-abuse frequency and severity over time and continue despite knowing the consequences and stigma that go along with this behavior (Mitten et al., 2015). Adolescents who have engaged in self-harm often discuss experiencing judgment. Adolescents are more prone to keep their cutting a secret, which makes help-seeking difficult (Mitten et al., 2015). When adolescents do seek help from a medical or mental health professional, they often report experiencing judgment and disdain from professionals (Miner et al., 2016).

It is important to understand the cutting, coping, and self-regulation of adolescents (approximately 12-18 years old). However, there are benefits to interviewing adults about their adolescent experiences because in instances of cutting lessons as they enter adulthood along with a less chance of retriggering trauma and objectively recounting their experiences. Christoffersen et al. (2015) studied NSSI during childhood as the potential for retriggering trauma and NSSI during childhood and adolescents can become serious. It is important to minimize the potential risks associated with cutting as retriggering trauma can potentially lead to another NSSI activity (Lloyd-Richardson et al., 2015). Researchers have also shown that individuals no longer involved in NSSI or out of their adolescent years were better to manage difficult emotions and more accepting of their emotional experiences (Lewis et al., 2019). By focusing on the experiences of adults, there is less risk of retriggering trauma and more chance of identifying alternative coping skills for cutting.

Although the prior research regarding NSSI illustrates important findings, I found no research that examines the relationship between adolescents that cut and their use of alternative coping strategies and self-regulation. Further research was warranted to examine if there are any alternative coping skills or strategies that can be used to decrease the instances of cutting in adolescents. Thus, the results from this study may inform additional ways to lower adolescent cutting instances. The goal of this research is to understand if adolescents were given and/or used alternative coping skills during their time of cutting, what were the skills, and did they decrease their instances of cutting. The application of the findings of this study demonstrated the potential to decrease the instances of NSSI which would lower the risk of emergency visits, as well as reduce physical lifelong scars, social stigma, and potentially, suicide (Centers for Disease Control and Prevention, 2019).

Purpose

The purpose of this generic qualitative study was to explore the positive alternative coping strategies used by young adults instead of cutting in adolescence, what these alternatives were, and how this affected the number of cutting instances. This study examined the experiences of finding alternatives to self-harm (cutting) in individuals aged 18-23 years, who engaged in cutting behavior during their adolescent years and found alternative coping skills to cutting. This provided perspectives on alternative coping mechanisms the participants had used and the outcome of using the alternative method(s).

Research Questions

RQ 1: What strategies did young adults (age 18-23) use as alternatives to cutting when they were adolescents?

RQ 2: How do they believe that these alternative strategies assisted them with controlling their cutting behaviors?

Theoretical Framework

The theoretical framework used for this study is self-regulation theory. The concept of self-regulation originated from the work of Albert Bandura (1991). Bandura primarily focused on the social cognitive aspect of self-regulation in regard to human behavior. He labeled three subfunctions within self-regulation that included self-monitoring of behaviors, the judgment of one's behavior, and self-reaction to the behavior. The self-monitoring of behaviors includes concepts of performance (i.e. productivity, morality) and quality (i.e. informativeness, regularity) to help identify if the activities are considered acceptable. During the self-judgment aspect, individuals will consider their standards, referential performance, the value of actions, and other personal and external determinants. Lastly, for self-reaction, the individual will evaluate their reaction if it is positive or negative and determine the tangible elements of the reaction (i.e. reward, punishment, no action). Bandura's work of social cognitive theory of self-regulation was foundational for the self-regulation theory that is utilized by other theorists today (Liu et al., 2020).

Roy Baumeister (2007) continued to expand on the self-regulation theory. The theory focuses on an individual's ability to alter their thoughts and behaviors in order to achieve specified goals (Baumeister & Vohs, 2007). The theoretical work does not only cover how to positively change one's actions but also the failure to adapt one's actions to meet specified goals (Baumeister & Heatherton, 1996). Self-regulation is used when an individual chooses to use positive coping strategies as an alternative to NSSI or cutting behaviors. This action is done when individuals utilize self-control "muscles" to assist with the improvement of willpower and explain the depletion of the ego (Baumeister et al., 2018). For adolescents wanting to practice coping alternatives to cutting, it is important to have the ability to build up willpower and self-control. This is done through structured tools, goal-setting, and intrapersonal rewards associated with the self-regulation theory (Veijalainen et al., 2019).

Self-regulation theory provides a solid framework for understanding the link between how an individual regulates their emotions and perceptions towards outward actions. Modecki et al. (2017) highlighted that emotional regulation is directly linked to the coping and decision-making skills in adolescents. The authors also discussed how these linked skills help adolescents externalize their problems. This would branch into the externalization of actions that manifest in NSSI and cutting. There are three steps in order to put this theory into practice: diagnosis, intervention, and evaluation (Kuhl et al., 2006). Experiences of self-regulation and positive coping skills in relation to self-harm cutting instances will be explored in this study to see if are commonalities in the behaviors that

lowered participants' instances of self-harm. The link between instances of self-harm and self-regulation has not been thoroughly studied, and it is essential to address this gap to explore potential positive coping strategies.

Nature of the Study

This study used a generic qualitative research approach. Cooper and Endacott (2007) stated that generic qualitative studies "seek to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved" (p. 817). Using generic qualitative research data can be derived from first-person reports of their lived experiences. The information collected for this study was their experiences with cutting and their discovery of alternative coping strategies. Data for general qualitative studies are often collected through semi-structured interviews (Kahlke, 2014). For this study, the data was gathered through interviews with open-ended questions and dialog to obtain experiences and descriptions from the interviewee.

Moustakas (1994) utilized a modification of the Van Kaam method of analysis for qualitative research data. This method of transcribing the information from each interviewee is critical to clustering and theming data to determine relevancy and invariant constituents This method of coding the information from the interviews is important to show the validated constructs based on the lived experiences of the interviewees.

The sample size for this generic qualitative study had a target range of 8-12 participants. Biddle et al. (2014) examined self-harm research studies and found that 10 to 20 participants were common in this type of research (Biddle et al., 2013). Lewis et al.

(2019) recommended the use of adults for interviews regarding self-injury during adolescence for a more reliable recounting of experiences. The interviews will consist of open-ended questions about any alternative coping mechanisms used as well as the effectiveness of these alternatives.

Definitions

Coping: "Coping is an evolving process that changes in response to context, in an effort to manage different internal and external demands" (Heffer & Willoughby, 2017, para. 3).

Cutting: Cutting is a self-injury where an incision is made on the skin and deep enough to be accompanied by blood (Jacquin & Picherot, 2016).

Non-Suicidal self-injury (NSSI): NSSI is a behavior in which a person inflicts physical harm upon themselves without the intent to die by suicide (Carroll, 2019).

Trauma: Trauma is an emotional response to a traumatic event. A traumatic event is any event where an individual feels physically or emotionally threatened, painful, stressful, or life-endangering (Roley-Roberts et al., 2017).

Assumptions

During the selection process, it was assumed that participants that choose to participate have met the requirements outlined. It was assumed that the individuals interviewed gave an authentic account of their cutting behaviors and coping strategies. Another assumption was that the participants interpreted the questions in the same manner based on the terms and descriptions discussed.

Scope and Delimitations

The scope of the study was to understand if alternative coping skills lessened the amount of cutting in adolescents. The delimitations for the study included using young adults that had previously used cutting as self-harm to recant their cutting experiences and coping skills during their adolescent years. All participants were between 18 and 23 years old. The reason for this narrow age group was to limit the chance of retriggering by being outside of adolescent years and still close enough to the events to recant the experience (Lloyd-Richardson et al., 2015).

Limitations

The limitations of this study included ethical standards and bias. The ethical line between human service workers and participants cannot become blurred (Kim, 2012). Being in a human service role it is important to keep a separation of roles and to not interject clinic positions to push research and cross ethical boundaries, as a researcher may know the participant prior to conducting research, and the participants must have full confidentiality. Even though researchers can be passionate about their research, it is important to put any bias and previous notions aside and be completely objective throughout the study (Babbie, 2015).

One of the biggest challenges is secondary trauma and traumatic stress during the interviews (Shannonhouse et al., 2016). When learning of their experiences with self-harm, it can be retraumatizing for the interviewee in reliving their cutting experiences. There may also be trauma to the researcher in being exposed to traumatic stories. These

traumas include psychosocial distress and cognitive shifts. The secondary trauma may also affect the trust and the building of a relationship between the interviewer and the interviewee (Shannonhouse et al., 2016). As a researcher, it is good to be aware that probing questions on sensitive subjects can harm the participants' self-esteem (Babbie, 2017). Within the informed consent, there will be a list of places and resources for participants to reach out to if they are triggered or face secondary trauma. These include national crisis text lines, national phone contacts, websites, and local resources.

One of the biggest barriers to this research will be finding enough participants for interviews. The challenge was finding adults within the age range (18-23 years) that engaged in cutting during their adolescent years. While the age range ensures that they are not far out of their adolescent years, it narrowed down the pool of interviewees. Due to the nature of the research, there could also be a limitation on demographics (i.e. an imbalance of female to male).

Significance

NSSI is increasing (47% from 2010 to 2017) and this has become a social problem affecting many communities (CDC, 2019; Morgan et al., 2017). Cutting can lead to scarring and social stigmas that affect the adolescent for life (Mitten et. al., 2015). There is a lack of research regarding substantial coping alternatives for cutting by adolescents (Clare, 2014). Interviews conducted with young adults who had cut in adolescence allow the individual a platform to describe their emotional experiences with

cutting and coping strategies. This has the potential to extend upon the current research regarding cutting by looking specifically at the coping skills or strategies used.

Receiving preventative care along with good coping skills or strategies is beneficial for preventing NSSI (Wu & Liu, 2019). Clinical practices, which include mental and physical health, could also benefit from research that fills the gaps for coping alternatives. This will allow clinical practitioners to provide care along with positive coping skills to adolescents that cut. By finding alternative coping strategies that have worked, adolescents will decrease the amount of physical self-harm, emergency room visits, and scarring on their bodies. This, in turn, could reduce the negative social stigma associated with cutting. Furthermore, the impacts of this study could reach further than just adolescents by being impactful to all individuals regardless of age.

Summary

Instances of cutting are prevalent for adolescents, and it is important to find ways to reduce these instances and the lasting negative outcomes and effects. These instances of cutting have risen to 47% in recent years (CDC, 2019). By finding positive alternatives to coping, it may be possible to provide resources to reduce cutting instances. Self-regulation is a concept that can be beneficial in the positive alternative coping strategies to cutting. The literature review for this research will focus on background on self-regulation and related theories, how cutting and NSSI impact adolescents, and how coping strategies work.

Chapter 2: Literature Review

Introduction

Clare (2014) noted in their research on self-harm, that there was a lack of effective alternative coping skills given by mental health professionals that could meet the needs of the individual. Additionally, the Mayo Clinic (2018) suggested that there are little to no evidence-based established methods for treating self-injuring behavior. With NSSI sharply rising in recent years, it is imperative to find alternative positive coping strategies for these adolescents (Cutler et al., 2015).

Individuals who engage in cutting are at risk for physical, mental, and emotional difficulties along with increased suicide risk (Mitten et al., 2015). These difficulties include personality disorders, anxiety, depression, and substance abuse. Many adolescents that cut themselves increase their self-abuse frequency and severity over time and continue despite knowing the consequences and stigma that go along with this behavior (Mitten et al., 2015). Adolescents who have engaged in self-harm often discuss experiencing judgment. Adolescents are more prone to keep their cutting a secret, which makes help-seeking difficult (Mitten et al., 2015). When adolescents do seek help from a medical or mental health professional, they often report experiencing judgment and disdain from professionals (Miner et al., 2016).

It is important to understand the cutting, coping, and self-regulation of adolescents (approximately 12-18 years old). However, there are benefits to interviewing adults about their adolescent experiences because in instances of cutting lessons as they

enter adulthood along with a less chance of retriggering trauma and objectively recounting their experiences. Christoffersen et al. (2015) conducted research on NSSI during childhood using adults due to the potential for retrigging NSSI and trauma. It is important to minimize the potential risks associated with cutting as retriggering trauma can potentially lead to another NSSI activity (Lloyd-Richardson et al., 2015). Researchers have shown that adults are able to manage difficult emotions and are more accepting of their emotional experiences than adolescents (Lewis et al., 2019). By focusing on the experiences of adults, there is less risk of retriggering trauma and more chance of identifying alternative coping skills for cutting.

Although the prior research regarding NSSI illustrates important findings, I have found no research that examines the relationship between adolescents that cut and their use of alternative coping strategies and self-regulation. Further research is warranted to examine if there are any alternative coping skills or strategies that can be used to decrease the instances of cutting in adolescents. Thus, the results from this study may inform additional ways to lower adolescent cutting instances. The goal of this research is to understand if adolescents were given and/or used alternative coping skills during their time of cutting, what were the skills, and did they decrease their instances of cutting. The application from the findings of this study has the potential to decrease the instances of NSSI which would lower the risk of emergency visits, as well as reduce physical lifelong scars, social stigma, and potentially, suicide (Centers for Disease Control and Prevention, 2019).

The purpose of this generic qualitative study was to explore the positive alternative coping strategies used by young adults instead of cutting in adolescence, what these alternatives were, and how this affected the number of cutting instances. This study examined the experiences of finding alternatives to self-harm (cutting) in individuals aged 18-23 years, who engaged in cutting behavior during their adolescent years and found alternative coping skills to cutting. This resulted in interview data that helped gain perspective on what alternative coping mechanisms the participants had used and the outcome of using the alternative method(s).

