1-1-2009

The phenomenology of self -injurious behavior

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This is to certify that the doctoral dissertation by

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ABSTRACT

The Phenomenology of Self-Injurious Behavior

by

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Dissertation Proposal Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Psychology

Walden University
November 2009

ABSTRACT

Self-injurious behavior (SIB; e.g., wrist-cutting, burning) is a pervasive coping phenomenon that may be indicative of dysfunctional affect regulation and complex developmental trauma. Previous research findings identify the incidence rate of SIB to be approximately 10% to 15% of the general population with 5% to 10% of those engaging in repetitive or recurring SIB. Other sources identify approximately 2 million individuals active in this behavior within the United States; 70% of those individuals are female. However, limited research has used internet technology as a data gathering tool to access individuals who have engaged in SIB and are apprehensive to participate in face-to-face interviews. The purpose of this qualitative study was to examine the fundamental nature of SIB using an interpretive-phenomenological methodology via internet interviews. Data were gathered from a convenience sample of 18 adult female participants with a reported history of SIB recruited through SIB oriented websites. The data were analyzed through a phenomenological interpretive approach using axial and thematic coding. Results indicated that SIB is a method of coping with stress and emotions as well as a way to regulate and control affect from perceived historical trauma. These findings may advance empirical evaluation of SIB by expanding research designs and informing practitioners about how those who have engaged in SIB view therapeutic treatment. The positive social change implications include generating knowledge useful for program developers, educators, psychologists, and other invested professionals who search for sound, innovative ways to address SIB among women based on the words and experiences of survivors; potential long-term outcomes include improved coping strategies, reduced incidences of bodily harm and improved self-concepts.

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DEDICATIONS

I owe everything to God. Without God working through me none of this would have been possible.

I also want to thank my wife, Lorin Hosmer, for her unending understanding, support, and patience through this dissertation process—I love you, now and eternally. Lorin; without you I would not be earning my PhD—words cannot truly express my heartfelt thanks to you.

To my miraculous son, Paxton John Hosmer. I only thought I knew what love was until you came along. God has truly blessed me with you and it is beyond what I can eloquently conceptualized into words how I feel towards you.

My mother in-law, Ruth Basile, without your humorous attitude and unconditional support this dissertation and PhD would not have come to fruition—I want to thank you from the bottom of my heart for believing and supporting me towards my dream.

To my parents Dolores and Roland Hosmer. Dad, I know you have been watching me from above through all this; I can't thank you and mom enough for being the truly best parents anyone could ever have while here on earth. The both of you and my whole family in particular mean more to me than words could ever convey and I thank you for not only your confidence in me but for providing me with a loving, nurturing, caring, and moral upbringing.

Furthermore, I want to express my genuine admiration and appreciation to all the participants who voluntarily gave their time and insights in order to bring this research

study to fulfillment. Not only did you give your time and personal experiences, but an eagerness to bring insight, solace, and hope for others to cope, heal, and grow.

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude towards my dissertation committee: Amy Sickel, PhD, Robyn Trippany-Williams, Ed.D., and Tiffany Rush-Wilson, PhD., for their expertise, collaboration, and supervision on this research study. Once more, I would like to give an added "thanks" to my dissertation committee for their unrelenting persistence in not only seeing the "best" in me but for being able to bring it out of me.

I especially want to thank Dr. Tiffany Rush-Wilson, dissertation chairperson, for her endless amount of patience, encouragement, and knowledge—you have been an exemplary role model as a dissertation chairperson in demonstrating unending persistence in assisting me to accomplish my dissertation research for the PhD. You are truly an amazing person, without you I wouldn't have made it.

And almost all things, according to the law, are cleansed with blood: and without shedding of blood there is not remission

—Hebrews 9:22 (Douay-Rheims version)

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CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

Self-injurious behavior (SIB) is becoming an increasingly pervasive problem (Kadison & DiGeronimo, 2004; Wester & Trepal, 2005). The most recent statistics indicate the incidence rates of SIB to be approximately 10% to 15% in the general population and around 5% to 10% of those people engage in repetitive or recurring SIB (Yates, 2004). Other sources identify approximately 2 million individuals active in this behavior in the United States of America; 70% of those who engage in SIB are female (Yates, 2004). This qualitative research study on the phenomenon of self-injurious behavior (SIB; wrist cutting, burning) was inspired by the growing frequency of this behavior along with the researcher's clinical experiences working with those who engage in SIB. Understanding this phenomenon from the perspective of one who engages in these behaviors is paramount to enhancing the limited knowledge now held by the psychological world. It has been documented that SIB is about reducing psychological grief rather than ending one's life. It is separate from suicide and not necessarily a gesture of imminent ideation or intent (Walsh, 2006). In Western societies SIB is on the rise and is identified most often seen in girls and women in preadolescence through emerging adulthood (Arnett, 2000; McAndrew & Warne, 2005; Suyemoto, 1998; Wester & Trepal, 2005).

Existing research findings suggest the purpose of SIB is to alleviate negative emotions, regulate affect, release emotions one finds difficult to outwardly express, and function as a coping strategy arising from prior abuse or invalidation (Alexander & Clare, 2004; Brown, Comtois, & Linehan, 2002; Comtois, & Linehan, 2002; Claes,

Vandereycken, & Vertommen, 2005; Gratz, 2006; Lindgren, Wilstrand, Gilje, & Olofsson, 2004). A contemporary method for gathering data includes soliciting and using email narratives from participants (Kadison & DiGeronimo, 2004; Ross & Heath, 2002; Wester & Trepal, 2005; Whitlock, Powers, & Eckenrode, 2006; Yates, 2004). Presently, no known research studies on SIB have used the internet as a data collecting method. Given the universal use of the internet, SIB message boards, and "chat rooms," use of the internet is a means to obtain data that is more accessible and as a medium where some individuals who engage in SIB may be more willing to participate in research studies. Building on the content and methodological limitations of the existing research, the present study is a Heideggerian-hermeneutic phenomenological (interpretive) study that questions the meaning of SIB among adult females (Crist & Tanner, 2003; Kendler, 2005). An extensive account of SIB is provided in chapter 2.

Background of the Problem

Engaging in SIB goes against North American social-cultural norms and as a result, has become a taboo in society. Members of Western society do not accept the individuals within the populace engaging in SIB (e.g., wrist cutting, burning) when attempting to manage psychological distress (Favazza, 1996). Yet, SIB is on the rise in North America beginning in preadolescence and continuing into early adulthood (McAndrew & Warne, 2005; Wester & Trepal, 2005; White, Trepal-Wollenzier, & Nolan, 2002; Yates, 2004). SIB is typically characterized as "acts people direct toward themselves that result in tissue damage" (Schroeder, Oster-Granite, & Thompson, 2002, p. 1) representing the many possible practices individuals use to engage in SIB such as

wrist cutting, burning, self-biting, head banging, and eye enucleation (Favazza, 1996; White et al., 2002; White-Kress, Gibson, & Reynolds, 2004).

Statement of the Problem

Research indicates that SIB is used as a coping strategy to manage emotional pain and continues to be a mounting and worrisome phenomenon (Alexander & Clare, 2004; McAndrew & Warne, 2005; Walsh, 2006; Yates, 2004). As stated earlier North American sociocultural norms view SIB as an unacceptable way to cope with psychological distress. The associations of blood and pain, visible and sometimes horrific scarring on the body, a lack of understanding of SIB from the individual making an observation of the wounds, the premonition of a suspected underlying severe pathological disorder by the general public, and the confound of SIB with suicide has created a taboo in the society at large. For instance, society has created a stigma that is attached to SIB and not enough research has been conducted to understand and help those who self-injure. Therefore, the use of the internet as a data collection and interview method provides a way to allow others to participate in research without feeling as though they will be judged due to the stigma associated with SIB when confronting others face-to-face.

The aim of this research study was to understand the experience and meaning of SIB among adult females participants (18 or more years old) from a Heideggerian-hermeneutic phenomenological approach using electronic correspondence (Cohen, Kahn, & Steeves, 2000; Crist & Tanner, 2003). This method was selected in light of the reported difficulty many participants engaging in SIB have in expressing emotion in

adaptive ways, a hallmark of SIB. The virtual medium of this study allowed for such expression.

Research Questions

Several research questions guided this study. The general questions are: *From the perspective of the adult female, what is the essence of SIB? What does it mean to adult women to engage in SIB?* In order to narrow the responses to these two broad questions, several specific sub-questions were asked of the participants. Each of these questions can be found in Appendix A.

The focal point of this research study was to question the way adult females who engage in SIB experience their world (Van Manen, 1990). A qualitative research method in the phenomenological tradition using a Heideggerian hermeneutic-interpretative procedure was put into practice using internet-email correspondence to identify the core meaning of the SIB phenomenon from the perspective of participants who have or are engaging in SIB (Addison, 1989; Cohen et al., 2000). As a result, the need for an increased understanding of the meaning of SIB from the participants who engage in SIB was considered necessary (Claes et al., 2005).

Purpose of the Study

The purpose of this study was to discover and understand the core meaning of SIB among an adult female (18+ years old) population by the use of email correspondence. Previous studies have explored the phenomenon of self-injury from a quantitative (Croyle & Waltz, 2007; Hilt, Cha, & Nolen-Hoeksema, 2008) and etic (Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008; Yates, Tracy, & Luther, 2008) vantage point. These

studies and their findings provided the psychological community with foundational data from which to draw preliminary conclusions about clinical practice to remediate SIB (Nock, Teper, & Hollander, 2007; Trepal, Wester, & MacDonald, 2006) as well as comparisons between people who self-injure, and those who do not, on multiple psychological constructs (Armey & Crowther, 2008; Klonsky & Muehlenkamp, 2007). These studies do not, however, provide the reader with information about SIB from the perspective of the actor using an emic, qualitative framework. Allowing the reader to share the experiences of a person who has a history of intentional self-injury, using their own words allows unique access into the private thought processes of the person who self-injures. Further, this study represents an attempt to increase participant candor using the internet as a medium for data collection. The level of control that the participant maintained over their identity, word choice, sharing of experiences and even scheduling replies impact the assumed power differential within research and practice. In sum, this study sought to both allow that personal access for the reader and to allow the participants the empowerment that accompanies informing theory that describes one's own experience.

Theoretical Framework

There are many theoretical approaches that explain the etiology and treatment of SIB. The salient theories that provide the foundation for this study are affect regulation theory, attachment theory, coping theory, emerging adulthood development theory, neurobiological theory, object-relations theory, and stress theory. Research findings

suggest that these perspectives form the foundation for the origins of SIB (Yates, 2004). Each of these theories is described in the following paragraphs as it relates to SIB.

According to the affect-regulation approach, by engaging in SIB, the individual manages, appraises, and is able to adapt her emotional reactions (Silk, Steinberg, & Morris, 2003). Attachment theory and affect regulation are often viewed from a psychoneurobiological perspective (Schore, 2000; Zilberstein, 2006). Attachment emerges between two organisms (i.e., primary caregiver and child) with the intent to regulate emotions; this is accomplished by closer proximity to a responsible and available caregiver for security, comfort, and care taking (Bowlby, 1969; Zilberstein, 2006). Coping, whether it is problem-focused or emotion-focused (Littleton, Horsley, John, & Nelson, 2007), is a way to manage the stress in one's life. How successfully each person manages such stress depends on how each individual perceives and responds to the demands of the environment (Grant et al., 2003).

Object-relations theory describes how the intricate emotional processes of emotional relationships with others are formed and maintained, and the diverse ways in which people are impacted by them (Scharff, 1996). Neuroscience and right-hemisphere research domains provide a biological perspective on SIB, whereas emerging adulthood within a developmental psychopathological framework informs us as to how this unique developmental stage of life contributes to SIB from a lifespan perspective (Arnett, 2000; Cicchetti & Rogosch, 2002; Joseph, 1992; Paludi, 1998; Schore, 1994, 2001). These theories merge to inform this study's approach by allowing for a multi-perspective analysis of the critical biological, developmental, and psychological viewpoints of the

human condition. Overall, these theories guide the study (i.e., interviews, analysis of the data, interpretation).

Operational Definitions

The core philosophy behind this qualitative study was the Heideggerian-hermeneutic phenomenological-human science method (Creswell, 2003; Giorgi & Giorgi, 2004; Hein & Austin, 2001; Spinelli, 2005). In essence, this study investigated, using a purposive sample, the interpretation and experience of each of the participants who engaged in SIB. In order to assist the reader in understanding the terms of this study it is important to identify certain key terms. The following terms were used consistently throughout this research:

Affect regulation. The adjustment or correction of emotional responses (Fonagy, Gergely, Jurist, & Target, 2004; Schore, 2003a).

Attachment. "An enduring affective bond characterized by a tendency to seek and maintain proximity to a specific figure, particularly when under stress. The attachment is the emotional bond, not the behavior" (Colin, 1996, p. 7).

Being. "The most general feature of everything that is," sometimes referred to as "essence" (Inwood, 1999, pp. 26–27).

Complex developmental trauma. Sometimes referred to as disorders of extreme stress not otherwise specified (DESNOS), or complex posttraumatic stress disorder (PTSD)/DESNOS: "The enduring developmental effects of trauma" (Van der Kolk & Courtois, 2005, p. 387).

Dasein (da-sein). Human existence bound within possibilities (Heidegger, 1926/1962).

Emerging adulthood. In general, the developmental period between 18 and 25 years of age (Arnett, 2000).

Heideggerian-hermeneutic phenomenological, human-science approach. This is a qualitative research approach from a phenomenological perspective that seeks to interpret the meaning of a phenomenon from the data gathered directly from the individuals (Crist & Tanner, 2003).

Object relations. The quality of an individual's relational characteristics is formed by the individual's external interpersonal interactions and internal images (actual or made-up) of the self and other human beings (i.e., objects) that are attained in the course of early development (E. G. Goldstein, 2001; Gomez, 1997; Greenberg & Mitchell, 1983).

Assumptions, Limitations, Scope, and Delimitations

This study has delimited several factors. Among the most salient delimitations within this study were the researcher's choice to examine the topic of SIB using the framework of phenomenology, the preference to use an all-female, adult sample (18+ years old), and a phenomenological-interpretive design.

This study was limited by the use of a small purposive sampling (nonprobability) convenience method that did not involve random selection of participants (Gay & Airasian, 2003). This, however, is a common practice in phenomenological research (Gay & Airasian, 2003). Purposive sampling is based on the researcher's informed knowledge

base and experience of the phenomenon under examination, which is then used in the selection criteria for the sample chosen. Inaccurate and biased selection criteria based from the researcher's viewpoint were potential confounds with the use of this technique (Gay & Airasian, 2003). It is important to keep in mind that the premise of this qualitative research study was to capture the meaning of SIB from the perspective of those who had personally experienced this phenomenon with the information gained being based on their ipsative expertise. The goal was to represent the participants using personal interpretation rather than statistical analysis, prediction, and/or generalizability of results that are typical of the quantitative approach (Creswell, 1998; Gay & Airasian, 2003).

Interpretation and analysis of findings were limited by the sources obtained, including year of publications and the researcher's clinical experiences. Limitations are also noted in the sample characteristics used in this study (e.g., adult females only, small sample size). Overall, the purpose was to understand the meaning of SIB for adult females. This study did not intend to quantify, correlate, or test hypotheses of SIB. This study strictly sought out the essence or meaning of SIB. Chapter 3 provides an in-depth examination of the methodological issues.

Significance of the Study

This study has considerable implications for future assessment and treatment of individuals with SIB. Further, the social-change implications for this research study have the prospect of contributing positively to both the general human and specifically the social conditions in which women who engage in SIB exist. This research provided a

foundation for future study for the development of evaluation and intervention methods for the SIB phenomenon.

This study provided an important contribution to the scholarly literature on the essence of SIB from the perspective of those who have experienced it and using the participants' own words. The use of electronic correspondence as the medium by which data was obtained about the meaning of SIB was groundbreaking. This particular methodology may have represented a unique sample of interviews by individuals who would never have participated in a face-to-face interview. Because of the anonymity of this type of information gathering format, the participants reported feeling more secure when discussing their very personal circumstances which in turn was reportedly the deciding factor cited for participation in this study.

The results obtained from this study are not generalized abstractions from a large sample based on numerical and normative findings. The results from this study are derived directly from the individuals themselves who have experienced the phenomenon of SIB in their own lives and are therefore not generalizable. In-depth questioning was conducted with each participant to get at the essence of SIB. The majority of the participants discussed their viewpoints on counseling and psychotherapy and what they thought was useful or not helpful in their own healing process. This study provides the clinical practitioner as well as the scientist with findings that can inform clinical practice and with theories that can be further developed and tested empirically. This may in turn affect society positively.

This study promotes social change by providing results that can aid an understanding for the reader, as well as having applicable value to the clinical practitioner by informing him/her about what the individuals themselves found to be effective and not effective in the therapeutic process. For the researcher, this study promotes future research on SIB by introducing an innovative and distinctive data-collection method. There was a need to capture the essence of SIB from the individuals themselves, especially those individuals who would not have participated in face-to-face interviews due to an apprehension about discussing their personal circumstances openly in front of an interviewer.

Summary

SIB is characterized as a method of coping with underlying psychological distress emerging from perceived trauma. SIB falls along a continuum ranging from hair pulling and wrist cutting to eye enucleation and the severing of limbs. Typically, when there is more severe SIB, there is a greater chance of severe psychopathology such as schizophrenia. A number of theoretical perspectives were used in this study to understand SIB, including affect regulation, attachment, coping, emerging-adulthood development, neurobiological, object-relations, and stress theories. In the United States of America and Great Britain SIB has been on the rise for the past 15 to 20 years from preadolescence through adulthood (Kadison & DiGeronimo, 2004; Wester & Trepal, 2005; Yates, 2004).

The aim of this research was to focus on the essence of SIB from the adult female's experience using a phenomenological-interpretative methodology. Data collection was conducted through email interviews and is the first known study to use

that technique to study SIB. This study was also unique in that a majority of the participants sampled for this study stated they chose to volunteer because it was not a face-to-face interview. Participants reportedly felt more secure conducting the interviews through email where they could still dialogue on their experiences with SIB. Hence, an essential contribution toward social change is found at the clinical-practice level where the findings of this study will describe the essence and therapeutic aspects of SIB as experienced directly by the participants. A significant contribution to the research field is through the use of the email interview. To the best of this researcher's current knowledge, the email interview technique has not been used before in this context and will have rewarding outcomes in using Internet technology to advance behavioral science research.

Chapter 2 presents a detailed examination of the types of SIB, prevalence, comorbidity, historical account, theoretical perspectives, and treatment methods. Chapter 3 provides a detailed account of the Heideggerian-hermeneutic phenomenological-human science research methodology, sample characteristics, data collection, and analysis techniques. Chapter 4 details the results including participant profiles, data collection, data analysis, and meaningful themes. Chapter 5 outlines the overall interpretations and conclusions from the study including the general interpretations, theoretical considerations, implications for social change, and recommendations.

CHAPTER 2: REVIEW OF LITERATURE

Introduction

This chapter provides an overview of the most salient research articles related to this topic. Each of the following sections presents a detailed examination of the knowledge pertaining to the phenomenon of SIB: research questions and objectives, literature search strategies, SIB overview (e.g., prevalence, clinical taxonomy, general site of injury, description, categories, types, and aim), complex developmental trauma, historical context, theoretical aetiology (e.g., affect regulation, attachment theory, stress, coping, object-relations theory, neuroscience, and emerging adulthood), treatment methods, and a justification for the research study.

Research Strategy

The literature was examined by accessing the following databases: PsycARTICLES (1985-2008); Academic Search Premier (1975–2008); MEDLINE (1902–2008); PsycINFO (1800–2008); Pre-CINAHL (2003–2008); CINAHL Plus with Full Text (1937–2008); Health Source: Nursing/Academic Edition (1975–2008); SocINDEX with Full Text (1895–2008); and CINAHL (1973–2008).

The following search terms were used to gather information about this topic: adult, attachment, borderline personality disorder, complex developmental trauma, coping, cutting, deliberate self-harm, Edmund Husserl, emerging adulthood, female, girls, hermeneutic, human science, Martin Heidegger, neuroscience, object relations, phenomenology, qualitative research, right-hemisphere, self-cutting, self-harm, self-injury, self-inflicted violence, self-injurious behavior, self-mutilation, self-mutilative behavior, stress, wrist cutting, and young adult.