Literature Search Strategy

To create an extensive literature review, I conducted an exhaustive search using multiple databases. Terminology included multiple variations of self-harm and cutting along with self-regulation theory and coping. The searches also included varying combinations of the terminology. Databases include but are not limited to the Center for Disease Control and Prevention, EBSCO, Google, and Sage. Search terms for NSSI include: non-suicidal self-injury or NSSI or self-harm or self-injury, cutting or self-harm, cutting or self-cutting. For coping skills and the theory, the search terms include: coping or coping skills, or coping mechanisms and self-regulation theory, or regulation theory. These terms were then combined with additional terms to ensure that all components were addressed. More detailed information on what search terms were used and the combinations of terms can be found in Appendix A.

Theoretical Foundation

History of Self-Regulation Theory

Most research prior to 1996 focused on punishment and behavior modification treatments in children that are not considered ethical by today's standards. It is essential to explore theories that would assist mental health and healthcare workers along with families on alternative, positive coping skills for NSSI in adolescents. Since many NSSI actions are considered to be deliberate, it is essential to find a behavioral theory that is focused on the evaluation of these deliberate actions.

Bandura (1991) explained that the self-regulatory system is a process in which human behavior is a purposeful action that is regulated by forethought. Intentional and purposeful action is rooted in this system. Roy Baumeister then expanded on this and solidified the self-regulation theory. His focus was on an individual having the ability to alter their thoughts and behaviors to achieve a goal (Baumeister & Vohs, 2007). Burnette et al. (2020) acknowledged that people can improve or alter self-regulation through learning new skills and strategies and applying them.

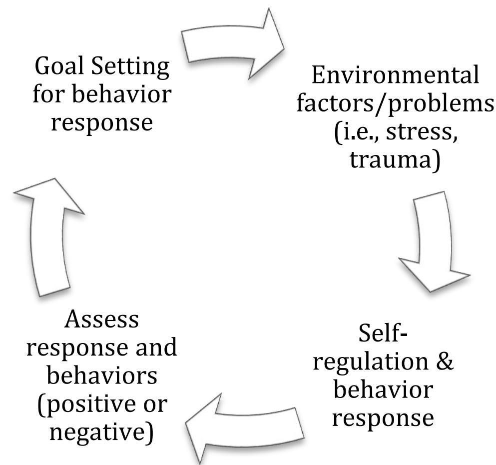
Components of Self-Regulation Theory

Self-regulation is any action or process that an individual does for themself (Fomina et al., 2020). Self-regulation is the process in which a person controls their thoughts, emotions, and actions (self-control). Self-regulation also encompasses the regulation of elemental factors such as stress, mood, emotions, and impulses. This is done

by setting goals and choosing behaviors and strategies accordingly to meet the goals (Cameron & Leventhal, 2003). Figure 1 below illustrates these concepts.

Figure 1

Cycle for self-regulation goals and responses.



For self-regulation theory, this expands into an individual controlling what they think, say, and do. This can apply to both positive and negative behaviors. Short-term desires might not match long-term goals. For example, with NSSI, the short term of cutting and the instant gratification of making the pain on the outside match the inside is not going to be the same as the long-term goals of dealing with the trauma, emotions, or whatever is causing them to self-harm at that moment. Behaviors can then be evaluated and corrected to achieve goals (Ozhiganova, 2018). Researchers have shown that those who develop self-regulation skills during adolescence have a higher level of positive

effects and overall well-being. Whereas poor self-regulation skills increase the likelihood of harmful behavior (Fomina et al., 2020).

Self-Regulation Theory & Adolescents

Self-regulation is a complex process that is developed throughout childhood and adolescence and has an impact on a variety of outcomes from academic success to health and mental well-being outcomes (Howard & Williams, 2018). Howard and Williams (2018) explained that "A particular period of developmental interest is adolescence, in which early self-regulation predicts the likelihood of engaging in harmful lifestyle behaviors as an adolescent (i.e., smoking, school dropout, unplanned pregnancy)" (p.2). NSSI and cutting are considered harmful behavior which has impacts throughout adolescents and into adulthood.

Positive self-regulation also involves self-correction skills that can guide a person in making positive changes to reach longer-term goals (Gestsdottir & Lerner, 2008). While these skills may be learned, individuals must take an active role in the adaption of their behavior or emotional strategies to achieve the desired goals (Dias & Cadime, 2017). Children and adolescents with these higher self-regulation abilities and skills are more likely to resist intrusive thoughts and behaviors related to self-harm (Howard & Williams, 2018).

Self-Regulation Theory & Negative Behaviors

Self-regulation is also part of an individual's self-control. Self-regulation is a positive, conscious effort and impulse control to guide one's behaviors which includes

coping strategies (Gillebaart, 2018). Poor self-regulation can lead to problematic behavior. A study on problematic cell phone use suggested that this was related to poor-self regulation (Coyne et al., 2019). Another study on eating disorders also identified the link between negative behavior and poor or impaired self-regulation (Van Malderen et al., 2019). Lockwood et al. (2016) suggested that interventions focusing on reducing rash reactivity or improving self-regulation skills may offer the largest benefit to those who self-harm.

Lack of self-regulation resources or skills leads to disruptive and deviant behavior outcomes (Wang et al., 2021). Having self-regulation skills and strategies can lessen the negative behaviors used by an individual. Additionally, engagement in behavior may have a temporary desired outcome, but not meet the long-term benefits sought (Black et al., 2017). For example, a negative behavior may improve the situation for a moment, but long term it may not have the desired effect or goal.

Literature Review Related to Key Variables and/or Concepts

Non-Suicidal Self-Injury (NSSI)

NSSI is described as behavior in which a person inflicts physical harm upon themselves without the intent to commit suicide. John Bachman (1972) referred to this phenomenon as self-injurious behavior (SIB). This behavior has since been defined as deliberate self-harm (DSH), parasuicide, self-mutilation, and NSSI (Carroll, 2019). These varying terms all have the same distinct focus on self-injurious behaviors. NSSI has become more of a focus within larger self-injury research and psychology (Cipriano et

al., 2017). However, since the research on NSSI is relatively new, there are gaps in linking concepts together such as NSSI to regulatory theories and coping mechanisms.

Individuals who engage in NSSI do not typically pose a threat to the safety of others, but a threat to themselves. Due to the rise in NSSI and cutting rates in adolescents, it has been seen as a threat to health and safety. NSSI was recently labeled as an international public health concern due to the rate at which it is affecting young adults and adolescents (Emery et al., 2016). The designation of NSSI as a public health concern indicates that there is a need for continued research and treatment for NSSI behaviors.

Westeran et. al (2016) suggested that less than 25% of adolescents who self-harm use healthcare services. Adolescents often try to conceal their self-injurious behavior and, therefore, go undetected within the health care system (Singhal & Bhola, 2017). Researchers have shown that adolescents often believe their self-harm is not a serious problem and do not need nor want help from anyone else to deal with their NSSI (Tillman et al., 2018)

Forms of NSSI

Forms of NSSI include but are not limited to, cutting, scratching, burning, branding, biting, head-banging, hair pulling, and hitting oneself (Roley-Roberts et al., 2017). Lesser-known forms of NSSI also include eating and substance disorders as well as wall and object punching that causes injury (Lloyd-Richardson et al., 2019). Actions that are not generally considered NSSI include nail-biting, body piercing, tattooing, or scab picking although they could be NSSI depending on the intentions behind the

behavior (Lloyd-Richardson et al., 2015). Physical signs that may indicate someone has recently engaged in self-injury may include fresh scars (often in patterns), bites, or wounds. Frequent reports of accidental injuries may also be a sign of self-harm (Mayo Clinic Staff, 2018).

Many researchers have attempted to figure out how to detect and predict self-injury. This is done by identifying factors and reasons why an individual engages in self-harm (Ammerman et al., 2018; Barreto et al., 2017; Fox et al., 2019). NSSI is very complex and contains multiple determinants and variables that are individual to each person and signs and detection can be very challenging. Self-harming behaviors are often thought of as impulsive when in actuality the behavior can be very deliberate and planned actions (Allen, 1995). Cutting is the biggest contributing factor in NSSI health complications, scarring, and lifelong stigma (Todd et al., 2012)

NSSI and Adolescents

Non-suicide self-injury is equally present in both adolescent males and females. Females are more likely to engage in cutting behaviors while males are more likely to hit themselves (Berger et al., 2017). Some subgroups within adolescents see a higher risk of engaging in NSSI. The subgroups include individuals who are living apart from their families or within foster care and have higher self-harm rates compared to their peers (Epstein & Ougrin, 2020).

Adolescents are learning a multitude of skills to assist them throughout their life. One of these skills includes making positive healthy choices. Adolescents are also

developing autonomy during their preteen and teen years which helps them think, act and make decisions (Russell & Bakken, 2002). Adolescents are also learning how to navigate interpersonal relationships and peers play a role in their emotional development. Negative relationships with peers can lead to distress and be associated with a higher rate of engaging in NSSI (Xavier et al., 2016). Wu et al. (2019) highlighted that adolescents with positive peer relationships and acceptance have fewer depressive symptoms and better self-regulation. This in turn assisted with lowering the rates of NSSI. These peer relationships also travel into the online and media communities.

Cutting

Cutting is one of the most used methods of self-injury among multiple populations including those incarcerated and adults with mental health diagnoses (Kokaliari & Berzoff, 2008). Self-cutting is also the most common form of NSSI in adolescents (Hawton et al., 2012). Cutting is an incision made on the skin and deep enough to be accompanied by blood (Jacquin & Picherot, 2016). This can vary from a superficial scratch to a deep cut that needs medical attention. There is no diagnostic test to know when someone has been self-cutting. It is usually discovered by seeing a pattern of scars or fresh injuries by friends, family, or healthcare workers or a confession by the individual (Mayo Clinic Staff, 2018). The skin cuts are often seen in a pattern of parallel lines, perpendicular to the axis of the limb, sometimes many cuts in a grid pattern or word that may be written (Jacquin & Picherot, 2016).

A common myth about cutting in adolescence is that if sharp objects are taken out of the individual's environment, this will lower or stop the cutting instance, but this is not the case (World Health Organization, 2019). When an individual engages in cutting, a multitude of sharp objects may be used including common objects such as blades, razors, and knives. The Self-Injury Institute (2015) stressed that even if you took away these common sharp objects, individuals would turn to anything they can find. This includes but is not limited to pens, paperclips, forks, jewelry, floss, paper, broken glass, and even removing carpet staples. Due to the removal not working, it is imperative that an adolescent be given alternative coping skills so that they do not continue to find other means to cut their skin (Self-Injury Institute, 2015).

When someone is engaged in cutting, they may not limit each act to one cut, but instead, each act can be comprised of multiple cuts (Selby et al., 2019). Gardner et al. (2020) found that premeditated cutting was less likely to be visible and done in an area that can be concealed. Individuals who made deeper cuts tend to self-cut with sharpened objects and would cut in multiple places (Fujioka et al., 2012). Self-cutting can involve deep cuts that require medical attention. Deep cuts can damage nerves and have the potential to cause permeant disabilities (Park et al., 2020). Deep cuts can also injure muscles and damage organs depending on where the cut is located.

Miner et al. (2016) stated that there is a recognized cutting subculture. Within this subculture, adolescents turn toward each other for support and advice. These groups also discuss other concepts like skin modifications. Skin modifications can range from tattoos

and piercing to cosmetic surgeries. For those that cut to self-injure, they are also creating a skin modification. The wound is visible, and they are said to be “giving form” to their emotional pain (Le Breton, 2018).

Factors Related to NSSI

Those who engage in cutting do it for a multitude of reasons and motivations. Although most reasons include mental health difficulties and trauma, other reasons may include reducing or alleviating sadness, anger, and punishing oneself (Kutcher et al., 2020). Traumatic experiences and mental illness can lead to traumatic symptoms, and this leads to self-injury. There can also be more than one factor, trauma, or mental illness in those that engage in self-harm.

Trauma and NSSI

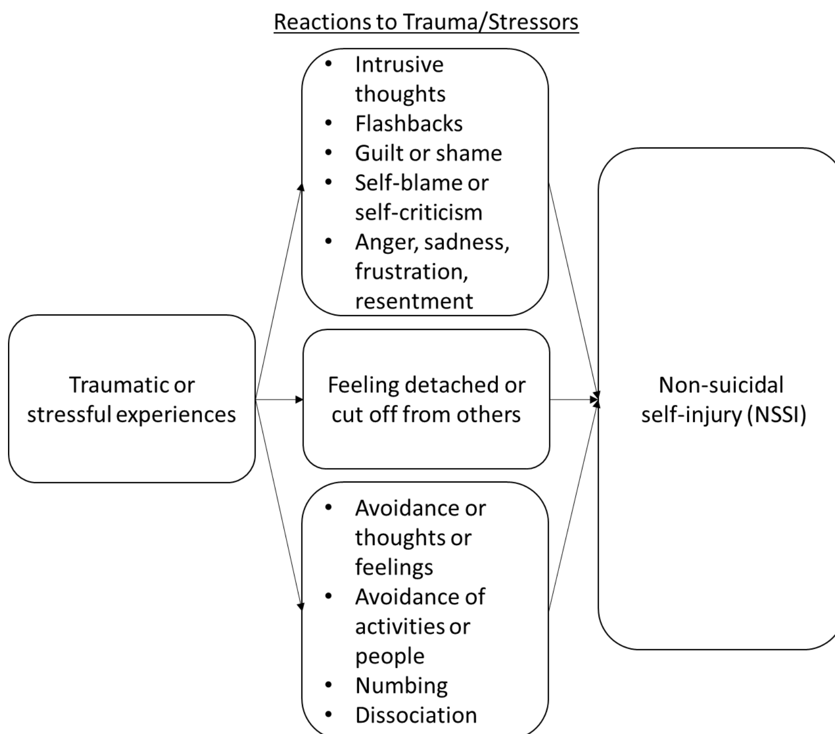
Adolescents that self-harmed commonly have a history of direct and indirect trauma (Carroll, 2019). Direct trauma can include sexual, physical, or emotional abuse, maltreatment, or neglect. Indirect trauma can include violence between parents, parental divorce, parental criminal activity, or the death of an individual close to the adolescent like a family member or friend (Russell et al., 2019). All trauma has a potential risk to lead to an individual engaging in NSSI as seen in Figure 2 adapted from Smith et al. (2013).