Aim of Research

The overall purpose of this research study was to gain an understanding of the adult female's experiences with SIB. In addition, the expectations for social change from this research would be to provide a comprehensive understanding of SIB that contributes both to the field of psychology, and related fields, and to the knowledge base of those who aid individuals that engage in SIB.

Prevalence

The most recent statistics indicate the incidence rates of SIB to be approximately 10% to 15% in the general population and around 5% to 10% of those people engage in repetitive or recurring SIB (Yates, 2004). Other sources identify approximately 2 million individuals active in this behavior in the United States of America; 70% of those who engage in SIB are female (Yates, 2004), yet other sources claim that such statistics are not reliable (Whitlock et al., 2006). Further, these numbers appear to be increasing on college and university campuses (Kadison & DiGeronimo, 2004; Wester & Trepal, 2005). The discrepancy between these prevalence findings was possibly influenced by ways in which researchers have defined SIB, sample characteristics, and method of data collection.

Reported frequency rates range from 750 to 1,800 per 100,000 annually in the general population (Farber, 2000; Favazza & Conteiro, 1988) and as elevated as 12% to 14% in the college/university and high school samples (Ross & Heath, 2002) with college students from 18 to 22 years old falling into the highest risk period for SIB (Gratz, 2001; White et al., 2002). Yet, other data reveal a plausible reason to believe there is an

underestimation of SIB among the adolescent population (Rodham, Hawton, & Evans, 2004).

Furthermore, SIB is typically observed more among female than male members of the U.S. population (Alexander & Clare, 2004; McAndrew & Warne, 2005; Suyemoto, 1998). However, the research is mixed on these statistics (Muehlenkamp, 2005; White-Kress et al., 2004) and may have more to do with how SIB is defined, sample characteristics, and type of diagnostic category (e.g., borderline personality disorder).

Childhood Sexual Abuse (CSA) and Eating Disorders

Some study results of prevalence rates indicate childhood sexual abuse occurs in approximately 20% to 30% of the female population (Philips & Daniluk, 2004) while others indicate as high as 45% (Bogar & Hulse-Killacky, 2006). Researchers' findings on this topic reveal a significant association between childhood abuse and SIB among the female participants studied (Weierich & Nock, 2008; Zila & Kiselica, 2001). Exposure to traumatic events such as sexual abuse occurred in a vast majority of females who engage in SIB, resulting in both a lack of trust in their world and a negative sense of self (Alexander & Clare, 2004; Bogar & Hulse-Killacky, 2006; Deiter, Nicholls, & Pearlman, 2000; McAllister, 2003; McAndrew & Warne, 2005; Philips & Daniluk, 2004; Reece, 2005; Van der Kolk, McFarlane, & Weisaeth, 1996).

In addition, a relationship of SIB to both childhood sexual abuse and eating disorders has emerged in the literature, linking the two with similar histories of trauma and dissociation experiences (Favaro & Santonastaso, 2002; Paul, Schroeter, Dahme, & Nutzinger, 2002; Richards, Hardman, & Berrett, 2007; Sansone & Levitt, 2002; Walker,

Carey, Mohr, Stein, & Seedat, 2004). The association between SIB and childhood sexual abuse seems to be connected by unresolved historical perceived trauma that occurred in one's life, becoming the trigger for SIB (e.g., childhood sexual abuse). Likewise, the relationship between SIB and eating disorders appears to be connected with unresolved historical perceived trauma in the individual's past as well. For instance, past traumatic events are a trigger for an eating disorder. Other researchers consider SIB and eating disorders to be two different options for coping with comparable conditions (Connors, 2001; Hund & Espelage, 2005; Zila & Kiselica, 2001).

Gender

Sampling characteristics, presentation of SIB by gender, and definitional issues are two aspects that have contributed to the potentially false belief that SIB occurs more often among the female population (Gratz, Conrad, & Roemer, 2002).

A review of the literature reveals both similarities and differences between females and males who engage in SIB (Gratz & Chapman, 2007; Gratz et al., 2002; Hilt, Cha, & Nolen-Hoeksema, 2008). According to Gratz and Chapman (2007), "childhood sexual abuse, maternal emotional neglect, paternal emotional over involvement, and insecure paternal attachment were significantly associated with [deliberate self-harm] among women" (p. 2). On the other hand, "caregiver separation was the only environmental risk factor uniquely associated with [deliberate self-harm] among men" (p. 2). Regardless of gender differences, the largest portion of the shared variance was found in emotion dysregulation. Keep in mind; these studies indicate that it may well be the frequency and severity of any of the precipitating factors that contributes to these

differences (Gratz et al.). In a study by Hawton, Bergen, Casey, Simkin, Palmer, Cooper, Kapur, Horrocks, House, Lilley, Noble, and Owens (2007), 57% of the clinical population seen that engaged in SIB were females and 43% were males, whereas the female to male ratio decreased with age.

Clinical Taxonomy

At the present time, SIB is not considered a mental disorder by established clinical nomenclature (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 2000). Despite this fact, the Diagnostic and Statistical Manual of Mental Disorders specifically lists Impulse-Control Disorders Not Elsewhere Classified and Borderline Personality Disorder with features of SIB (e.g., skin picking, self-mutilating behavior, and self-mutilative acts; White-Kress, 2003). However, researchers have recommended clinical nomenclature such as self-mutilation (Zila & Kiselica, 2001), self-injurious behavior (Stone & Sias, 2003), deliberate self-harm (Crouch & Wright, 2004), self-injury (White-Kress et al., 2004), self-cutting (Suyemoto & MacDonald, 1995), self-inflicted violence (Brown & Bryan, 2007; Connors, 2000), self-inflicted injury (Matthews & Wallis, 2002), and nonsuicidal self-injury (Klonsky, 2007; Weierich & Nock, 2008).

General Site of Injury

The most common site of injury is the wrist (Suyemoto & MacDonald, 1995; White et al., 2002). SIB differs from those who are suicidal by intent; those individuals who engage in SIB aim to alter their awareness in order to decrease distress, while the

suicidal individual's intention is to eliminate their awareness in general (Nock & Kessler, 2006; Walsh, 2006).

Basis of SIB

SIB is a phenomenon believed to be a coping strategy to reduce psychological distress (Alexander & Clare, 2004; Connors, 2000; Lindgren et al., 2004; Walsh, 2006) by attempting to manage and regulate affect (Suyemoto & MacDonald, 1995) and gain self-control (Wester & Trepal, 2005). Other researchers have claimed individuals who engage in SIB are attention needing rather than attention seeking, and the lack of a nurturing relationship in childhood produces multifaceted problems (McAndrew & Warne, 2005). Research reveals SIB to be a coping strategy used to manage intrusive thoughts and numbing symptoms involved in the individual's traumatic coping experience (Weierich & Nock, 2008). The primary reasons individuals start engaging in SIB are, "sexual abuse, family stress, rejection or blame, physical, emotional and psychological abuse" (Liebling, Chipcase, & Velangi, 2002, p. 429).

Correspondingly, Nock and Mendes (2008) theorized that it is not the inability of individuals who engage in SIB to generate appropriate solutions to their situational difficulties, but their failure to select the most adaptive strategy in response to their situational difficulties that creates the quandary. According to Weierich and Nock (2008), "Individuals who engage in [nonsuicidal self-injury] have been shown to exhibit difficulty with suppressing unwanted thoughts in general and may experience particular difficulty with suppression of trauma specific thoughts and images" (p. 39).

There are an assortment of meanings and functions among those who engage in SIB (Deiter et al., 2000): (a) impairments in self-capacities such as the ability to endure intense emotions; (b) preservation of a positive sense of self-worth and maintenance of a feeling of connection with others, have been known to be underlying factors in the reasons individuals engage in SIB. Furthermore, the underpinning of SIB is, "the substitution of one kind of pain for another to divert oneself from the original pain" (Farber, 2000). The typical age of onset is in early adolescence (Clery, 2000; Favazza & Conteiro, 1988; Nock & Prinstein, 2004) with females reported as being one to three times more likely to engage in SIB than males (Favazza, 1996; Nock & Kessler, 2006; Shaw, 2002).

A multitude of diverse dissertation studies on SIB encompass quantitative and qualitative studies, and literature reviews (Carey, 2005; Costosa, 2007; Craigen, 2006; Crum, 2007; DiLazzero, 2003; Fountain, 2001; Impey, 2003; Kashgarian, 1999; McArdle, 2003; Rao, 2000; Richards, 1999; Vanderhoff, 2004; Williams, 2005; Yates, 2005). The quantitative research points toward key factors being affect regulation, trauma, and clinical depression (Costosa, 2007; Fountain, 2001; McArdle, 2003; Vanderhoff, 2004; Yates, 2005) whereas, qualitative studies reveal agency, control, guilt, sense of abandonment, and power to be the main themes (Craigen, 2006; Kashgarian, 1999; Rao, 2000; Richards, 1999).

An examination of the phenomenological studies revealed a Husserlian/descriptive approach only, with sample sizes ranging from three to six (Kashgarian, 1999; Rao, 2000; Richards, 1999), contrary to the amount the literature

recommends (Creswell, 1998). Existing phenomenological studies have comprised samples with age ranges from 18 to 56 years old (Kashgarian, 1999; Rao, 2000; Richards, 1999) and a researcher confession, "There is no vantage point without presuppositions. My access to the phenomenon is and always was perspectival access; I can never step outside my own situatedness" (Rao, 2000, p. 97). This is aligned with an interpretative phenomenological approach (Crist & Tanner, 2003) that produced a new and original perspective to the literature on SIB.

Furthermore, the present study used online data-collection technology (i.e., message boards, email) to recruit and interview the participants. A considerable amount of research revealed that the use of online technology for research and intervention is a valuable resource both for the field and for society (Layne & Hohenshil, 2005; Mallen, Vogel, & Rochlen, 2005; Reynolds & Stiles, 2006). In fact, numerous studies in psychology have used online technology to assist in the research process (Cook & Doyle, 2002; Kenardy, McCafferty, & Rosa, 2003; Leibert, Archer, Munson, & York, 2006). In addition, this procedure also contains a more efficient component of transcription, as each interview was nearly transcribed at the completion of each interview.