Cutting and NSSI rates are higher in individuals that have a history of childhood maltreatment than in the general population (Serafini et al., 2017). Common reasons for NSSI include forgetting their problems, relieving emotional pain with physical pain,

stopping flashbacks, and keeping bad memories away (Evans & Hurrell, 2016). Individuals may also use self-injury to communicate about their trauma or sort out reality (Smith et al, 2013). These lasting marks or scars from the cutting can be a constant reminder of past trauma (Burke et al., 2016).

Figure 2

Relational Model of Traumatic Experiences to NSSI



Note. This model shows how an individual goes from traumatic experiences to self-injury. These actions are then cyclic and can create new traumatic experiences. This shows why it is important to break the self-injury cycle using self-regulation and alternative positive coping skills. Figure adapted from Smith et al. (2013).

There is evidence that suggests that there is a relationship between childhood sexual abuse and self-harm in adolescents (Gratz, 2006; O'Neill et al., 2018). It is estimated that as much as 20% of women and 10% of men worldwide have been sexually abused during their childhood (Mossiage et al., 2014). These survivors of childhood sexual abuse often face dissociation.

Dissociation often comes from traumatic events and is a disruption in normal consciousness, memory, motor control, and behavior. Dissociation often helps an individual survive their traumatic experiences by removing their consciousness from the environment (Polskaya & Melnikova, 2020). Those that have dissociation events have varying experiences. These can range from loss of memory and control of their emotions, thinking, and behaviors. Self-harm can be used to disrupt a dissociation episode by feeling that their body is real and alive (Talmon & Ginzburg, 2018). When they use self-harm to stop their dissociation, those self-harm actions can cease the negative effects of the dissociation and help them escape the traumatic memories.

Mental Health and NSSI

Youth who engage in NSSI are more likely to have at least one diagnosed mental illness (Lewis, et al., 2019). Multiple researchers have found that individuals who engage in NSSI are at a higher risk of mental health difficulties (Duggan et al., 2015; Lewis et al., 2019; Richmond-Rakerd et al., 2019). Mental health issues include depression, anxiety, substance use, and post-traumatic stress disorder (PTSD) (Chapman et al., 2006). Many individuals that cut also believe there is a link with depression (Brown et al.,

2018). While researchers have shown a link between mental health challenges and NSSI, a majority of those that engage in NSSI do not seek any mental health treatment (Wester & McKibben, 2016)

It is notable that the type of care provided to adolescents who self-harmed influenced their outlook on self-harm actions and recovery (Lewis et al., 2019; Taylor et al., 2009). For adolescents that sought out outpatient treatment or support groups, they recalled that they often felt positive about aftercare programs and activities. However, adolescents that were admitted to in-patient care reported poor communication, withholding of pain medication for wound treatments, and lack of mental health treatment or therapy (Williams et al., 2018). This shows that those admitted felt that in-patient care was punishment and resented being admitted.

Media Influence and NSSI

On the social network Instagram, of the photos that were tagged with the hashtag #depression, 27% of them also with the #cutting (Brown et al., 2018). Self-injury rates have continued to rise, and the presence of NSSI in the media has also increased (Polskaya & Yakubovskaya, 2019). Puringot and Whitlock (2010) highlighted that the internet allows people to communicate and exchange experiences with NSSI, but it also could inadvertently suggest that NSSI is an effective coping strategy. In reality, this would be maladaptive and only effective in helping with short-term relief and not long-term.

Before the 1980s, NSSI in the media was not commonly found (Purington & Witlock, 2010). NSSI is now more prevalent in media, and adolescents are the biggest consumers of media (Bareiss, 2021). Access to the internet, social media, and television have all increased the ease with which people can get information.

Researchers have indicated that many adolescents that engage in NSSI go online and connect with others who also have engaged in NSSI (Purington & Whitlock, 2010; Scherr et al., 2019). While this can be a form of support, it also carries the risk of reinforcement and triggers (Lewis et al., 2012). Messages discouraging NSSI are often absent from social media like Facebook, Twitter, YouTube, and Instagram – all of which have a high adolescent presence (Scherr et al., 2019).

The use of social media can also shift social norms relating to NSSI. For example, a Google search of self-injury in 2010 yielded over 2,100 results of videos on YouTube (Purington & Whitlock, 2010). There are now over 7 million videos listed as well as having a national suicide hotline plus a 24/7 crisis hotline at the top of the page. This shows a concerning rise in the social media content for NSSI. Instagram has also acknowledged that it might be dangerous to be exposed to hashtags like *#cutting* which depicts pictures of cutting self-injuries (Scherr et al., 2019).

Negative Long-Term Implication of NSSI

NSSI and cutting are not just short-term problems. It has lasting effects that can be devastating and impact life even after the individual is no longer cutting (Christoffersen et al., 2015). These include permeant deep scars, shame, stigma, mental

health difficulties, relationship hardships, long-term treatments, and a higher risk of suicide (Morales et al., 2018).

The impact of NSSI with cutting can vary with each individual. NSSI cessation is not a finite state and clinicians may still consider an individual at risk for repeat self-injury (Kelada et al., 2018). Though there is a risk for relapse, there are also other impacts including physical scarring, stigma including shame and social isolation, and suicide risk. It is important to understand the impacts since there are avoidable outcomes from cutting and NSSI.

Halpin and Duffy (2020) found that NSSI rates are lower with increasing age, stable interpersonal relationships, and mental health treatment. However, those that did not receive any treatment or have stability in interpersonal relationships continued to engage in NSSI into adulthood. Self-harm prevalence typically peaks in adolescents, but research has shown that as much as 5.5% of people continue to engage in NSSI as an adult (Daukantaite et al., 2020). The longer a person engages in NSSI increases their risk of increased stigma, scaring, and suicide. There are multiple considerations when looking at impact, mental health challenges, and NSSI.

Harm to Relationships

Those who engage in NSSI not only harm themselves, but also cause family, friends, or anyone close to them distress (Greene et al., 2020). Those close to the individual often find out by noticing cuts or scars. Adolescents can be scared to talk to parents, caregivers, or medical professionals and go to lengths to hide or cover the marks.

When parents and caregivers learn of an adolescent's NSSI behaviors, many have feelings of distress, anxiety, guilt, and helplessness (Bareiss, 2021). Fu et al. (2020) stated "Compared with other parents, the parents of teenagers with NSSI have higher levels of stress and lower levels of satisfaction" (p. 2).

Physical Scars

NSSI can lead to permanent scarring of the skin. Scars play a role in an individual's sense of self and identity (Lewis & Mehrabkhani, 2016). Scars are permanent and can be located on any part of the body that has been injured. Individuals who self-harm most commonly injure their arms, legs, wrists, and stomachs (Cipriano et al., 2017). Most of these places may not be visible depending on the clothing worn. Others have inflicted injury on their face, eyes, neck (jugular), breast, or genitals though rare (Whitlock, 2010)

With many adolescents choosing not to seek treatment for NSSI, this leaves the injuries unattended which then leads the individual to deal with scars after they have formed. There are no standard treatment guidelines for self-injury wounds or scars, and, in many cases, the patterns of the scars make them socially recognizable (Takaya et al., 2020). Scars are raised, bumpy, and discolored. Scars can become tight, itchy, and painful. Scar treatment includes topical treatments, injections, dermabrasion or chemical peels, laser therapy, and surgery (Hultman, 2020). These treatments can help flatten, smooth, and even lessen the appearance of scars, but scars often do not go away fully even with treatment.

While some individuals embrace their scars and accept them, other individuals who have permanent scarring feel shame and insecurity about it (Lewis et al., 2019). Chandler (2017) stated, “people who self-harm often go through great lengths to hide the damage” (p. 321). This is so that they are not judged for their scars. The presence of scarring may also contribute to relapse and factor in how people perceive their recovery (Lewis et al., 2019).

Stigma, Shame, and Social Isolation (Mental Scars)

Stigma is a negative perception that one has about themselves that they think that others believe about them (citations). Adolescents who engage in NSSI are “at risk for experiencing stigma as a result of their self-harming behaviors” (Mitten et al., 2015, p. 1). Individuals do not report to their family, friends, or medical professionals when they self-injury due to fear of stigma, shame, and embarrassment (Morales et al., 2018). They often go above and beyond to hide their self-harming behaviors and marks.

The stigma and shame are often caused by others being overly critical without being understanding of the situation. Shame is a feeling of distress or humiliation which can be painful and debilitating (Kammerer, 2019). Individuals who engage in NSSI report feeling shameful about their bodies and report higher self-objectification. Research has supported the relationship between shame and NSSI severity and frequency (Duggan et al., 2015).

NSSI is often done in private settings and in secret which can lead to further social isolation (Duffy, 2009). The shame and guilt of self-harming may also lead those

who self-harm to isolate themselves and diminish social relationships (Burke et al., 2017). Scarring can create social anxiety with other people's perceptions of the scars may be. This leads individuals to try to conceal their scars in some situations (Mitchell et al., 2019). Other ways individuals conceal scar visibility without medical treatment to lessen stigma include covering the scars with clothing, makeup, or even permeant tattoos (Stacy et al., 2017).

Intentional or Unintentional Suicide

Suicide is the second leading cause of death among individuals 10-24 years old (Epstein & Ougrin, 2020). Monto et al. (2018) showed a progression of risk behavior from sadness or bullying to NSSI. The continued progression to suicidal thoughts, plans, or attempted suicide is not as common but still occurs.

Those who engage in suicidal ideation and suicide often also have poor coping strategies and avoidance of stressors. This follows the same pattern as those that engage in NSSI (Ong & Thompson, 2019). Multiple researchers have illustrated that those who engage in NSSI are at an increased risk of suicide (Epstein & Ougrin, 2020; Hawton et al., 2012; Stanford et al., 2017). In the United Kingdom, a history of self-harm is the single largest indicator of suicide risk (Department of Health, 2017). In many cases, self-harm comes shortly before someone attempts or commits suicide (Department of Health, 2017). The intentional suicide risk is seven times greater for those who have a history of engaging in NSSI (Emery et al., 2016). Individuals who go to the emergency department for NSSI wounds are identified as high risk by the National Strategy for Suicide

Prevention in the United States because of this elevated risk (Cutler et al., 2015). Carvalho et al. (2017) noted that increased repetitive self-harm behaviors can also lead to unintentional suicide.

Self-injurious behavior such as cutting may be done without suicidal intent, but the severity of the injury could lead to unintentional death (Singhal & Bhola, 2017). In adolescents that reported having suicidal ideation, 40% reported that they had previously engaged or currently are engaging in NSSI (Voss et. al, 2020). Nearly half of the adolescents that died due to suicide studied had a history of some type of self-injury activity (Morgan et al., 2017).

Interruption of NSSI Cycle

D'Arcy (2015) stated that you cannot force someone who self-injures to stop. This is where harm mitigation may need to occur. In this approach, the goal is to reduce rather than eliminate self-harm. Individuals who self-harm can continue to do so in a safer manner, whilst learning and developing other coping strategies and addressing the reasoning for the self-harm (Sullivan, 2018). Though, there is still a risk that an individual's self-harm may become more extreme and severe should this not work so this intervention is controversial.

If the self-injury is severe enough to seek medical treatment, many go to their primary doctor or their local emergency room. Most of those that seek medical treatment are under the age of 18 years (Richmond-Rakerd et al., 2019). Once the wounds have healed and NSSI behavior has ceased, the treatment to lessen scars involves an

expensive, lengthy, and limited process that may include surgical options (Todd et al., 2012). Newer clinical trials have shown progress in using laser treatment to lessen the appearance of scars (Guertler et al., 2018). With either option, the scars are not erased but lessened and there are risks with the procedures.

Treatments for NSSI

Treatment for NSSI often includes mental health treatment/counseling and medical treatment. Some of the mental health treatments include cognitive-behavioral therapy (CBT), person-centered therapy, and solution-focused therapy (Wester et al., 2016). There is a specific CBT for trauma-focused treatment (TF-CBT). This treatment includes providing coping skills and strategies to assist youth with experience in trauma-related problems (Cohen et al., 2012) CBT has been shown to reduce the risk of suicide attempts, but has shown weaker results for lowering NSSI and while this has shown some reduction, this is not often used for NSSI without suicidal attempts or other underlying mental health illnesses (Lyengar et al., 2018).

Another treatment used by some mental health professionals is dialectical behavior therapy (DBT). Working within this framework, they can assist clients in decreasing their NSSI urges and behaviors by changing or setting aside their maladaptive behaviors. Although, they acknowledge that NSSI habits are hard to break and some can find engaging in NSSI comforting (Swerdlow et al., 2020). Those who participated in a 20-week DBT during adolescence reported improved emotional regulation and having more adaptive coping skills to use posttreatment (Yeo et al., 2020). While these therapies

show promise, many who self-harm hide it from others, and only a fraction of those that engage in NSSI reach out for help or engage in therapy (Bareiss, 2021).

There are no specific pharmacological treatments for the reduction of self-harm (Iyengar et al., 2018). However, many people are offered pharmacological treatment for co-occurring symptoms that can lead to self-harm These include antidepressants, antipsychotics, anxiolytics, and mood stabilizers. Some even use natural products to include Omega-3 fatty acids, vitamins, and aromatherapy oils. A growing number of trials are using a combination of both pharmacological treatment and therapy (Witt et al., 2020). The downside is both therapy and medication (natural or prescription) can take four weeks or longer to see results and they do not specifically address self-harm nor be evaluated for their efficacy to lower self-harm (Lyengar et al., 2018).

As recent as 2012, up to 95% of health professionals and teachers reported that they felt that they could use more training on addressing NSSI behaviors (Mitten et al., 2016). Health care providers commented that they thought the foundation for treatment should be focused on learning positive coping skills and teaching alternative problem-solving (Lovell & Clifford, 2016). Ougrin et al. (2015) expressed that “little knowledge exists about the precise mechanism of action for therapeutic interventions in the treatment of adolescent self-harm” (p. 105). Despite the high number of adolescents who self-harm, only some schools have a policy in place to assist students who engage in NSSI (Stargell et al., 2017).

Coping Strategies

Coping responses and strategies have an impact on how an individual handles the impact of trauma or stress (Horwitz et al., 2018). Positive coping strategies include positive problem-solving, support seeking, and cognitive restructuring. While negative includes distraction and avoidance (Yang, 2021). Heffer and Willoughby (2017) stated that a good coping response is "successful coping involves an ability to adjust and change coping strategies in a way that facilitates positive outcomes" (p. 2). Self-harm can be a type of distraction or avoidance coping response. Avoidance coping strategies are consistently associated with self-harming behaviors (Horwitz et al., 2018). Using self-regulation and positive coping skills, they have the potential to lessen the rates of NSSI among adolescents.

Adolescents and Coping Strategies

The adolescent years are a time when individuals establish behaviors and are impressionable to positive and negative social factors (Gwon & Jeong, 2018). Their brains are not only impressionable but also vulnerable as they are developing. Adolescent years include a developmental shift from dependency to self-sufficiency. When these changes are combined with other stress it makes it imperative that adolescents have and use effective coping strategies and skills (Chapman & Mullis, 1999). Coping responses in adolescents affect their well-being and psychopathology. Effective coping with stress is important to positive growth and development. Maladaptive coping styles are more likely to be problematic long-term (McNicol & Thorsteinsson, 2017). Coping strategies (both

positive and negative) can include both cognitive and behavioral efforts (Ong & Thompson, 2019).

Negative Coping Strategies

The most common reason that individuals self-harm is to self-regulate intense emotional distress and self-punishment (Lloyd-Richardson et al., 2019). Self-harm is a highly maladaptive regulation strategy used to decrease negative emotions (Mikolajczak et al., 2009). Individual reasoning for self-harm includes making emotional pain into physical pain and to block bad memories (Edmondson et al., 2016). While self-harm temporarily reduces distress, the cost of this response is physical injury, long-term psychological impairment, and physical welfare (Mikolajczak et al., 2009). When an individual becomes distressed but lacks healthy or positive coping strategies, the distress can manifest in deliberate self-injury (Tresno et al., 2013). Wu and Liu (2019) found that more frequent internet use and marijuana usage in adolescents also were associated with NSSI. On the other hand, they found that rational coping styles were beneficial for preventing NSSI.

Individuals often try one other coping strategy other than NSSI, but it is often other maladaptive or negative coping behaviors (Wester & McKibben, 2016). Other non-productive coping skills include self-blame, keeping to self, and ignoring the problem (Hall & Place, 2010). Those who did use active and adaptive coping behaviors like talking to someone reported it had helped cut back on the behavior (Wester & McKibben,

2016). Working with an individual to identify alternative strategies and behaviors could lead to positive goals and the replacement of self-harm (Edmondson et al., 2016).

When maladaptive coping skills are being used, interventions that promote the healthy use of coping strategies and reduce unhealthy coping may be needed. One challenge is that more research is needed that targets coping interventions to reduce NSSI (Garcia, 2010). Another challenge is that adolescents are first introduced to coping strategies by what their parents and caregivers modeled for them. These coping strategies can vary greatly from one individual to another (Vescio, 2016).

Positive Coping Strategies

While there may not be a lot of information on coping skills and specifically self-harm, researchers have focused on effective coping strategies among adolescents with depression (Heffer & Willoughby, 2017), anxiety (Pereira et al., 2017), and substance abuse (Schwinn et al., 2016). With positive coping strategies, individuals were able to lower their depression and anxiety rates and cut back their substance use. This research will use this same model of thought, that positive coping skills and self-regulation may also be able to lower the instances of self-harm.

Positive Coping Strategies and Depression

Positive psychology is an umbrella term that refers to promoting physical and phycological wellbeing and is being used to assist with problems such as depression and anxiety (Muris et al., 2018). Adolescents with depressive symptoms benefited from an intervention that focused on coping skills, and the benefits continued during the year

follow-up as well (Puskar et al., 2003). Having multiple positive coping strategies increases coping flexibility and is associated with better adjustment to include lower suicide ideation, higher self-esteem, and lower rates of depression. (Heffer & Willoughby, 2017). For example, there are correlations between positive coping strategies such as support seeking, reassuring thoughts, and active tackling that lowered depression and anxiety. While maladaptive coping styles were negatively correlated (Muris et al., 2018).

Positive Coping Strategies and Anxiety

Anxiety disorders in childhood have serious negative consequences that can extend into adulthood (Pereira et al., 2018). While CBT treatment can be effective, the success rate can be as low as 46%. Exploring other options, enhancing positive coping strategies, and eliminating maladaptive coping styles assisted with lowering anxiety levels (Pereira et al., 2018). In one study, the children were taught other positive coping strategies including relaxation and effective problem-solving. This helped children feel that they can bring down their anxiety levels (Pereira et al., 2018). After being taught coping strategies, with practice, the adolescents' anxiety also lessened over time (Bradley, 2001).

Positive Coping Strategies and Substance Abuse

The use of alcohol, marijuana, and harder drugs has been attributed to having maladaptive coping strategies (Lee-Winn et al., 2018). Large quantity alcohol consumption motives can be contributed to avoidance coping motives. Intervention

efforts that focus on targeting coping motives have been promising (Blumenthal et al., 2019). Avoidance and limited problem solving are also associated with adolescent marijuana use (Lee-Winn et al., 2018). Avoidance coping strategies (i.e., risky behaviors, self-harm, substance abuse) are ineffective long-term and it. Healthy and positive coping has the potential to prevent or lower adolescent marijuana use (Lee-Winn, 2018). Lee-Winn et al. (2018) also recommend exploring healthy coping as a universal strategy for the prevention of risky behaviors. Another study also revealed that effective and positive coping skills were associated with less drinking and less substance use or substance abuse (Schwinn et al., 2016).

Summary and Conclusions

After reviewing the literature on non-suicidal self-injury, self-regulation, and coping responses, multiple trends emerged. The first trend was that most NSSI research was focused on reasons and rationale that led to self-harm. The second trend was that coping skills are often focused on much broader concepts of self-harm or emotional regulation instead of specific actions like cutting. The last trend was that self-regulation was not a predominant psychological theory utilized when trying to understand the activities within NSSI. These trends highlighted two gaps: (a) a lack of positive coping strategies for NSSI, specifically in cutting; and (b) self-regulation is overlooked as a theory for addressing positive, alternative coping skills for NSSI and cutting.

The first notable gap was that most research on NSSI did not address positive coping strategies. While there are positive coping strategies, they are not mainly focused

on the physical harm of NSSI. They were used in other areas such as depression, anxiety, and substance abuse. Thus, it is important to understand and evaluate what alternative physical coping skills were available to those who engaged in cutting previously as adolescents. This will bridge the gaps in what alternative coping skills can be emphasized in the future with others to reduce the incidence of cutting for NSSI.

The second gap was that self-regulation was not specific to NSSI in the past. Often, self-injury was focused on other theories. As noted in the literature review, most research before 1996 focused on a self-preservation instinct for research subjects. Since children were moved to a vulnerable population category by NIH, NSSI research has mainly focused on the trauma and stressors that led adolescents to engage in self-harm. It is important to bridge the gap from reasons that led to self-harm to how to regulate these actions going forward with positive, physical, alternative coping skills.

Chapter 3: Research Method

Introduction

The purpose of this generic qualitative study was to explore the positive alternative coping strategies used by young adults instead of cutting in adolescence, what these alternatives were, and how this affected the number of cutting instances. This study examined the experiences of self-harm in individuals aged 18-23 years, who identify as individuals that cut during their adolescent years and used alternative coping skills to cutting. In this chapter, I will explain the research design, methodology, the role of the researcher, and trustworthiness.

Research Design and Rationale

For this study, I used the generic qualitative research design to address the following research questions:

RQ 1: What strategies did young adults (age 18-23) use as alternatives to cutting when they were adolescents?

RQ 2: How do they believe that these alternative strategies assisted them with controlling their cutting behaviors?

Generic qualitative research studies are common in psychology and social sciences (Percy et al., 2015). Looking at a research problem within a generic qualitative research design allows for creating a greater understanding of participants' experiences. Using this approach allowed the participants to give reflections on their experiences (Marshall & Rossman, 2011). I focused on the experiences of participants and their

reflections on coping strategies and cutting to find patterns and themes associated with an individual's coping strategies.

Percy et al. (2015) noted that approaches such as ethnography, case studies, and grounded theory are often not suitable for psychological studies. Researchers who use ethnography typically focus on culture, social customs, and society. Case studies are investigations of cases and not groups of people. Researchers use the grounded theory approach to develop or explain a theory (Percy et al., 2015). Due to the nature of this study and its focus on the experiences of multiple people, these other approaches are not suitable for this study.

Role of the Researcher

Within the role of the researcher, there is a responsibility to conduct research honestly and ethically (Banks, 2018). In this study, I held the role of the observer. I interviewed the participants using a semi-structured interview over the Zoom videoconferencing platform. Zoom allowed the interviews to be recorded. Using Zoom videoconferencing during research has shown to be a good tool for the collection of qualitative data due to its ease of use, cost-effectiveness, and security options (Archibald et al., 2019). With the information collected, I then coded the results for themes and emerging patterns.

The recollected experiences of the participants were critical to understanding how to address the research problem of NSSI by identifying positive coping strategies that were utilized by the participants. Also, as Moustakas (1994) highlighted, intersubjectivity

is critical to the research process and foundational to codifying lived experiences for qualitative research.

I did not know the participants or have a personal or professional relationship with any of them. Due to the sensitive subject matter, it is important to exclude any participant with which I could have a present or future relationship (Banks, 2018). All participants were volunteers, and I am not providing any types of incentives for participation. I had no supervisory rules that could impact participants during this process.

Qualitative research involves reflection on the researcher. Researchers cannot be completely separated from their biases in qualitative studies (Creswell & Creswell, 2018). Therefore, bias and subjectivity must be articulated in a manner that is clear for the readers (Sutton & Austin, 2015). I took notes during the interview to record my impressions and assist with recollection and reflection. These were analyzed later to determine if any bias exists by identifying thoughts, feelings, or impressions which might lead to bias if unchecked (Chenail, 2011).

Methodology

Participant Selection Logic

The population consisted of young adults aged 18 to 23 years old who engaged in cutting behaviors during their adolescence (12 to 17 years old) and who have found positive coping strategies for their cutting. Due to the trauma, a person's memory can be distorted and the more time that goes by, the more the memories can fade (Strange &

Takarangi, 2015) so I wanted to recruit young adults just out of adolescence or no more than 5 years out of adolescence. Purposive sampling of adults was used to recruit participants who meet the inclusion criteria and can participate in the interview process with a lower chance of retriggering trauma or anxiety. This was done by telephone screen to let them know the risks involved along with making sure they meet the requirements for this study (Draucker et al., 2009).

Instrumentation

The interviews were semi-structured for this study to promote guided information gathering that still allows for exploration of lived experiences. This allowed for open-ended questions (see Appendix B) using an interview protocol. The questions were based on the research question and other research studies that had similar aspects of cutting and/or coping (Halpin & Duffy, 2020; Muris et al., 2018; Yang, 2021). The questions focused on NSSI and cutting, alternative coping strategies, and the effectiveness of the alternatives used. The start of the questionnaire included introductory questions that are used to break the ice and verification demographics for criteria. Due to the sensitive nature of NSSI and the possibility of retriggering trauma, it was imperative to build up trust and rapport by starting with positive, easy questions for breaking the ice.

For the demographic interview questions, the primary focus was to provide information on age and gender. This was due to most research regarding cutting and NSSI showed notable differences mainly in age and gender (Park et al., 2020; Carroll, 2019). The third interview question was formulated to provide past experiences in cutting

to further gain context on the type of cutting, the extent of cutting, and how it impacted the participant's life since these are critical for understanding motivation (Gardner et al., 2020; Halpin & Duffy, 2020). Questions four and five focused on the coping strategies used (Jaffe, 2020; Wu & Liu, 2019). The remaining questions focused on the relationship between coping strategies and cutting impact since this had the majority of gaps within the research. These questions explored the linkage between coping strategies and cutting instances.