Historical Context

Documentation of known SIB dates back to the fifth century B.C. when Herodotus referred to a Spartan leader who engaged in self-mutilation with a cutting edge (Turner, 2002). The Egyptians and Aztecs were known to have conducted piercings of the body as well as tattooing (Sanders, 1989; Strong, 1998). Approximately 2,000 years ago (8 BCE) the Roman poet Ovid wrote Metamorphoses. In this story, he described a

situation where Neptune raped Caenis and then when Caenis was granted a wish, she chose that her genitalia be ablated. This cutting away of the female genitals is known as female genital self-mutilation or Caenis syndrome (Alao, Yolles, & Huslander, 1999; Goldney, 1980).

In the New Testament of the Bible, the Gospels of Mark and Matthew describe several individuals who engaged in SIBs (Favazza, 2009). These acts include cutting themselves with stones, removing an eyeball, cutting off a hand, or self-castration. Similarly, in the book of Kings in the Old Testament, individuals lacerated themselves with knives and lances (Conterio & Lader, 1998; Favazza, 1996; Turner, 2002). In addition, various saints, such as Saint Catherine of Sienna and Saint John of the Cross, flogged themselves with chains until they drew blood (Favazza, 1996; Turner, 2002). Favazza (2009) proposes:

> In addition to the standard psychological reasons I propose an additional one, not found in other chapters of this book, to explain the profoundly unsettling effect of self-injury on those who witness or have to deal with it. I believe that self-injury rattles one's equanimity because its bloody tendrils reach out to touch the Sacred, which is a holy and scary space that has existed in the human mind since the beginnings of recorded time. The construct of the Sacred involves veneration of a mysterious spiritual power, distinct from the reality of the profane world, that governs the universe, bestows blessings and curses upon humankind, and endures myths. The ancient origins of sacred violence can be traced back to the most early, deeply layered, and prestigious myths in all cultures-namely, myths of creation (p. 30).

According to Brumberg (2006), one of the first accounts of female self-injury was documented by E. L. Emerson in 1913 followed by Menninger (1938) who claimed that SIB falls on a continuum of severity and type as well as that self-mutilation has been part of religious ceremonies in some cultures throughout history. However, it was not until the 1960s and 1970s that female SIB became more prevalent in the literature, claiming

females engaged in SIB as a means of communication because they were unable to articulate their feelings due to abandonment or loss (Lester, 1972; Phillips & Alkan, 1961; Siomopoulos, 1974). From the mid 1970s to the early 1980s there appeared to be a drop in the amount of literature addressing the topic of SIB (Conn & Lion, 1983). However, from the mid 1980s to the present time there appeared to be a rise in SIB (Favazza, 1998; Shaw; 2002) that is said to be due to the increased acceptance of mental health issues (i.e., less stigma) and research in neuroscience and trauma.

Characteristics of SIB

A variety of descriptions have been assigned to the phenomenon of SIB: self-mutilation (Zila & Kiselica, 2001), self-injurious behavior (Stone & Sias, 2003), deliberate self-harm (Crouch & Wright, 2004), self-injury (White-Kress et al., 2004), self-cutting (Suyemoto & MacDonald, 1995), self-inflicted violence (Brown & Bryan, 2007; Connors, 2000), self-inflicted injury (Matthews & Wallis, 2002), and nonsuicidal self-injury (Klonsky, 2007; Weierich & Nock, 2008). Even though there is no consensus on a universal definition and designation of SIB at this time, this study employed Favazza's (1998) well-documented definition of SIB/self-mutilation; *moderate/superficial type*, "the direct, deliberate destruction or alteration of one's own body tissue without conscious suicidal intent" (p. 225).

Culturally sanctioned SIB (e.g., rituals & practices; ear & nose piercing) and deviant pathological SIB (e.g., major, stereotypic, moderate/superficial; compulsive, episodic, and repetitive) structure the two main categories of SIB (Favazza, 1998). Culturally sanctioned SIB refers to the fundamental essentials of social life in a society,

whereas deviant pathological SIB consists of those self-mutilative acts that are not considered acceptable in a society.

The following are Favazza's (1998) all inclusive SIB subtypes:

Major self-mutilation. Considered the most severe form of self-mutilation, consisting of limb amputation, eye enucleation, self-castration, is sometimes associated with a psychotic psychiatric disorder.

Stereotypic self-mutilation. Usually devoid of symbolism, it consists of head banging, eyeball pressing, is typically a repetitive act, and is sometimes associated with mental retardation (Favazza, 1998).

Moderate/superficial self-mutilation. Typically symbolic, the most common, low lethality, episodic form, leaves less tissue damage than major or stereotypic self-mutilation and usually consists of wrist cutting, burning, and hair pulling. This category type consists of three subgroups: *compulsive type*; which occurs quite frequently on impulse on a daily basis (e.g., hair pulling), *episodic type*; typically linked to a clinical mental disorder and occurs intermittently in order to gain relief from painful emotions or thoughts, release tension, and regain control (e.g., wrist cutting), and *repetitive type*; with more of a preoccupation and an identity as a "cutter" at this level than at the episodic level, typically associated with eating disorders, substance abuse, kleptomania, intermittent explosive disorder, pyromania, and pathological gambling, and is syndrome-like in and of itself (Favazza, 1998). Favazza (1998) described this as, "a separate disorder of impulse control known as the repetitive self-mutilation syndrome" (p. 251).

Other researchers have conceptualized SIB as a method of managing anxiety to avoid retraumatization (psychoanalytic; Klein, 1976), replication through peer modeling for peer acceptance (social-learning theory; Bandura, 1973), attention seeking (behavioral perspective; Skinner, 1953), neurochemical basis (Schroeder et al., 2002), and historical cultural control and suppression of women in society (feminist; Shaw, 2006). Existing theories appear to be a mixture of several aspects of the above-mentioned SIB theories (Hilt et al., 2008; Nock & Prinstein, 2004).

Treatment Methods

In general, psychotherapy is considered effective (Asay & Lambert, 1999; Lambert & Barley, 2001; Lambert & Ogles, 2004), feminist psychologists advocate for a more relationship-oriented and meaning-creation approach (Shaw, 2002). Four critical factors are supported in providing justification for psychotherapy's effectiveness: client and therapeutic characteristics (40% of outcome variance), relationship features (30% of outcome variance), expectations (15% of outcome variance), and method (15% of outcome variance) (Hubble, Duncan, & Miller, 1999; Roth & Fonagy, 2005). Each provides significant support for this postulation (Hubble, Duncan, & Miller, 1999). The literature also supports the notion that the therapeutic relationship, otherwise known as the, "therapeutic alliance" (Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007) is not only crucial in psychotherapy where it promotes affect regulation in association with attachment, but psychotherapy itself as a process of change where the therapist acts as an interactive regulator for the client, creating an interactive repair that is an attempt to reduce stress in the client and restore psychobiological balance. This is

viewed as a significant component of psychotherapy in itself (Bowlby, 1969; Schore, 2003b; Wampold, 2007; Zuroff & Blatt, 2006).

The early treatment of choice for SIB was psychodynamic therapy (Kafka, 1969). In contrast, empirically supported treatments such as problem-solving therapy and dialectical-behavioral therapy are prominent in contemporary research and clinical practice (Muehlenkamp, 2006). Yet, the significance of an essential therapeutic partnership between client and therapist continues to be recognized, and the sustainment of long-term therapeutic gains after therapy has ended remains questionable. Likewise, present-day psychotherapists concur with the vital importance of such issues in the therapeutic encounter like trust, healthy attachment, and abandonment, especially, among those individuals who engage in SIB (Farber, 2000; Levenkron, 1998; Strong, 1998).

Further, McAndrew and Warne (2005) claimed cognitive-behavioral therapy, brief therapies, and the use of psychopharmacology, without long-term therapy such as psychodynamic therapy cannot meet the multifaceted needs (e.g., trauma) of those who engage in SIB. They also caution,

> In a world increasingly driven by economic exigencies and professional performance management, we are concerned that there is a risk that some individuals will be unable to have their story heard and mental health needs met due to the way mental health care is provided (p. 179).

Overall, a multimodal or multifaceted approach (e.g., problem-solving therapy, dialectical-behavioral therapy, cognitive-behavioral therapy, replacement-skills training, contingency management, body-image work, exposure therapy, psychoeducation, psychopharmacological treatment, family therapy, and feminist therapy) is recommended and supported in the treatment of SIB (Enns, 2004; Muehlenkamp, 2006; Smith & Peck,

2004; Walsh, 2006) in view of the fact that not one single treatment method has been found to be effective for all SIB (Wester & Trepal, 2005).

Complex Developmental Trauma

Research reveals that emotional and sexual abuse has a significant association with SIB (Glassman, Weierich, Hooley, Deliberto, & Nock, 2007; Kilpatrick et al., 1998; Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999). PTSD and mood disorder are part of the constellation of an individual's attachment history, biology, affect regulation, dissociative symptoms, behavioral control, cognition, and self-concept due to "complex trauma" (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Kilpatrick et al., 2003; McCann & Pearman, 1990; National Child Traumatic Stress Network, 2003; Pearlman & Courtois, 2005; van der Hart, Nijenhuis, & Steele, 2005; van der Kolk & Courtois, 2005). According to Kilpatrick (2005):

> It is irrefutable that PTSD is a key negative consequence of exposure to these types of events. There have been numerous well-designed studies that demonstrate that exposure to these types of events also increases the risk of many Axis I and Axis II DSM-IV disorders, so it is clear that PTSD is not the only consequence of traumatic event exposure (p. 379).

Therefore, SIB and its underlying impairments (e.g., affect regulation, attachment) may be accounted for by "complex developmental trauma" (McCann & Pearman, 1990). Kilpatrick et al. (2003) state, "The prevalence of PTSD in this probability sample of adolescents is particularly noteworthy because it indicates that a high percentage of youth in the United States encounter traumatic events and experience significant emotional responses associated with these events" (p. 699).