These questions were developed through a review of the literature and finalized using an expert review. I used the expert review to look over and ensure that the interview questions are aligned with the study. The reviews also ensured that any potential problems are identified before the research (Olsen, 2010).

RQ 1: What strategies did young adults (age 18-23 years) use as alternatives to cutting when they were adolescents?

RQ 2: How do they believe that these alternative strategies assisted them with controlling their cutting behaviors?

See Appendix B for interview questions used in the interview.

Procedures for Recruitment, Participation, and Data Collection

Recruitment

I focused on the recruitment of participants through established professional and personal networks. These referrals were individuals that did not have a close personal tie to the researcher to prevent a potential conflict of interest between the participant and

researcher. I also recruited over social media. I used Facebook and Instagram to post a recruitment flyer. This allowed users to maintain anonymity by using recruitment posts with a link to a participation survey (Gelinas et al., 2017). The survey included requirements and information on how to reach me. Potential participants were able to include an email or a phone number where I could reach them (Appendix E). Individuals were then contacted by email or phone with general information on the research study, their role as a participant, any compensation (if applicable), and the possible risks. Once they agree to continue, an interview time was arranged.

Participation

The interviews took place over the Zoom videoconferencing platform. Zoom allowed the interviews to be recorded. Participants were allowed to leave their camera on or have it off. This was at the choice of the participant and their comfort level. These interviews were conducted from my office without anyone else present. However, I could only determine relative confidentiality for interviews due to not knowing if there may be someone that can overhear the participant from their location. The interview consisted of an introduction of the researcher, ensuring the participant understands the interview is being recorded, breaking the ice and demographic questions, and then six open-ended research questions. The interviews lasted approximately one hour in length. This time varied depending on the experiences of each participant and any follow-up questions that were needed to have an in-depth understanding

Due to the sensitive nature of the questions, debriefing after the interview was essential. Each participant was debriefed at the end of the interview due to stirring up emotions or retriggering that might have occurred during the interview. I provided a list within the informed consent document of local and national resources in case the participant experiences distress, anxiety, or retriggered trauma after the interview (Appendix C). I explained each resource and allowed the participant to ask questions.

Data Collection

Data Collection was completed by the researcher and included the requirement survey (Appendix E), the interview questions (Appendix B), and an observation sheet. Having a printed copy of the survey and interview questions ensure that the same questions and protocol are followed for each participant. The observation sheet was blank at the start of every interview and used to document any non-verbal behaviors that were observed. The interview was recorded on the Zoom platform.

Data Analysis Plan

Once all data was collected from the interviews, I used a transcription service to transcribe the interviews. The service I used is Otter. They allowed recordings to be uploaded straight from Zoom to be transcribed. Before analysis of the interview, I provided all participants with a copy for a member check if requested. I emailed them the information, and the participant had up to two weeks after being provided the information to let the researcher know if there were any concerns. I then utilized Otter's qualitative software for keyword codification. I then conducted codification and identification of

themes from the data based on the clustering concept from the modified van Kaam method (Moustakas, 1994).

Qualitative analysis requires attention to detail. During codification, I read the transcriptions and the observations. While using the coding software, I made notes of possible reflections and potential significance (Ravitch & Carl, 2016). Using the reflection, notes, and phrases that were noted during codification, concepts, themes, and patterns emerged (Rubin & Rubin, 2012). These themes and patterns were used in the final analysis.

Issues of Trustworthiness

The foundation for qualitative research adheres to standards and criteria of trustworthiness including credibility, transferability, dependability, and confirmability (Ravitch & Carl, 2016). Being able to trust the information within a study and the findings is a crucial part of research (Birt et al., 2016). By following multiple standards outlined below, it ensured the results and conclusions are trustworthy and valid.

Credibility

Triangulating is the process of using multiple credible sources and data collection tools in which the researcher can draw conclusions (Cope, 2014). Multiple sources and databases were used in this research. For credibility, the vast majority of articles used in the literature review came from peer-reviewed journals. All other sources used come from credible organizations or government entities. Data collection used interviews and

journaling notes to gain a comprehensive view of the interviewee's experiences (Cope, 2014).

To assist in trustworthiness and credibility, the first and second committee chair vetted the research and information submitted within this study. They also received copies of any transcribed interviews when requested (Morrow, 2005) Another part of credibility was to ensure that the researcher is aware of the potential for bias. It was essential to remain neutral with this sensitive subject during the interviews, data collection, and coding (Sutton & Austin, 2015).

To ensure credibility, member checks of the interview transcripts should occur. Member checking is a concept of allowing participants to ensure the accurate interpretation of their lived experiences (Birt et al., 2016). Each participant was provided a copy of the transcript as well as any interviewer notes to ensure the validity of the interview if requested. Any feedback from the participant was noted in the collection of data as well as utilized with the codification of data.

Saturation is also an essential element of credible qualitative research. This is known as the point in which observing more data will not lead to any significant discovery of information in relation to the research question (Lowe et al., 2018). Using purposive sampling ensures that the interviewees meet the specific requirements of the study. Since this study uses this sampling technique, the codification of themes becomes more laborious and repetitive with higher sample sizes (van Rijnsoever, 2017). I can safely assume that 8-12 participants should achieve saturation.

Transferability

Transferability is how a study's finding can be valuable to others within similar constructs, situations, research, or practices (Marshall & Rossman, 2011). Cope (2005) explained that individuals not involved in the study can associate the results with their experiences as well. Since this study focuses on NSSI cutting, the results of this study may be transferrable within the NSSI cutting construct. However, this research may not be transferrable to other types of coping strategies due to the limited focus of this study.

Dependability

Dependability can be achieved with another researcher being able to agree with the research process and findings (Cope, 2014). The study may also be able to be replicated in similar conditions and following the process outlined. This study also used appropriate data collection methods and consistency throughout. By utilizing saturation of participants with semi-structured interviews, multiple perspectives are considered for the dependability of this study (van Rijnsoever, 2017). Lastly, an audit trail was conducted to ensure validity by validating that all the information is accurately transcribed, codified, and documented (Carcary, 2020).

Confirmability

Confirmability is acknowledging our biases using researcher reflexivity and external audits (Ravitch & Carl, 2016). Having confirmability means that there is a level of confidence that this research is without bias. This research study could be audited and confirmed by others in the field and other researchers. One method of doing this is to

utilize reflexivity. This is when the researcher has a contextual relationship with the participant (Dodgson, 2019). To achieve reflexivity, I provided a rationale for decisions I made during the research process along with backing it with literature and documentation to show that this study is not swayed due to biases.

Ethical Procedures

The researcher has completed human subjects training as noted in Appendix F. The informed consent will be written using a template from Walden University (2021) to ensure its easily understood by potential interviewees. The potential participants were emailed a copy of the informed consent (Appendix C) to review before they schedule an interview time (approximately one week prior). Due to the potential for secondary trauma or triggering acute psychological states, resources will be included within the informed consent. They were also allowed to ask any questions before giving consent and scheduling the interview and again before the start of the interview. The researcher kept a signed copy of the informed consent and did not conduct the interview without the signed copy on file.

At the beginning of the interview, I let the participant know that I am starting recording and then read the informed consent while asking them if they continue to consent to participation so that I have a verbally recorded consent. No participants changed their consent during this time, so steps put in place for non-consenting participants were not utilized during interviews.

While there were protocols in place if there was triggering of an acute psychological state during the interview, the researcher did not need to stop the interview due to triggering. If it were necessary, the researcher would have used mindfulness techniques of being aware, empathetic, and understanding while keeping the tone and body language neutral to show nonjudgmental awareness (Lemon, 2017). The researcher would have also given a referral to local resources that offer acute crisis services. If the interview were unfinished, the researcher would have confirmed with the participant if the partial interview should be considered for the study. However, none of these steps were necessary during the interviews.

Data for this research study included Zoom recordings, field notes, transcripts, and analysis of information collected. This data is kept on physical storage devices (i.e., hard drives, handwritten notes) under the supervision of the researcher (Walden Center for Research Quality, n.d.). When not in use, items are electronically locked needing a password, or located in a physical lockbox at the researcher's home. Also, pseudonyms were used for participants preventing any names to be in transcripts or data analysis. Once the research was completed, data will be stored for 5 years using the safeguards above for any auditing purposes. Once this time has elapsed, data will be destroyed using physical shredding devices or electronic programs designed to sanitize data sources. These safeguards will ensure the protection of the sensitive data of participants.

Summary

This chapter shows the design and considerations for this research study. By utilizing a qualitative, phenomenological method with semi-structured interviews, I gathered information from the lived experiences of participants to address gaps between NSSI and positive, alternative coping strategies. With the strategies in place, I ensured the proper sampling of the population and trustworthiness by utilizing credibility, transferability, dependability, and confirmability. This chapter provides the framework for data collection and analysis essential for Chapter 4.

Chapter 4: Results

Introduction

The purpose of this general qualitative study was to understand the connection between positive coping skills and those who cut during their adolescent years. This was done through interviews with individuals between the ages of 18-23 years who had previously cut during their adolescent years. The participants provided information about their cutting experiences and their alternative coping. The research questions were as follows:

RQ 1: What strategies did young adults (age 18-23 years) use as alternatives to cutting when they were adolescents?

RQ 2: How do they believe that these alternative strategies assisted them with controlling their cutting behaviors?

In this chapter, I present the findings in relation to these research questions. I also present all the information, coding, and themes from the interviews that were conducted. This chapter includes the interview setting, types of data collection, data analysis, and trustworthiness. Findings and future research will then be discussed further in Chapter 5.

Setting

After obtaining IRB approval (approval number 10-21-21-0985383 and expires on October 20, 2022), I posted my recruitment post on social media and those people also sent it to people they thought might be interested leading to a snowball effect. The recruitment post included a link to fill out a small survey to see if they met the

requirements and were interested in participating. Once people submitted this online, they were contacted by email and sent the welcome letter and the informed consent and asked when a good time for them would be to meet over Zoom for an interview. Of the 16 interested parties, only half (8) went on to participate in the interviews.

For the interviews, the participants that met the requirements were sent a Zoom link. During the Zoom call, the researcher was on video, but participants were not required to be on camera if they were not comfortable. To ensure privacy and protection, I let them know that this was recorded, but their information was kept confidential. I could only ensure relative confidentiality as I could not ensure no one could hear from their location. Once they agreed to the consent and recording, the recording and interview were started. The interviews approximately lasted 20-40 minutes.

Demographics

For this study, I selected and interviewed eight people between the ages of 18 and 23 years. The participants had self-reported that they engaged in self-harm in the form of cutting during their adolescent years. All the participants were English speaking. The only demographic information collected included their current age, age during cutting, and gender. Of the eight participants, six participants identified as women while two identified as nonbinary. Of the nonbinary, one was born male, and one was born female. Table 1 provides a summary of these demographics.

Table 1

Participant Identifiers and Demographics

Participant Identifier	Age	Ages During Cutting	Gender
P4	23	13-17	Female
P6	22	15-20	Female
P7	19	13-18	Female
P9	18	14-17	Non-Binary
P10	19	11-17	Non-Binary
P12	20	13-19	Female
P15	23	12-15	Female
P16	23	10-19	Female

Data Collection

Recruitment and interviews occurred over 15 weeks. The initial plan was to recruit and interview for only eight weeks. However, many of the interested parties that agreed to the interview did not show up to the Zoom videoconference at the agreed-upon time. I attempted to contact them to determine if they were still interested but received no reply. These challenges led to posting the recruitment post multiple times and over a longer period. There was a total of 16 people that filled out the interest form, met the criteria, and conducted the initial screening that agreed to participate, but in the end, only eight individuals participated in the research interviews, thus meeting the minimum number of participants for this study.

Each participant was asked if they were able to read through the consent form and agreed to continue. After they agreed, I let them know that this interview was being recorded for my purposes, but that their information would be kept confidential. Once they agreed, the recording was started. These were recorded on my PC desktop and kept in a secure folder with password protection. The interviews ranged from 15-35 minutes in length and followed the semistructured interview structure.

The participants started by answering the demographic questions of age, gender and what ages did they engage in cutting. They were then asked the other interview questions (Appendix B). On research question number three, describe their instances of cutting and the impacts that it had on you, most interviewees needed clarification on what I meant by impacts. I followed up by clarifying if their cutting had affected or impacted other parts of their life.

During the interview, I asked some follow-up questions to ensure I understood what their answer meant or to know more details. For example, I asked participant P15 what they meant by using a rubber band as an alternative. At the end of the interview, I asked the participants if they would like a copy of the transcription for member checks. During the interviews, I took notes in addition to the recording. The recordings were then transcribed and added to the notes for coding and analysis. This was done after each interview on an ongoing basis to ensure saturation was met and more recruiting would not be required. Once the transcription was done, it would then be sent to participants that request it when asked. The transcription was sent to two participants that requested it and

they did not reply within the two weeks allotted for member checks. The transcription was also kept in a secure folder on my PC and the name was changed to match the interviewee's identification number as shown in Table 1.

Data Analysis

Data analysis and coding were done with both the Otter program and also hand-coding. This was done in different cycles as recommended by Saldana (2016). The first pulling out keywords, then putting these into categories and subcategories followed by looking at emerging themes and concepts. I read each transcript and looked over it to make sure all the transcription came through correctly and printed it. I then attached my notes to the printed copies so I could look through both together. The Otter program pulled out a summary of keywords and included those at the top of the transcripts. As I looked over all the transcripts, I used different colored highlighters and wrote notes on the papers. This provided good visualization of what I was going through with each set of transcripts and notes.

The participants could list as many coping skills as they wanted. Some listed many, while some only listed one or two. Some of the keywords or phrases that appeared on multiple transcripts include cutting, permanent scars or scarring, negative outcomes, not seeking help, therapist, and coping. The keywords that appeared were then categorized. These categories were impacts, self-regulation, and coping.

The impacts for participants were largely the same with a few varying words including embarrassment, external scarring, judgment, questions by others, and constant

reminders. In the self-regulation category, participants discussed that they learned on their own, figuring out their alternatives, help from others (this included peers, parents, and therapists), just stopping, and getting away from the situation. Coping skills were much different for every person. There were a few that had overlapped alternative coping skills but overall, it was very individualized. The overlapping ones were coloring/drawing/art and music. All others were unique to the interviewee. This included using glue, rubber band snapping, long drives, marking the body with pens/markers, swinging, taking walks, skateboarding and meditation. After organizing them into categories, and then taking them into smaller groupings, themes started to emerge as seen in Figures 3, 5, and 6.

Evidence of Trustworthiness

Credibility

During the interview, I was able to remain neutral and not show bias with my words or body language. I was able to remain subjective and ask factual questions as follow-ups when needed. The transcripts were transcribed throughout the 13 weeks of interviews. This ensured that when the information received started repeating, we were reaching saturation. To assist with credibility, each interviewee was offered a copy of their transcript. Two participants requested their transcript, and it was promptly sent to them after it was transcribed. I asked the participants to provide any feedback or correction that may be needed. They were given a two-week window to reply, but neither participant choose to reply.

Transferability

The results from this study could not transfer to the general population as not everyone has NSSI cutting construct during adolescent years. However, this study may transfer to others outside the age range followed in this study. While the recollection is more detailed the closer to the event, they are still talking about something that happened in the past and that would not change as they age (Strange & Takarangi, 2015).

Dependability

This research was documented and carried out exactly as planned and described. There was a consistency in the data gathering, analysis, and interpretation that demonstrates dependability. An audit trail was conducted to ensure validity by validating all the information was accurately transcribed by Otter. To do this, I compared the recordings to the transcripts and fixed any errors I found to reflect the recordings. I also coded not only with the Otter program but also by hand to ensure that nothing was missed, and the results of the coding were closely matched as suggested by Saldana (2016).

Confirmability

Throughout the research, the documentation and data were checked multiple times. The semi-structured interview questions were asked exactly as stated within the interview guide. There were notes kept with each interview which were checked against the transcripts to ensure all information was accurate. I will provide a rationale for all decisions I made while picking out themes and stating the findings.

Results

I conducted interviews with eight participants to answer the following research questions: what strategies did young adults (age 18-23 years) use as alternatives to cutting when they were adolescents and how do they believe that these alternative strategies assisted them with controlling their cutting behaviors. During the interviews, some questions required a follow-up for clarification. This includes clarification of what I meant by the statement “instances of cutting” and for me clarifying back to them to be sure I understood their coping skill examples. Once the interviews were completed, I was able to transcribe and code them. After coding the interviews, then grouping them, themes started to emerge.

Emerging Themes

Three main themes emerged from the coding of interview data, transcripts, and notes. These themes were self-discovery of skills, individualized coping skills, and recommending outside help. Within the self-discovery of skills, there was a subtheme that emerged and that was wishing for external help sooner (before or early in self-harm) and not just self-discovery or learning skills well after cutting had been going on or even subsided.

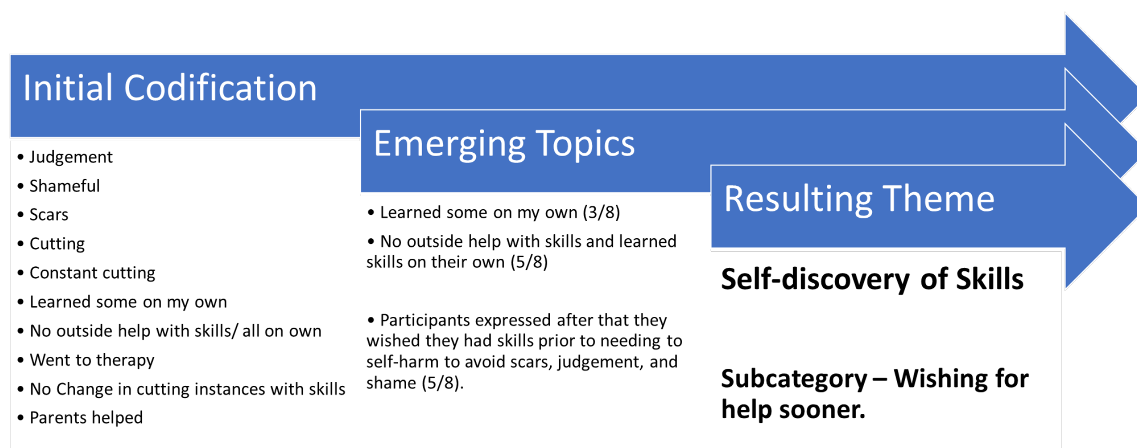
Self-Discovery of Skills

Each participant outlined what their coping skills were. While some had negative skills or behaviors (e.g., drugs, drinking, driving recklessly, and other forms of self-harm), they all had positive coping skills that they also used. These positive skills were

very individualized for each person and there were multiple skills listed by each participant.

Figure 3

Keyword Grouping for Self-discovery of Skills



Seven of the eight participants stated that they learned skills only on their own, P7 also stated their parents helped and P4 stated a therapist helped with additional skills too. When asked how they learned their alternative coping strategies, P16 responded “I didn’t have other coping skills until a therapist gave me some alternatives and this was after many years of cutting already” and P15 stated “Other children my age who knew I was cutting suggested doing something other than cutting but I had to find out what worked for me on my own.” The participants all noted that they wished that they had learned skills earlier to mitigate some of the risky and self-harming behavior that has lasting impacts. P12 clarified that her scars are a constant reminder and are embarrassing. She wished that she didn’t have them and that she had the skills to not reach for drugs or engage in self-harm.

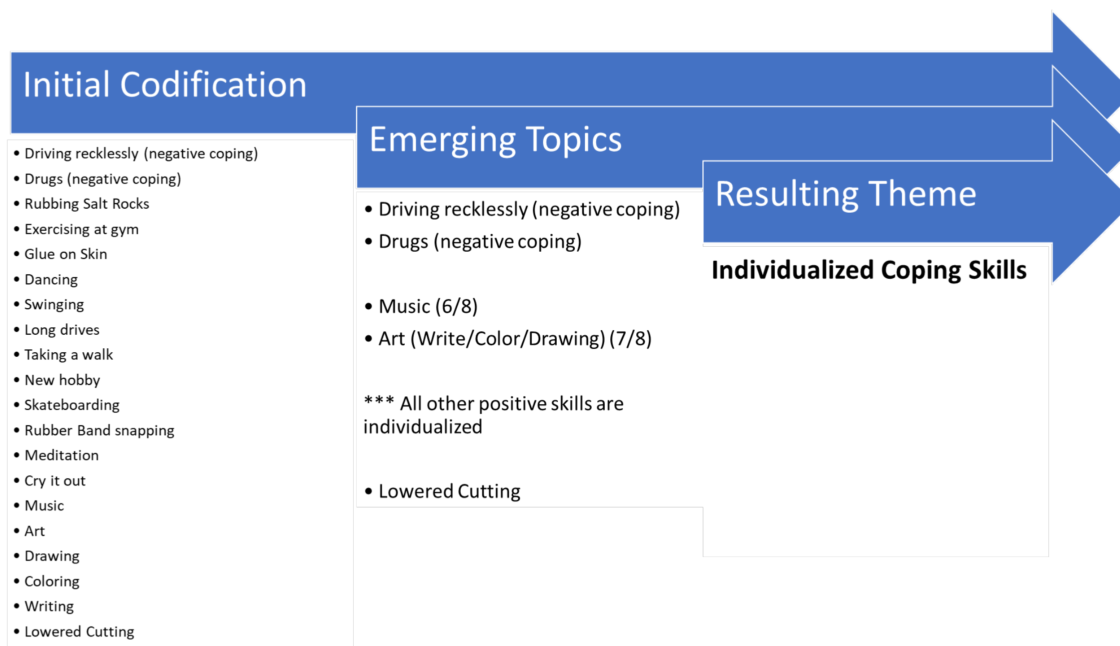
When asked how their learned coping skills impacted their cutting, they all agreed that it did lessen the amount of cutting they did. P9 and P4 explained that not only did their cutting lessen over time, but they were also eventually able to stop completely after gaining more positive coping skills. However, many did not learn any positive skills until they already had cut for a longer period and were used to using that to cope. This was evident by many stating they had scars, faced judgment, shame, and other lasting effects. P16 participant shared that "by the time I learned better coping skills, I was already covered in scars, what did it matter then?" She went on to describe her scars from head to toe and that there was no way to cover all of them up. Therefore, no one specific skill completely stopped their cutting, but a variety of skills that they learned over time along with self-regulation, lowering stress, attending therapy, and time is what eventually led them to lessen their cutting until they could completely stop altogether.

Individualized Coping Skills

Each participant had different coping skills or strategies. Five participants mentioned some type of art (writing, coloring, drawing), and two more mentioned that they use that type of coping skill today, but not at the time. Three participants mentioned music and three more mentioned they use music as a coping skill today, but not at the time.

Figure 4

Keyword Grouping for Individualized Coping Skills

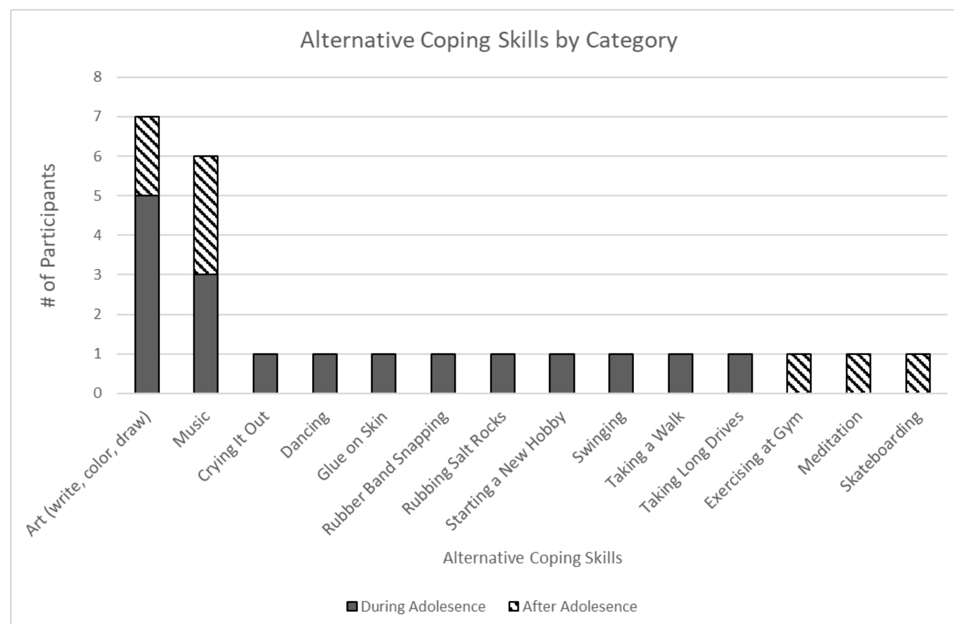


During the interview, P6 expressed that they liked to "drive around and listen to loud music" and they still do this when they need to "clear their head". All the other skills or coping strategies that they listed were very individualized to that participant. Each participant had at least one skill that no other person had listed. These skills shown in Figure 5 include glue on the skin, rubbing salt rocks, taking long drives, rubber band snapping, crying it out, swinging (on a swing), dancing, taking a walk, and starting a new hobby. P7 explained that they put on headphones with loud music both while swinging and while alone in their room and stated "This helped me focus on something other than the bad feelings. I was able to lose myself in the music and the swinging helped keep my body moving."

Every participant listed out multiple skills and there were no less than three positive skills each. P4 stated that she wanted to be a tattoo artist when she grew up. So she learned to draw out her tattoo ideas both on paper and on herself. This drawing then helped her when she was feeling upset and wanted to cut. This skill was very individualized to them due to the fact they wanted to be a tattoo artist and were able to see their ideas come out and use that as a positive coping skill. There were some skills named that they use currently and would recommend to others. They had not used these skills during their adolescents, but afterward to help keep their self-harm away. This included art, music, exercising at the gym, meditation, and skateboarding.