According to Pearlman and Courtois (2005), complex developmental trauma arises from, "severe cumulative interpersonal violence, neglect, or abuse" (p. 449) and results in difficulty with emotional regulation, attachment and relationship difficulties, abandonment issues, dissociation (a strategy to manage emotions related to the trauma), low self-esteem, anxiety, depression, PTSD, spiritual problems, risky sexual behaviors, and substance abuse (Green et al., 2005). From an object-relations and self-psychology perspective, self-injury is used as a method to self-sooth and contain emotional distress, and those who self-injure are, "often reenacting some aspect of previous interpersonal trauma" (Pearlman & Courtois, 2005, p. 455). Constructivist self-development theory views complex trauma in relation to self and attachment problems focusing on safety, trust, esteem, intimacy, control, affect tolerance, worth, and inner connection as they relate to the individual and their trauma experiences (Pearlman, 2003; Pearlman & Courtois, 2005).

Psychotherapeutic treatment of complex developmental trauma is one modality of treatment (e.g., dialectical-behavioral therapy, interpersonal therapy, cognitive-behavioral therapy, feminist-relational therapy). Psychotherapeutic approaches should emphasize respect, information, connection, and hope in the therapeutic relationship where underlying attachment issues can be modified (Pearlman & Courtois, 2005). Therefore, this relationship-attachment approach will target the individual's attachment need that is behind the trauma, bringing it to a conscious level for the individual to recognize, then using the therapeutic relationship to work on a better understanding of it's connection to past traumatic events, at the same time building up the individuals' ability to regulate

their emotions, while increasing their self-capacities (e.g., personality, identity, and consciousness).

Affect Regulation

An abundance of the scientific literature maintains that SIB is a form of affect/emotion regulation (Brown et al., 2002; Favazza, 1996; Gratz, 2006; Gratz & Chapman, 2007; Lindgren et al., 2004; Nock & Prinstein, 2004; Schore, 2003a; Suyemoto, 1998; Suyemoto & MacDonald, 1995; Yates, 2004). Emotional inexpressivity (Gratz, 2006) and emotion dysregulation are the critical factors in understanding SIB (Chapman, Gratz, & Brown, 2006; Gratz & Chapman, 2007). The following theoretical perspectives are an attempt to provide a more in-depth understanding of SIB.

Affect regulation, attachment, object-relations, neuroscience, and coping theory

The literature on SIB reveals that affect regulation is a significant factor in the intention of individuals who engage in such behaviors (Suyemoto, 1998; Walsh, 2006; Yates, 2004). Affect regulation can take the form of either *interactive* or *autoregulation* (Schore, 2001). Interactive regulation occurs between two individuals and autoregulation takes place within the individual without another person being present. Schore (2003b) claims that "cutting" (a form of SIB) is an effort to autoregulate out of emotional distress or a dissociative state.

Affect regulation is described as the adjustment or correction of emotional responses (Fonagy et al., 2004; Schore, 2003a). Conversely, affect dysregulation is known as the central characteristic of all psychopathologies (Schore, 2003a) where underregulation gives way to the external psychopathologies (e.g., oppositional-defiant

disorder, conduct disorder) and overregulation produces internalizing psychopathologies (e.g., mood disorders). However, affect regulation "is not just the reduction of affective intensity, the dampening of negative emotion. It also involves amplification, intensification of positive emotion, a condition necessary for more complex self-organization" (Schore, 2001, p. 21). This is strikingly similar to emotional regulation, "the process of initiating, maintaining, modulating, or changing the occurrence, intensity, or duration of internal feeling states and emotion-related physiological processes, often in the service of accomplishing one's goals" (Eisenberg, Fabes, Guthrie, & Reiser, 2000, p. 137). Further, affect regulation signifies the incorporation of both the biological and psychological domains and is sometimes known as the fundamental organizing driving force of human development (Schore, 2001).

In view of SIB through an attachment-theory perspective, an individual's attachment history becomes an important factor in those who engage in SIBs (Suyemoto, 1998; Yates, 2004; Yip, 2005; Zila & Kiselica, 2001). An attachment viewpoint has been coined a regulatory theory of dyadic interactive synchrony regulating emotion (Schore, 2000; Sroufe, 1996). Reite and Capitanio (1985) viewed the function of attachment as promoting, "the synchrony or regulation of biological and behavioral systems on an organismic level" (p. 235). Moreover, Allen and Land (1999) asserted that infant and adolescent attachment behavioral differences are more alike than different; the primary function of attachment is emotion regulation where attachment strategies are passed on through the generations.

In addition, affect regulation is included in the scientific theory of emotional intelligence (Mayer, Salovey, & Caruso, 2004; Salovey & Grewal, 2005) and the assessment of emotional intelligence (Mayer, Salovey, Caruso, & Sitarenios, 2003).

Object-relations theory has also been linked as a theoretical conceptualization of SIB (Gardner, 2001; Suyemoto, 1998; Turp, 2002; Yates, 2004; Zila & Kiselica, 2001). Object relations refers to the quality of an individual's relational characteristics by way of their external interpersonal interactions and internal images (actual or invented) of the self and other human beings (i.e., objects) that are attained in the course of early development (Goldstein, 2001; Gomez, 1997; Greenberg & Mitchell, 1983).

A neuroscience perspective approaches SIB from a developmental psychoneurobiological model position. Such a perspective suggests the right or unconscious brain and the orbitofrontal cortex play a significant part underlying both attachment and object-relations functioning (Joseph, 1993; Schore, 1994, 2001, 2003a, 2003b). John Bowlby's (1969) control system, the orbitofrontal cortex (expanded in the right hemisphere), and the "senior executive" of the emotional part of the brain (Joseph, 1996) give credence to not only an underlying biological aspect to emotions but also emphasizes the vital role of the nervous system. In addition, it is understood that the socioemotional environment, especially within the first 2 years of one's life between the child and the primary caregiver not only has a significant influence on the developing brain formation but also on the socioemotional performance for the rest of the person's existence (Schore, 1994).

Schore (2003b) maintained, "regulation theory suggests that attachment is, in essence, the right brain regulation of biological synchronicity between organisms" (p. 41). In return, attachment experiences have an impact on the developing right brain consistent with brain neuroanatomy research (Joseph, 1992, 1996; Schore, 1994, 2000, 2001, 2003a). Contemporary neuroscience research findings, on the other hand, reveal that "the limbic system is intimately tied to attachment functions" (Schore, 2001, p. 48). Hence, scientific findings support a psychoneurological link between attachments and affect regulation. Bowlby (1969) asserted that attachment's function is linked with the organisms' arousal-neurological mechanism in the midbrain nuclei and limbic system, with the goal of looking for an individual to attach to that is emotionally accessible and understanding.

Additionally, a body of research maintains that both the mother's and infant's right brain are involved in attachment (Henry, 1993; Schore, 2000; Siegal, 1999; Wang, 1997). For example, when "relational objects" are formed between the transactions of the primary caregiver (i.e., mother) and the child, as conceptualized through object-relation theory (Winnicott, 1971), the specialization of the right hemisphere for these subjective objects are noted in the neuroscience literature (Atchley & Atchley, 1998). For that reason, it is suggested that, "the regulators of both the infant and mother's brains are located in specifically the right limbic brain" (Schore, 2001, p. 22).

Imprinting, which mediates attachment, is an active dyadic course of action between the mother and child's right hemispheres that orchestrates (i.e., synchronizes) emotional meaning between the two hemispheres. In retrospect, "the caregiver's

attachment function acts as a regulator of the infant's arousal" (Schore, 2001, p. 38) drawing from the right brain that stores the internal working models of the attachment relationship (Schore, 1994). Schore stated, "attachment can be defined as the regulation of biological synchronicity between organisms" (Schore, 2001, p. 21).

These early forming object relations and the phase of the sudden increase in early brain development overlap with each other providing both a psychoanalytic and neurobiological foundation to their developmental significance of socioemotional progression (Schore, 2003b). The scientific literature reveals SIB is a form of coping with a distressing situation and/or emotions where the right brain specializes in recognizing facial expressions, nonverbal affective signals, gestures, and vocal tone, which enables the individual to cope with stress (Schore, 2001; Suyemoto & MacDonald, 1995; Walsh, 2006; Zila & Kiselica, 2001).

According to Folkman, Lazarus, Pimley, and Novacek (1987), "coping refers to the thoughts and acts people use to manage the demands of stressful transactions. These thoughts and acts can be directed both at altering the troubled person–environment transactions (problem-focused coping) and regulating distressing emotions (emotion-focused coping)" (p. 172). Emotion-focused coping is underdeveloped in childhood through adolescence and is a coping strategy and style used more by females than males (Hampel & Petermann, 2005; Olff, Langeland, Draijer, & Gersons, 2007). Additionally, the type of coping strategy used has been viewed as a pathway to meaning in one's life (Jim, Richardson, Golden-Kreutz, & Andersen, 2006).

Ayers, Sandler, West, and Roosa (1996) found evidence for a four-factor model of coping (i.e., active, distraction, avoidance, & support-seeking strategies). This four-factor model of coping could have the potential of determining which strategies individuals select depending on their coping style in a given situation. Consequently, this would provide a framework for both researchers and practitioners to better understand why those who engage in SIB may select a certain coping method over another in a given situation. Interestingly, Bowlby's findings (1969) and the existing scientific literature reveal that the affect of attachment between the primary caregiver (e.g., mother) and the child forms the scope of the child's coping reactions (Francis & Meaney, 1999).

Stress and Emerging Adulthood

Research supports a relationship between SIB and inescapable stress whether real or perceived (Strong, 1998). Lifespan developmental stress is created as an individual moves through the various developmental stages throughout their life (Aldwin, Spiro, Levenson, & Cupertino, 2001; Arnett, 2000). Hence, understanding the mechanisms underlying stress may provide insight to why a portion of adult females engages in SIBs.

Stress is recognized as having a significant impact on the development of psychopathology in the human condition (Grant, Behling, Gipson, & Ford, 2005; Grant et al., 2006; Grant & McMahon, 2005; McMahon, Grant, Compas, Thurm, & Ey, 2003). Likewise, gender differences exist in the affect of stress where females demonstrate higher rates of depression as an outcome of stress (Compas, Orosan, & Grant, 1993). Scientists have also provided evidence on the significance of discovering meaning in the milieu of stressors in one's life (Jim et al., 2006) and have gone on to define stress as

"environmental events or chronic conditions that objectively threaten the physical and/or psychological health or well-being of individuals of a particular age in a particular society" (Grant, Compas, Stuhlmacher et al., 2003, p. 449).