Figure 5

Alternative Coping Strategies by Participant and Phase of Life



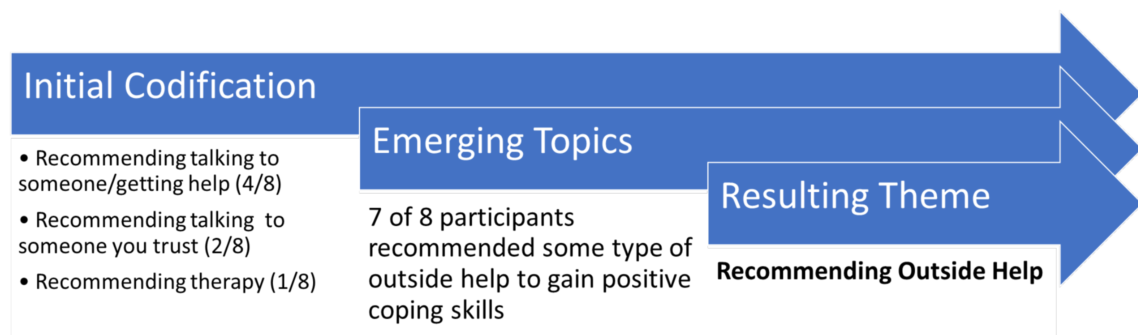
As the skills were coded and grouped, two negative coping skills emerged with multiple participants who mentioned using drugs (e.g., marijuana, alcohol, LSD, meth) and/or reckless driving. While this study was looking for positive coping skills and their impact on cutting behaviors, these were still notable as they were done at the same time as the cutting behaviors. We do not know if these had an impact on cutting as this was not discussed in these interviews.

Recommending Outside Help

The last question was what alternative coping strategies would you recommend to others that are currently cutting? While some participants mentioned specific skills, seven of eight went on to state that those currently cutting should seek outside help. The outside help suggested did vary a bit from a trusted friend, parent, or therapist.

Figure 6

Keyword Grouping for Recommending Outside Help



P16 stated that the only thing that helped them was many years of therapy, but it came too late. They would suggest seeking therapy earlier even if you don't want or think

you need therapy. Many went on to suggest different coping strategies, support systems, or therapies that work for them today.

Additionally, P12 stated "I would recommend talking to someone you trust, and that can be anyone. Let them know you are cutting, and they may be able to help or at least be there for you as a support" P7 also made a point to mention that getting help could be for what was triggering the cutting (e.g., stress, trauma) or the cutting itself (to replace it with a positive skill). P6 stated, "The best advice I have for others is to get help for the reason behind the cutting" P10 explained that although they had a therapist, they did not let them know they had cut. Instead, they suggested talking to friends you are comfortable with. As they explained, they were not taught other positive skills or that cutting did not mean something was not wrong with them. P6 stated that they did not want to be judged and has never told anyone of their cutting. P6 went on further explain that she has kept it private to this day due to shame but wishes others had talked to her about cutting, coping with feelings and emotions, self-regulation skills to how to deal with trauma in other positive ways. of the participants also stated that they had relapsed before finding what worked for them and at the time of cutting did not know how to tell anyone.

Research Questions

Utilization of the emerging themes bridged the gap from the literature review and assisted with answering the research questions. For RQ1, all three themes assisted with answering this question. While the research question was looking for specific strategies

that young adults (18-23 years) used as an alternative during cutting, the answer was not straightforward. The three themes helped provide a comprehensive review of the lived phenomenon that could provide context for the research question.

Within the self-discovery of skills theme, it shows that other negative behaviors were co-existing that were also forms of self-harm along with cutting. To illustrate some of these negative behaviors, 5 of the 8 participants expressed that they wish they had skills prior to self-harm to avoid scars, judgment, and shame. Scars are permeant and can be a source of stigma and trauma themselves (Mitchell et al., 2019). If adolescents had the positive coping skills before self-discovery, then there would be less scarring if they were used in place of self-harm. The problem that arose in this study, though, is the participant's skills were individualized to their backgrounds and experiences.

Instead of finding a skill or strategy that may work across the board, it was specific and individualized to the person. This is the second emerging theme from the study. There were two categories of skills that multiple people used. These were different forms of art and listening to music. All other skills discovered during the research were used by a single participant as seen in Figure 5.

The third theme was the recommendation for outside help. Seven of the eight interviewees mentioned that they would recommend outside help to gain positive coping skills. This shows that there were not enough coping skills learned on their own or had knowledge of prior to cutting to assist with lessoning the cutting. The research illustrated that the answer is complex for the research question, so parents, caregivers, and medical

professionals must understand the unique and individualized coping skills needed for adolescents. While some suggestions can be basic like music or art, the rest need to be tailored to the person. Each person needs to learn alternative coping skills that would assist them with self-regulation and positive decision-making, but they are not given a way to learn these skills.

Research Question 2 focused on the perception of the alternative strategies helping them. The participants were able to give examples that showed the few skills they did have were used instead of cutting in those instances. However, it was not until they gained more skills through other means along with aging into adulthood and/or getting out of their situation allowed all the participants to self-regulate and no longer cut themselves. P15 expressed that when they used the skills they had, the skills were “a place holder which led to less cutting but did not eliminate it right away”. P4 expressed that while they were eventually able to stop completely, they did relapse after stopping more than once even into adulthood and that “I would have benefitted with more coping skills when I was young to be able to stop sooner”. So, there was confirmation that the skills helped the participants with cutting behaviors, but the path to this realization was different for every participant.

Self-Regulation Theory

An element of self-regulation theory focuses on effective decision-making. As Modecki et al. (2017) stated, “Emotional regulation, coping and decision-making fall within the general concept of regulation of action” (pg 4). If an adolescent has not

acquired positive coping skills, they would likely not be able to self-regulate their actions. As P12 explained, they felt that they may not have turned to cutting if they had been given other positive skills to use. Without being given coping skills to help an adolescent deal with their emotions, trauma, or other triggers, adolescents will not have the tools for self-regulation and instead turn to maladaptive coping such as cutting.

Summary

The purpose of this generic qualitative study was to understand the alternative coping skills used by adolescents and how these strategies assisted them with controlling their cutting behaviors. Eight participants took part in this study. The three main themes that emerged from the responses to the interview questions were the discovery of new skills, individual coping skills, and recommending outside help. The research questions and self-regulation theory were then incorporated with the emerging themes to come up with the findings and answers to the questions. In Chapter 5, I summarized the findings, discuss limitations, and make recommendations for future research.

Chapter 5: Findings

Introduction

Non-suicidal self-injury often starts during the adolescent years. CDC (2019) found that there was a sharp rise in emergency room visits for self-harm in adolescents over the last decade with the number continually increasing. Cutting is the most used type of self-harm (Cutler et al., 2015). Self-harm behaviors are typically a negative coping response associated with stress, negative family dynamics, trauma, and abuse. (Morales et al., 2018). A review of the professional literature shows a gap in understanding alternative coping strategies and how they impact cutting behavior. Therefore, the purpose of this general qualitative study was to examine if young adults who cut during adolescents used alternative coping strategies and how this impacted their cutting behaviors. I conducted eight interviews and then started the process of data analysis. When coding the data, three prominent themes were identified, and the interpretation of these findings is listed within this chapter.

Interpretations of Findings

I interviewed eight participants between the ages of 18 and 23 years who shared their experience with cutting, alternative coping, and impacts during their adolescent years. Their responses to the questions gave an in-depth account of how often they participated in self-harm, alternative skills used, how they acquired these skills, and impacts after using the skills. Three themes emerged from these interviews. These themes include self-discovery of skills, individualized coping skills, and recommending outside

help. Below will be my interpretation of the finding as a result of the three emerging themes along with the theory and research question.

Interpretation of Themes

Theme 1 - Self-Discovery of Skills

The first theme was the self-discovery of coping strategies or skills. During the interviews, participants were asked how they discovered or learned about alternative coping strategies for cutting. Of the eight participants, seven expressed that they learned some or all skills on their own with P7 saying they also had help from their parents and P4 saying they were given some alternatives from a therapist. Many went on to express that they learned too late and had already been cutting for a while and had lasting scars. P16 indicated that they were covered “head to toe” with scars while P6 indicated they had a large amount of scarring on their body.

While each participant eventually learned positive alternative skills, the majority had no outside help in finding these skills. Some expressed that they also used other negative skills such as drugs, drinking, driving recklessly, and other forms of self-harm along with cutting. This is where the subtheme emerged that they expressed that help would have been useful before they engaged in cutting or at the beginning of their cutting. P12 stated that they “would have benefitted from other positive skills before turning to cutting”. These participants were no longer using the negative skills at the time of the interview, and many expressed that they continued to use the positive skills. When asked how the positive coping strategies impacted their cutting, seven participants stated

that it had lowered it in some compacity, P10 explained “they were not sure, but they think it may do a little” and P16 answered that “Nothing would have lowered it as their cutting was constant for years. I had other negative behaviors such as hard drugs at the time too” They went on to discuss that it was into adulthood before behaviors lessoned and positive coping skills started working to lower the risky behaviors and cutting instances.

The literature on the correlation between positive coping skills and cutting is scarce (Hall & Place, 2010; Le Breton, 2018; Mikolajczak et al., 2009). Part of the gap in this research lies in the fact that if they are not being given the skills before they turn to self-harm and cutting. The participants expressed that they had to learn many skills on their own. In trying to find the correlation between coping skills and their instances of cutting, they would in fact need to have the skills during their time of cutting during their adolescent years as was the focus of this study. However, when the participants gained the skills, it did lower their cutting or altogether stop it later on.

When taking into account that they did eventually stop cutting before participation in this study, the data collected from this research also is consistent with other comparable studies. Research has also shown that cutting instances typically lessen as individuals grow into adulthood, and this study follows that pattern. Though that pattern may also be attributed to the fact that gaining coping skills does lower the instances of self-harm and risky behaviors. Lee-Winn et al. (2018) observed a link between healthy and positive coping skills having the potential to lower or prevent risky

behaviors. Another study revealed that positive coping skills lowered the instances of drinking and substance use (Schwinn et al., 2016).

Theme 2 – Individualized Coping Skills

The second theme is individualized coping skills. During the interviews with the participants when asked what alternative skills or strategies they used, I was presented with skills specific to that individual as seen in Figure 4. While different types of art and music were common, all the others were individualized, and no subtheme emerged. This demonstrates that any help given to an adolescent that is currently cutting would need to be tailored to that individual depending on their needs and interests. Though, some may be able to be recommended such as art and music as a starting point. P7 echoed this finding stating, “they would recommend that adolescents who are currently cutting should find something they love to do and to keep doing it.”

Individualized coping skills may come from different factors. This includes the fact that the participants gained most of their skills on their own or after they began cutting. Self-harm is a maladaptive or negative coping skill and many forms of self-harm are individualized to the person (Lloyd-Richardson et al., 2019; Roley-Roberts et al., 2017). If the form of self-harm is individualized as a negative skill, then we can conclude that it follows the same pattern as what was found in this study for positive coping skills.

Theme 3 – Recommending Outside Help

The third theme is recommending outside help. During the interviews, the participants were asked “what alternative coping strategies would you recommend to

others that are currently cutting?". When they answered this question, seven of the eight suggested that they would recommend outside help. This outside help ranged from seeking a therapist, talking to parents, talking to peers, and talking to someone you trust. For example, P7 responded with, "I would recommend talking to someone you trust. When you talk to someone it helps and they may be able to suggest other coping strategies." Though they recommend it, six out of eight did not seek help during their adolescence until it reached "a point of no return". Another went on to say they wish they had more help but were afraid to talk to anyone for fear of getting in trouble or being judged.

Adolescents often go to lengths to hide or cover their marks and they do not disclose their cutting to parents, caregivers, or medical professionals (Bareiss, 2021). This poses a challenge in getting them the help they need when they do not come forward with the fact that they have been self-harming. Often, it is someone who notices the marks or scars before it is brought to attention (Greene et al., 2020). This poses the difficult question of how we get them the help they need or want when those around them do not know they need it and they do not disclose it. Without the help, they will likely continue till they can acquire the skills on their own or gain emotional regulation with aging and maturity(Lewis et al., 2019). P4 explained that they had relapses till they were able to receive help and gain more coping skills through self-discovery and eventually therapy.

Preventive and early intervention of self-harm poses a lot of challenges. Prevention and self-regulation can lead to a lower chance of negative long-term implications such as permeant deep scars, shame, negative social stigmas, mental health difficulties, relationship hardships, and a higher risk of suicide (Morales et al., 2018). Bailey et al. (2019) conducted research in a clinic setting to explore how to improve self-harm outcomes in teens. They concluded that preventative conversations about self-harm between medical providers and teens were largely absent. They went on to explain that preventative literature was deemed helpful, but that material on self-harm geared towards teens is hard to find. This is just one of the many challenges to talk to adolescents about prevention. Since adolescents are less likely to seek help from professionals but express that they needed the help, it is imperative that we give them skills to self-regulate earlier in childhood. This in turn can help to avoid the self-harm spike during adolescent years. Future research would need to be done on the best ways to talk to adolescents about self-harm before they engaged in self-harm and letting them know the recommendation of talking to a trusted individual. The other challenge is if the trusted individual is knowledgeable or able to help.

Self-Regulation Theory

Self-regulation is achieved through structured tools, goal setting, and interpersonal rewards(Veijalainen et al., 2019). When it comes to using alternatives to cutting, an individual needs to choose to use a positive coping skill instead of self-harming. The problem is that if an adolescent is not given or acquiring the skills needed

in a timely matter (i.e. before turning to self-harm), then they cannot be expected to self-regulate without harming. The participants in this study explained that when they did use alternative coping, it did cut down on their cutting. However, due to not having the skills, they were not able to do so until these skills were acquired by self-discovery or given to them from other sources such as therapists, friends, and family.