Stress has also been defined as asynchrony (Schore, 2001). Neuroscience data on the role of stress suggests structural changes in the hippocampus that occur when stress-induced, result in the development of psychopathology (McEwen, 2000). Also, the general conceptual model of the role of stressors in development may function as a tool that can provide an understanding as to how stressors may trigger SIBs (Suyemoto, 1998). The general conceptual model contains four-elements (p. 452): (a) stressors (e.g., minor & major life events, chronic circumstances); (b) moderators (e.g., individual characteristics; age, gender, social support, parenting, economics, and environmental contexts); (c) mediators (e.g., biological/psychological/social modes); and (d) psychopathology (e.g., disorders, symptoms). As a result, each of these elements can be examined in a systematic manner to gain a more complete understanding as to how stressors may contribute (mutually exclusively, dynamically, or systematically) to abnormal development resulting in psychopathology and SIB.

Bearing in mind a lifespan developmental framework, the college-age population are members of the developmental stage identified as emerging adulthood (Arnett, 2000). Emerging adulthood consists of a distinct period of lifespan development occurring in highly industrialized/postindustrial societies between the ages of 18 to 25 years (Arnett, 2000) where the brain continues its development (Pujol, Vendrell, Junque, & Marti-

Vilata, & Capdevila, 1993). The concept of "emerging adulthood" is also congruent with the work of Hall (1904). Arnett (2000) defined emerging adulthood as:

> Neither adolescence nor young adulthood but is theoretically and empirically distinct from them both. Emerging adulthood is distinguished by relative independence from social roles and from normative expectations. Having left the dependency of childhood and adolescence, and having not yet entered the enduring responsibilities that are normative in adulthood, emerging adults often explore a variety of possible life directions in love, work, and worldviews. Emerging adulthood is a time of life when many different directions remain possible, when little about the future has been decided for certain, when the scope of independent exploration of life's possibilities is greater for most people than it will be at any other period of the life course (p. 469).

Based on this conceptualization of emerging adulthood, this framework is a suitable perspective to incorporate into the overall developmental framework used in this research study. Overall, the literature points to several factors that may contribute to an individual to engage in SIB. The main area is emotional regulation dysfunction or difficulty with regulating one's emotions so the individual resorts to engaging in SIB to regulate their emotions when under distress. Secondly, there appears to be an ineffective attachment to primary caregivers early on in their childhood and right hemisphere dysfunction (Schore, 1994, 2000, 2001, 2003a, 2003b; Yates, 2004).

Research Justification

One reason for this qualitative-phenomenological research on SIB was because of the meager amount of qualitative studies available in this domain using Internet-technology methods (Harris, 2000; McAndrew & Warne, 2005). A second basis was the fundamental need to sufficiently understand the meaning of SIB from the viewpoint of the individual person who has engaged in SIBs (Connors, 2000). Apropos, Gardner

(2001) maintained that, "The understanding of the specific meaning of self-harm for any individual has to be seen as the central concern" (p. 127).

The relation between the meaning of SIB and affect regulation was a crucial point of interest in this investigation, as well as illuminating the purpose leading to a more complete understanding from those who have engaged in or are engaging in SIB. A variety of studies have acknowledged that SIB is a coping method to regulate affect in times of stress (Brown et al., 2002; Gratz, 2006; Yates, 2004). Therefore, this study went to the individuals themselves to gain an understanding of what the meaning was for the individual person. This study revealed whether or not an association exists between the meaning of SIB for the individuals and the results of the discovered factors (e.g., affect regulation) from existing research. Furthermore, this study provided the groundwork for future quantitative and mixed-methods studies to build on the essential meaning of SIB: without an understanding of the meaning of SIB from the individual's perspective, a solid foundation for future study would seem less probable.

Summary

Research indicates that SIB is on the rise and occurs in approximately 750 to 1,800 per 100,000 annually in the United States. Childhood sexual abuse increases the individuals' probability of engaging in SIB, and having a clinically diagnosed eating disorder can be associated with engaging in SIB. It is recognized that females are reported to engage in SIB more than males. However, this data may be illusory since females are more likely to seek assistance from mental health professionals and are more likely to be diagnosed with borderline personality disorder. Currently, SIB is not

recognized as a clinical disorder by the DSM IV (2000). Clinical practitioners have suggested using the DSM classification of *Impulse Control Disorder, Not Otherwise Specified* or *Borderline Personality Disorder*, and researchers have recommended the term, *Repetitive Self-Mutilation Syndrome*. The general site of SIB on the body is the wrist. However, burning, hair pulling, and eye enucleation have also been used.

SIB has occurred throughout history tracing back to ancient times when some of the Roman solders would cut themselves with knives and sharp rocks, Saints such as Saint Catherine of Sienna used to flog herself. SIB has been categorized into subtypes by level of severity; major self-mutilation, stereotypic self-mutilation, and moderate/superficial self-mutilation. Dialectical-behavioral therapy, cognitive-behavioral, and interpersonal therapy are the most-used treatment methods for SIB. The literature suggests the underlying basis for SIB historical perceived trauma can lead to engagement in SIB as a coping method to regulate one's affect and inner emotional distress.

Chapter 3 discusses data collection and research design in detail. The research design is a qualitative method of the interpretive-phenomenological tradition. Data was collected through email interviews over the Internet. To date, this study is the first of its kind to use this type of data-collection method for an interpretative-phenomenological study of SIB. The sample consisted of adult females who were 18 years of age or older who had engaged in SIB.

CHAPTER 3: METHODOLOGY

Introduction

Self-injurious behavior (SIB) was examined through the lens of the primary researcher using a qualitative research methodology by means of a Heideggerian-hermeneutic phenomenological-human science approach. The phenomenological method is most suitable for the present study since it intends to understand the experience and meaning of the phenomenon under investigation (Cohen et al., 2000).

The function of the phenomenological researcher for this study on SIB resembles the four parts of a circle: *questioner*, *investigator*, *interpreter*, and *analyzer*. This research project started with a question (i.e., what is the meaning of SIB), transitioned into an investigation of the scientific literature on SIB, continued to question as the participants were interviewed, began to interpret the data, and analyzed the data for definitive meaning. This process was continuously circular and concluded with a final interpretation (Crist & Tanner, 2003). An outline of this particular procedure, sample characteristics, confidentiality, data collection, data analysis, and data-interpretation techniques are reviewed.

Autobiographical Statement

In qualitative research, the researcher is a vital tool in the process. Both emic information and etic perspectives of participants are filtered through the symbolic lens of the primary investigator. This investigator necessarily influences the reporting of this study. With this in mind, and in keeping with both feminist research traditions and qualitative research processes (Camic, Rhodes & Yardley, 2003), I will provide brief but

relevant information about myself, the primary researcher, to help facilitate a complete picture of who I am as a researcher and my influence on the final data.

My fascination with female SIB came about through my experiences as a licensed school psychologist. I encountered an increasing number of referrals from teachers, parents, friends of students, and adolescent females themselves who were engaging in SIB (e.g., wrist cutting, burning). As I continued in my doctoral program, I became more interested in SIB among the adult female population. I began to question whether they continued to engage in SIB after high school and whether they were more apt at this later age to better articulate the "meaning" of SIB as they contemplated their own childhood, adolescence, and now emerging adulthood and later adulthood.

The subject matter of SIB piqued my interest to the point that I decided to pursue SIB as an area of dissertation research in order to gain an understanding of the meaning of SIB from the perspective of the adult female. Thus, I selected a qualitative phenomenological research methodology to answer this inquiry (Creswell, 1998; Denzin & Lincoln, 2005; Ponterotto, 2005; Spinelli, 2005).

Research Methodology

Qualitative Research Strategy

The qualitative research approach is recognized as a valid scientific methodology (Camic, Rhodes, & Yardley, 2003; Creswell, 1998; Denzin & Lincoln, 2005; Ponterotto, 2005). Qualitative studies typically use small samples rather than large-scale samples (quantitative), are interpretive, context-specific, and center on the verbal and visual rather than on statistical-inquiry procedures.

Moreover, qualitative inquiry aims to "develop transferable theories, rather than generalizable ones" (Silverstein, Auerbach, & Levant, 2006, p. 352). For that reason, the aim in qualitative research is to describe and interpret rather than generalize from a sample to the population (Brown & Lent, 2000; Camic et al., 2003; Creswell, 1998; Denzin & Lincoln, 2005; Ponterotto, 2005; Smith & Peck, 2004).

In addition, Creswell (1998) delineated five qualitative research methodologies (i.e., biography, case study, ethnography, grounded theory, and phenomenology) by which to conduct qualitative research. The perspective used in this study was a phenomenological approach, specifically, of the Heideggerian hermeneutic-interpretive tradition (Cohen et al., 2000; Crist & Tanner, 2003, McCall, 1983; Spinelli, 2005).

Hermeneutic

Hermeneutic denotes the understanding of the works of human beings; uncovers the meaning of existence, and is grounded in interpretation (Creswell, 2007; Inwood, 1999; Packer & Addison, 1989; Palmer, 1969; Richardson, Fowers, & Guignon, 1999; Schleiermacher, 1998). Likewise, hermeneutic phenomenology is the study of how human beings "interpret their lives and make meaning out of what they experience" (Cohen et al., 2000, p. 5).

In addition, a part of the Heideggerian-hermeneutic phenomenological process is the hermeneutic circle. The premise behind the hermeneutic circle suggests that there is circularity to understanding and suggests that people understand from what they already know (Kezar, 2000). As a result, the hermeneutic circle is a working out of possibilities that consists of a process toward understanding. For instance, "the more we engage the

topic in reflection and practice, the deeper we come to know. Understanding develops as we become more engaged and concerned, through repeated experience, interaction with the issue in the real world, and reflection" (Kezar, p. 387).

Human Science

According to Kendler (2005), there are at least two distinct divisions in the realm of scientific methodology. One is natural science (e.g., physics, chemistry, biology) and the other is human science (e.g., understanding of meanings and uniqueness of each human being). Consequently, phenomenological research is not a natural but a human-science approach because it looks to explore the composition of conscious meaning (Van Manen, 1990).

Research Design

Phenomenological research seeks to capture the meaning of the phenomenon under investigation by carefully selecting participants who have experienced the phenomenon (Addison, 1989). Phenomenology is a search for wisdom as conceptualized by the Greeks, as contrasted from the empirical-science approach (Creswell, 1998). In addition, phenomenology is categorized as either a descriptive (Husserlian) or interpretive (Heideggerian) approach (Hein & Austin, 2001; Laverty, 2003).

Phenomenology is the study of the lived experience—the way things (phenomena) appear—and seeks to discover the core of conscious experience; it precedes all natural science (Cohen et al., 2000; Giorgi, 1985; Kendler, 2005; Sokolowski, 2000). Phenomenology is also considered a scientific way of answering questions, "Choosing a natural science [nonhuman] approach to psychology segments a part of inner experience

to meet the discipline's methodological requirements" (Kendler, p. 320). According to Van Manen (1990), the justification for the phenomenological method as a valid scientific method is based on the supposition that, "Phenomenology is scientific in a broad sense, since it is a systematic, explicit, self-critical, and an intersubjective study of its subject matter of the lived experience" (p. 11).

The role of the researcher

Unlike the role of the researcher in a quantitative research study (i.e., reductionism, isolation/separation from the participants) that strives for a more neutral stance, the role of the qualitative researcher in this study requires interaction with each participant to obtain a more in-depth understanding of the SIB phenomenon as each participant experienced it (Creswell, 2003, 2007). The researcher's views are taken in the context of his experiences in order to gain a clearer understanding of the biases that exist. The researcher in this study is a licensed school psychologist who has worked in the public sector serving the psychosocial needs of children, adolescents, and families, including those pre-adolescents and adolescents who engage in SIB. Therefore, this researcher's views are based on his own unique experiences which influenced the questions the interviewees were asked based on the researcher's professional opinion about what was most relevant to ask, the analyses of the interpretation of data, and the integration of the findings for social change.

Phenomenology Scholars

The philosophy-of-science foundation of a study holds considerable importance in scientific research (Ponterotto, 2005). This particular research study's philosophical

foundation was based on the philosophy of Heidegger. A contrast and comparison is provided between Husserl (originator of phenomenology) and Heidegger (a student of Husserl).

Martin Heidegger

The aim of conducting a Heideggerian-hermeneutic phenomenological study is to interpret data from the text of the participants' transcripts and examine them for common meanings from their lived experiences (Wilson & Hutchinson, 1991). This is reinforced by Heidegger's (1959/1969) definition for meditative thinking, that "contemplates the meaning which reigns in everything that is. Meditative thinking demands us not to cling one-sidedly to a single idea, nor to run down a one-track course of ideas" (pp. 46–53). Heidegger (1954/1968) further proposed,

> For all true thought remains open to more than one interpretation—and this by reason of its nature. Rather, multiplicity of meanings is the element in which all thought must move in order to be strict thought. Therefore, we always must seek out thinking, and its burden of thought, in the element of its multiple meanings, else everything will remain closed (p. 71).

Unlike the Husserlian stance (Giorgi, 1985; Moustakas, 1994), a Heideggerian-hermeneutic phenomenological perspective "does not require the researchers to bracket their own preconceptions or theories during the process" (Crist & Tanner, 2003, p. 203). Accordingly, the interpretive standpoint believes that one cannot leave interpretation out of the research merely by bracketing one's preconceived notions and nothing can be stumbled upon without a point of reference to an individual's background-historic understanding (Laverty, 2003). Therefore, discovering meaning and arriving at an understanding of why it is that females engage in SIB was the crux of this research and

aligns with a Heideggerian-hermeneutic phenomenological theoretical viewpoint (Crist & Tanner).

Daseinsanalysis

A psychotherapeutic method based on Heidegger's philosophy entitled *Daseinsanalysis* was developed and used by Boss (1963), a Swiss psychiatrist. The term *Dasein* means human existence and each human is considered a futural being with potential possibilities (Heidegger, 1926/1962). As a result, Dasein is ultimately bound to their possibilities (Heidegger, 1931/2002). The term's meaning, in contrast, is equivalent to the experiences Dasein has (Heidegger, 1953/2000) and *Being* is a process that unfolds and appears to emerge from concealment into unconcealment (Heidegger, 1953/2000).

As a result, a majority of mental health issues would be seen as the individual not realizing their possibilities. What's more, Heidegger's (1926/1962) claim, "because Dasein is lost in the 'They', it must first find itself. In order to find itself at all, it must be 'shown' to itself in its possible authenticity" (p. 313) hints at existentialism, contextualism, and self-psychology elements, apart from an entire psychodynamic viewpoint such as Daseinsanalysis (Boss, 1963). On the whole, Heidegger's philosophy can be incorporated with other psychotherapy theories or its own novel model.

> Similarly, Inwood (1999) explained *They* from a Heideggerian perspective: Dasein constantly measures itself against others, trying to keep up with them, catch them or outdo them. We always have an eye on what others are doing and how they are doing it. Hence what we do and how we do it is mostly determined by others (p. 212).

Further, when Dasein believes that something is not possible when it really is possible, depression could develop. Heidegger (1953/2000) also suggested that it is due

to a *spiritual* decline that human beings have lost the strength of the possibility to acknowledge a decline that could prove fateful. SIB is both a phenomenon of Dasein as well as one possible way to exist as Dasein. Therefore, from a Heideggerian-hermeneutic phenomenological research perspective, it is of paramount importance to acquire from each participant a sense of the world and the future. It should be further noted that philosophical terms have the potential to open up more subjective avenues of interpretation. Therefore, a crosscheck was conducted with, "A Heidegger Dictionary" for accuracy, added understanding, and validity (Inwood, 1999).

Edmund Husserl (Husserlian)

Husserl is considered the founder of phenomenology, originally a mathematician who crossed over to the field of philosophy (Laverty, 2003). Heidegger, in contrast, began his studies in the field of theology and crossed over to philosophy, Husserl's most prized and accomplished student (Moran, 2000). As opposed to the Heideggerian view, the Husserlian position is descriptive in nature and requires the researcher to bracket (i.e., suspend judgment) any presuppositions an individual may have (Hein & Austin, 2001).

Participants of the Study

In order to maintain the ethical integrity of the study, permission was sought from the Institutional Review Board. Approval number 02-22-08-0060980 was secured from Walden University IRB.

Sample

Eighteen female respondents who had a history of SIB and were at least 18-years of age were selected using a purposive-snowball sampling technique (Creswell, 1998;

Gay & Airasian, 2003, Oppermann, 2004; Trochim, 2001). A snowball technique is a procedure where the participant is encouraged at the conclusion of the interview to let others know who might be eligible and have an interest in participating. The participants were chosen from around the world using Internet technology (i.e., SIB message boards) by means of SurveyMonkey technology (http://www.surveymonkey.com/). The data became saturated with the 18 participants who engaged in the e-mail interviews. Therefore, the basis for the understanding of SIB was drawn from the in-depth e-mail interviews of the 18 participants sampled (Creswell, 2007). All participant data was kept confidential and will be stored in a locked, metal, fireproof box at the researcher's place of residence for a 5-year period before being destroyed.

Further, most of the literature uses samples of patients from clinics or hospitals or college campuses; this investigator believes sampling in isolation from an expanded environment that encompasses populations beyond the typical environments sampled in the current research literature may provide a unique theoretical perspective on adult female SIB. This sampling method gave "a voice" to those individuals who engage in SIB, who perhaps would not typically partake in face-to-face interviews or divulge that they engage or have engaged in SIB to present their meaning and experiences with SIB. Further, the present sample was not enticed by rewards such as extra credit for a college or university course or financial remuneration.

Selection of Participants

Participants were obtained through a convenience sample by means of SIB Websites/message boards on the Internet. This process was initiated by advertisements on

SIB Websites and message boards indicating voluntary participation for SIB research (Gay & Airasian, 2003). The researcher, a practicing licensed school psychologist with mental health training in addition to what has been gained in the current PhD program of study, followed the ethical guidelines outlined by the American Psychological Association Code of Ethics (Fisher, 2003). Participation was strictly voluntary and no remuneration of any kind was provided to the participants.

Data-Collection Method

The purpose of this research study was to gain an understanding of the adult females' experiences of SIB using Internet technology (i.e., e-mail questioning). For this particular study, SIB as conceptualized by Favazza (1998; wrist cutting, burning) was the criterion for participation in the study. A semistructured life world interview through e–mail correspondence was put into practice (Kvale, 1996). The interview protocol is listed in Appendix A. Participants provided the collected data directly into the survey monkey website. In addition to answering the questions identified by the researcher, participants were able to add additional information. Responses were compiled and themed to identify categories. Categories were combined into concepts. These procedures were subjected to verification for trustworthiness including credibility, transferability, dependability and confirmability (Lincoln and Guba, 1985, Creswell, 1997).

Further, as noted in the previous section, meeting full criteria for participation in this study included: (a) being female; (b) having a history of perpetual engagement or have engaged in SIB; and (c) being at least 18 years of age. In addition, populations excluded were males, females under the age of 18 years, pregnant women, a resident in

any facility (e.g., prisoners, juvenile detention centers, nursing homes, mental health facilities, and rehabilitation), not speaking English, and being elderly (65+). Interviews were conducted through e-mail correspondence over the Internet. The researcher used the "cut and paste" functions of the computer to obtain a transcript of each interview.

Research Questions

The purpose of this qualitative research study was to examine the adult female's interpretation of her historical experience of SIB using her own words. Therefore, no research hypotheses are presented. The broad research question guiding this study was: *What is the experience of SIB from the perspective of a woman who has engaged in this behavior?* From this broad question several, more specific, questions were derived and are listed in this section. Accordingly, the following inquiries about the participants' past behaviors were proposed:

1. Why do you engage or have you engaged in self-injurious behavior (SIB)?
2. How often do or did you engage in SIB?
3. What does engaging in SIB accomplish for you?
4. What is it like for you to engage in SIB?
5. What method(s) do you usually use?
6. Why do you choose one method over another?
7. When are you most likely to engage in SIB during the year?
8. How do you think you could stop engaging in SIB?
9. What does engaging in SIB mean to you?