Concepts not Fully Explored

During the study, while certain themes emerged some concepts were unable to be fully explored. For example, when asking them to describe their instances of cutting, many could not do so or did not want to divulge this information. Many left short answers like "I cut a lot" or "my cutting was constant". The second part of that question was about their impacts. These answers were also short and included lasting scars, being judged, and feeling embarrassed. While P16 went on to explain more about her scarring, many chose to not divulge these details. In the interview, when the participants were asked these questions, the participants often looked away or took a moment before answering. This topic of NSSI is still very much stigmatized and is difficult for people to openly discuss. Due to the participants stating they did not have the alternative skills before cutting and had to self-discover skills, it is hard to know the full impact it would have had on controlling their behaviors should they have had it earlier on

Limitations of the Study

A limitation of this study is the transferability. This is due to the specific nature of this study requiring though who previously self-harmed in the form of cutting. While you

may be able to transfer these results to other forms of NSSI or other age groups of self-cutting individuals, this would not be transferable to the general population. A second limitation is that there is a potential for inaccurate statements from participants. With the potential of a trauma background, participants may be prone to memory distortion (Strange & Takarangi, 2015). These memories can change over time, to get the best chance of accuracy, this is why I selected the age range close to their adolescent years.

The other limitation was the recruitment and retention of potential participants. Finding participants was hard due to the topic and specific age range. Self-harm is something that is not readily discussed as there is a stigma and shame attached to the topic (Morales et al., 2018). The age range limited my pool of participants but was needed to recall details as accurately as possible. While many individuals stated that they were interested in participating, they did not follow through with the interview. One expressed that they would like to help and said I could ask them questions over text but when I explained it would be done in an interview over zoom and recorded, they quit responding though they seemed eager to help before that point.

Recommendations

My study is only the beginning when it comes to coping skills, self-regulation, and self-harm. This study specifically focuses on cutting but there are many other forms of self-harm (Roley-Roberts et al., 2017). Different kinds of drug use and reckless driving were two forms of self-harming behavior that came up during this research. Future research is needed on the larger self-harm scale to see if there is a pattern across all types

of NSSI in which positive coping skills may lower the instances versus just cutting. Also, it would be beneficial to research more in-depth coping skills. This would be a good way to see what works and what does not work with the potential to use focus groups with those who are currently cutting and see if there is something that may be less individualized to help lower the instances of cutting. My suggestion would be to start with art and music as those were used by multiple participants in the study.

My study did not include demographics such as sexuality or the reason behind cutting (i.e., trauma). These can also be explored more in future research to see if there is a difference across the reasons for NSSI along with if it changes due to different demographics or specific trauma. Using positive alternative coping skills for self-regulation, we can further explore how to lower the instances of self-harm over multiple demographics(Ong & Thompson, 2019).

Implications for Social Change

As seen in the results of this study, many thought that help was important but they did not reach out for help themselves. They discovered positive coping skills on their own, often too late to avoid scaring, stigma and shame. The topic of self-harm is still not talked about in a general population environment (Bailey et al., 2019). The number of adolescents that engage in NSSI is continuing to increase on a global level (Scherr et al., 2019). With this research, the recommendation is that adolescents should be given positive coping skills to be able to self-regulate and lower self-harm instances. These

skills should be given as ways to deal with stress, trauma, abuse, mental health concerns, and emotional regulation they may face throughout adolescents (Morales et al., 2018).

The goal would be to educate others about alternative positive coping skills and offer ways in which people can help those who need it by offering alternative positive coping skills that are individualized to the person. This could in turn lessen the impacts of NSSI and has the potential to lower suicide rates as well. This study has the potential to open a dialog not only with those actively engaging in NSSI but also with the parents, social workers, peers, caretakers, teachers, and medical professionals who may not otherwise know how to help.

Conclusion

NSSI rates in adolescents are continually rising with cutting being the most common (Scherr et al., 2019). Based on CDC (2019), the number of adolescents treated for NSSI in emergency rooms grew at a rate of 47%. Those who attempt suicide are more than likely to have previously engaged in NSSI (Stanford et al., 2017). NSSI is a negative or maladaptive coping skill. This research found that when adolescents acquired positive coping skills, they were able to self-regulate and lessen their instances of cutting

Adolescents often had to learn these skills on their own. This was often after they already had lasting scars which led to stigma, judgment, and regret. If we create an open dialog with those in our communities, we can make the topic less stigmatized and bring awareness to what is needed to help people who engage in NSSI. Those around the adolescents can help them discover positive alternative skills that may help them self-

regulate sooner and avoid some of their scars and attached stigma. The participants expressed wanting to be able to talk to someone while they were engaging in NSSI but did not do so. To help it is best to not wait until they are already cutting but offer help earlier in childhood. This shows that we need to bring about a change where we can educate our communities on NSSI and how to help those that may need it. With the topic being discussed more openly, this can result in lowering the stigma, creating access to more help, and giving those people positive coping skills so they may self-regulate and lower the instances of NSSI.

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Appendix A: Literature Review Tables

Table 2

List of Databases Used for Literature Review

Host System	Database
Centers for Disease Control and Prevention	CDC Stacks Data & Statistics
EBSCO	Academic Search Complete Business Source Complete CINAHL & MEDLINE Combined Search Education Source ProQuest ProQuest Health Psychiatry Online PsycInfo ScienceDirect SocINDEX Taylor and Francis Online Thoreau UNICEF
Google	Google Public Data Directory Google Scholar (linked to Walden University library)
National Organization for Human Services	Journal of Human Services
SAGE	Journal of Social Work (Walden University library request)

Table 3

List of Search Terms Used for Literature Review

Primary Search Criteria	AND Secondary Search Criteria (1-2 criteria used)
Non-suicidal self-injury OR NSSI OR Self-harm OR Self-injury	Adolescent or teen Behavioral health Coping Coping skills or Strategies Cutting Employment Forms of NSSI or Forms of self-injury History or Historical Lived experience or phenological Media Mental Health Regulation Theory or Self-regulation Theory Scarring Social isolation Statistics Stigma Suicide Therapy Trauma Treatment Young adult
Cutting OR Self-harm, cutting OR Self-cutting	Adolescent or teen Behavioral health Coping Coping skills or Strategies Employment Lived experience or phenological Mental Health Regulation Theory or Self-regulation Theory Scarring Social isolation Statistics Stigma Therapy Trauma Treatment

	Young adult
Coping OR Coping skills OR Coping mechanisms	Adolescent or teen Alternative Coping skills Behavioral health Intervention Lived experience or phenological Mental Health Negative Positive Regulation Theory or Self-regulation Theory Statistics Therapy Trauma Treatment Young adult
Self-regulation Theory OR Regulation Theory	Albert Bandura Behavior History Impulse control Mental Health Model Pioneer Related theory Roy Baumeister

Appendix B: Interview Questions

Research Questions

RQ 1: What strategies did young adults (age 18-23 years) use as alternatives to cutting when they were adolescents?

RQ 2: How do they believe that these alternative strategies assisted them with controlling their cutting behaviors?

Interview Questions

1. What is your current age and gender? (Demographics)
2. At what age(s) did you engage in cutting? (Demographics)
3. Describe your instances of cutting and the impacts that it has had on you? (RQ 1, RQ 2)
4. How did you discover or learn about alternative coping strategies for cutting? (RQ 1)
5. What types of alternative coping strategies did you use? (RQ 1)
6. How did your alternative coping strategies impact your cutting? (RQ 2)
7. Which alternative coping strategies would you recommend to others that are currently cutting?

Appendix C: Informed Consent Form

You are invited to take part in a research study about the connection between positive coping skills and cutting during adolescence. The researcher is inviting individuals ages 18-23 who have engaged in cutting behavior during adolescence and are no longer engaging in cutting activities to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Nicoletta Weide, who is a Doctoral student in the Human and Social Services program at Walden University.

Background Information:

The purpose of this generic qualitative study is to explore if young adults used positive alternative coping strategies to cutting in adolescence, what these alternatives were, and how this affected the number of cutting instances.

Procedures:

This study involves the following steps:

- Taking part in a confidential, audio-recorded interview that takes place over Zoom. This interview will last 30-60 minutes.
- Opportunity to review interview recordings.

- Speak with the researcher one more time after the interview to hear interpretations and share any feedback. This takes 20-30 minutes and can be done over the phone.

Here are some sample questions:

- At what age(s) did you engage in cutting?
- Were you ever introduced to alternative positive coping strategies to use instead of cutting?

Voluntary Nature of the Study:

Research should only be done with those who freely volunteer. Everyone involved will respect your decision to join or not. You will be treated the same whether you join the study or not. If you decide to join the study now, you can still change your mind later. You may stop at any time. The researcher seeks 8-12 volunteers for this study.

Risks and Benefits of Being in the Study:

Being in this study could involve some risk of the minor discomforts that can be encountered in daily life, such as revealing things that are personal and possibly traumatic in nature. With the protections in place, this study would pose minimal risk to your wellbeing. Below is the contact information of local mental health resources due to the sensitive nature of the topic.

Colorado Crisis Services – 1-844-493-8255 or text “TALK” to 38255

Aurora Mental Health – 303-617-2300 for appointments or Walk-in Crisis Clinic 7 days a week from 8 am-11 pm at 2206 Victor Street, Aurora CO 80045.

National Crisis Text Hotline – Text HOME to 741741 for 24/7 Crisis counseling.

This study offers no direct benefits to individual volunteers. The aim of this study is to benefit society by exploring alternative positive coping skills in relation to adolescent cutting.

Payment:

As a thank you for participating in the interview, the participant will receive a thank you gift. This gift will be in the form of a $10 gift card to their choice of Amazon or Starbucks. The gift card will be emailed to the participant after the interviews have been conducted.

Privacy:

The researcher is required to protect your privacy. Your identity will be kept confidential within the limits of the law. The researcher will not ask for your name at any time and will not share any contact information with others. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the

study reports. If the researcher were to share this dataset with another researcher in the future, the researcher is required to remove all names and identifying details before sharing; this would not involve another round of obtaining informed consent. Data will be kept secure by password protection with a two-step identifier. The researcher will use codes in place of any names or identifying information. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You can ask questions by contacting the researcher at Nicoletta.Weide@waldenu.edu or calling (720) 663-8441. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at 612-312-1210. Walden University's approval number for this study is 10-21-21-0985383 and expires on October 20, 2022

You might wish to retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.

Obtaining Your Consent

If you feel you understand the study and wish to volunteer, please indicate your consent by ____.

Printed Name of Participant	
Date of Consent	
Participant’s Signature	
Researcher’s Signature	

Appendix D: Invitation to Participate

Dear Invitee,

My name is Nicoletta Weide. I am a doctoral student at Walden University's Human and Social Services Program. I am kindly requesting your participation in a doctoral research study that I am conducting titled: The Connection Between Positive Coping Skills and Cutting for Young Adults in Adolescence. The intention is to examine the connection between cutting behaviors and coping skills.

The study involves completing basic demographic information and a semi-structured interview online using Zoom. This interview will last approximately 30-60 minutes.

Participation is completely voluntary, and you may withdraw from the study at any time. Your information will be confidential. The study is completely anonymous; therefore, it does not require you to provide your name or any other identifying information. While this study may be published in a database, the actual interview transcripts will be kept private and not released and kept confidential.

If you would like to participate in the study, please read the Informed Consent letter below. Your participation in the research will be of great importance. Thank you for your

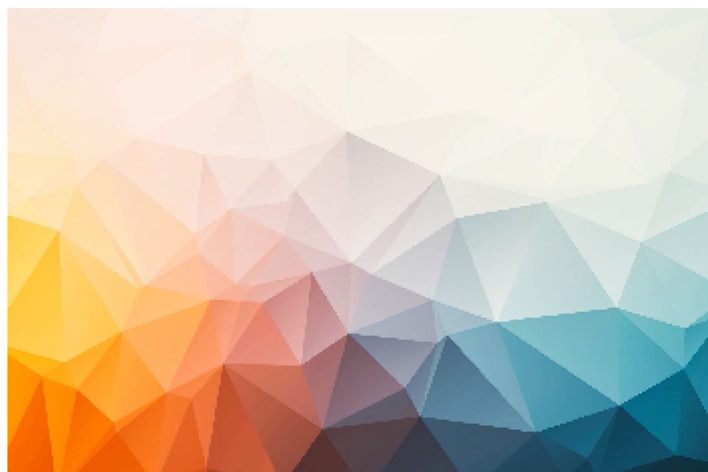
time and participation. If you have any questions, please contact me at any time. My phone number is (720) 663-8441 and my email is Nicoletta.Weide@waldenu.edu.

Thank you for your consideration.

Sincerely,

Nicoletta Weide, MHS, MPhil, Doctoral Student, Walden University.

Appendix E: Recruitment Post and Survey for Requirements



Volunteers Needed For A Research Study On Self-Harm in the form of Cutting

You may qualify if you

- Are between the ages of 18 and 23 years old
- Engaged in self harm in the form of cutting during your adolescent years

Potential Benefits

Participating in this study may assist in furthering research on cutting and coping strategies during adolescents.

Participation Involves

- An interview with a few questions about your experiences with cutting and coping during adolescents.

IF YOU ARE INTERESTED IN MORE INFORMATION, PLEASE FOLLOW THE LINK BELOW TO PARTICIPATION SURVEY

PARTICIPATION INTREST SURVEY

NICOLETTA WEIDE

WALDEN UNIVERSITY

NICOLETTA.WEIDE@WALDENU.EDU

(720) 663-8441

THANK YOU FOR YOUR TIME!

Appendix F: Human Subjects Training

Completion Date 26-Jun-2021
Expiration Date N/A
Record ID 43314111

This is to certify that:

Nicoletta Weide

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Student's
(Curriculum Group)
Doctoral Student Researchers
(Course Learner Group)
1 - Basic Course
(Stage)

Under requirements set by:

Walden University

Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w715aa012-3599-4d0e-b0de-5f5732a229a2-43314111