10. Can you identify any uninviting or significant events that may have happened to you during your lifetime?

Ethical Protection of Participants

The American Psychological Association's (APA) Ethical Code (Fisher, 2003) and the *Guidelines for Psychological Practice with Girls and Women* (APA, 2007) were followed.

All participant involvement in the study was on a volunteer basis only and consent forms were used (see Appendix B). There was risk and potential harm involved in the study because personal questions were asked during the interviews and distressing emotional subject matter occasionally was brought to the surface. Therefore, use of "911," local hospital emergency walk-in, local mental health agencies emergency walk-in, or personal therapists (if the client has one) were encouraged at all times. All participant information was kept confidential in a locked, metal, fireproof box at the researcher's residence. All participant data will be destroyed after a 5-year period.

In addition, all three dissertation committee members had access to each of the 18 participant transcripts that were analyzed for meaning. However, mainly the primary researcher completed the analysis. The dissertation research chairperson (Dr. Tiffany Rush-Wilson) completed a dependability check and submitted it to the primary researcher for final analysis. This process is called the, "hermeneutic circle" (Kezar, 2000). It should also be noted that member checking (Creswell, 1998) was used and therefore follow-up interviews conducted.

All consent forms and transcripts are stored in a locked fireproof box at the researcher's home. Any identifying information of the participants on any electronic communication were deleted and changed to, "Participant 1, 2, 3, etc." before the dissertation committee reviewed them. This procedure further ensured the confidentiality of the participants.

Procedures

The following research strategies were used:

First, females, 18 years of age and older with a history of SIB were contacted through the use of Internet technology, posted on SIB Websites/message boards advertising participation for a study on SIB. All interested participants were instructed to "link" onto the study's Website hosted by SurveyMonkey, complete the research form confirming that eligibility criteria were met, and electronically sign/click consent forms when completed (Appendix B). The researcher could view on the SurveyMonkey Website each of the participants' data. The consent form on SurveyMonkey provided an efficient means of simply "clicking" agree or not agree to participate and allowing the participant to easily understand what the study entailed. Risks and issues of confidentiality were also presented in the consent form.

Secondly, participant questionnaires were engaged through e-mail correspondence. After the participant completed the consent form (Appendix B) and interview questionnaire (Appendix A), two final questions asked each participant if she would like to continue to participate in an e-mail interview. If the participant indicated that she did, the participant was to provide her e-mail address for follow-up email

correspondence, thereby allowing each participant to voluntarily participate in an e-mail process where questions and responses were communicated through e-mail between the researcher and the participant. This process continued until a "saturation" point was met for each participant.

Third, at the completion of each e-mail correspondence, each participant was encouraged to recommend this study to others she knows that met the criterion for this study. This created a "snowball effect" sampling procedure.

Fourth, transcription of each interview involved the Microsoft Word "cut and paste" procedures. Since all interviews were conducted through e-mail correspondence, the researcher was able to rapidly and efficiently move through the transcription stage and into the analysis stage.

Finally, each of the participants' transcripts was assigned a code (e.g., participant 1, 2, 3, etc.) to enhance confidentiality. The researcher's dissertation chairperson (Dr. Tiffany Rush-Wilson) received a copy of each transcript to analyze and provide comments. In addition, the remaining committee members (i.e., methods and content experts) were also able to address transcripts for analysis as warranted. The final analyses were conducted by the primary researcher.

Data Collection

A semistructured life world interview (Kvale, 1996) was used. All communication was conducted through e-mail-interview correspondence over the Internet (Cook & Doyle, 2002; Kenardy et al., 2003; Leibert et al., 2006). All online communications were saved through a "cut and paste" procedure and put into a Microsoft word document for

transcription and analysis. Interviews were not conducted in real time and several e-mail correspondence interviews ensued with each participant (Seidman, 1991).

Data Analysis

Each of the participants' replies was "copy and pasted" from the electronic communication (i.e., e-mail) and put into a Microsoft Word document as a verbatim transcript for a written text analysis. In view of the fact that this is a hermeneutic interpretive phenomenological study, no bracketing techniques were used (Johnson, 2000; Lowes & Prowse, 2001). Crist and Tanner (2003) described this procedure as follows:

> The research process includes the significance of the existing world and its meanings for the investigator and the interpretive team; hermeneutic interpretive phenomenology's philosophical framework acknowledges that people are inextricably situated in their worlds. Recognizing assumptions made by the interpretive team [or individual] has been described as the forward arc of the hermeneutic circle and the interpretation as the return arc—the movement of uncovering of the circle (p. 203).
>
> As a result, the narratives of the transcribed interviews were examined alongside the researcher's interpretation in the confines of the interviewee's particular story. Reliability in the Heideggerian-hermeneutic phenomenological method according to L. M. Brown, Tappan, Gilligan, Miller, and Argyris (1989) is: The ability of two or more different interpreters to agree on their interpretation and understanding of a particular interview narrative. … The establishment of such agreement among interpreters (i.e., "interpretive agreement") creates a common ground for conversing about the data in question; it assumes that, within acceptable limits, both are reading the text in the same way, or interpreting the same text (p.156).

Data Interpretation

Each line of every participant's transcribed replies was reviewed and analyzed. The researcher noted unclear information in the narrative and participant follow-up ensued. Interpretation always remains open to new research questions (Benner, Tanner, & Chesla, 1996). During the continuation of this process, central concerns and important

themes and meanings were sought after through a procedure of the researcher's writing and rewriting of emerging interpretations of each transcribed interview.

The themes from the participant responses were selected by exemplars that occurred across these interviews after transcription by the researcher and the interpretive team. Consequently, the strategy was to parcel out the similar-meaning units from the participant answers as they related to the purpose of SIB for each individual. Next, shared-meaning units were cited from each of the participant interviews from the researcher and the interpretive team (Crist & Tanner, 2003).

This process entailed an ongoing interpretation with the objective of finding shared meanings for the participant replies based on the researcher's and the interpretive team's appraisal. The result was the meaning of SIB for the sample selected. Furthermore, the researcher continually sought shared meanings in and across narratives. Final analyses and in-depth interpretations containing the central themes and meanings were produced. Hence, the overall aim was to provide a deep, rich understanding of the phenomenon of SIB.

Verification of Findings

Verification of findings involved peer review, clarifying researcher bias, and member checking (Creswell, 1998, 2007). Furthermore, the researcher for this study had taken *PSYC 8310-Qualitative Analysis* at Walden University; the researcher's dissertation chairperson was involved in the hermeneutic circle (Crist & Tanner, 2003); the methods expert on the researcher's dissertation committee has expertise in qualitative research methodology; and the researcher is a licensed school psychologist. All individuals

involved in the validation-process procedures adhered to the American Psychological Association's (APA) Ethical Code of Conduct (Fisher, 2003) and Walden University's ethical code as put forth by the IRB.

The researcher's dissertation chairperson analyzed the interviewee transcripts in their entirety, making comments throughout the transcript, and then provided an interpretative synopsis to the lead researcher for an integrative analysis. Member checking with the interviewees then ensued and then the lead researcher commenced a final integrative analysis (Crist & Tanner, 2003). The dissertation committee identified overall core-meaning themes from the interview narratives and the dissertation-committee synopses. Interpretation is the main element in a Heideggerian-hermeneutic phenomenological research study where it is repetitive or cyclical rather than linear. Hence, the philosophic keystone is that one cannot bracket their biases but only become more aware of them through continual interpretation in a hermeneutic circle (Crist & Tanner, 2003).

Dissemination of Findings

The use of electronic technology (e.g., list serves, Websites, instructional CD videos, electronic newsletters), book binding (transforming this dissertation research into a book), a copy of this dissertation submitted to UMI, and publishing the findings in a peer-reviewed journal will be used in the distribution of research findings. In general, the purpose is to reach practitioners and researchers who may be able to use the data to inform clinical practice and further research in the area of SIB.

Analysis and Potential Confounding Variables

The main confounding variables include convenience sampling (i.e., not a representative or random-sampling method), lack of generalizability, and exclusivity of the sample due to the constructs of meaning themes for this particular sample (Gay & Airasian, 2003). As these concerns arose, they were addressed and described within the context of this study.

Summary

A Heideggerian-hermeneutic phenomenological research methodology was selected as the most appropriate procedure for examining the meaning of SIB among adult females 18 and over who have a history of SIB (Creswell, 1998; Crist & Tanner, 2003). The sample of participants obtained for this study included a convenience sample of adult females who are, or who have in the past engaged in SIB such as wrist cutting and burning (Favazza, 1998). Data was collected through a semistructured life world interview (Kvale, 1996) by means of the Internet through e-mail correspondence (Cook & Doyle, 2002; Kenardy et al., 2003; Layne & Hohenshil, 2005; Leibert et al., 2006; Mallen et al., 2005; Reynolds & Stiles, 2006). The data were analyzed by the dissertation chairperson and the lead researcher in a hermeneutic circle (Kezar, 2000), and examined by the lead researcher for a final analysis. In addition, clarifying researcher bias, member checking and peer review were used for verification (Creswell, 1998, 2007).

The Ethical Code of the APA (Fisher, 2003) was implemented. Positive social-change results comprise SIB theoretical advancement, educating individuals and clients on SIB, and enhancing future research endeavors pertaining to SIB.

CHAPTER 4: RESULTS

Introduction

This chapter outlines the findings derived from completing this study. Using internet technology, with its inherent advantage of potential anonymity, participants provided responses to several specific questions derived from the broad, defining question for this study. The purpose of this research was to gain an understanding for the meaning of SIB for adult females who are 18 years of age or older. This was accomplished through e-mail correspondence from the perspective of each of the participants' unique lived experiences of SIB. The intent of this discourse is to provide an interpretative account of the participants' experience and meaning of SIB. This procedure encompassed an outline of recruitment, participant profiles, data collection and storage, data analysis, data and themes verification, and summary.

Participant Profiles

Criteria and parameters for inclusion in the study reflected the following sample characteristics: all eligible participants were at least 18 years of age, female, had a history of SIB (e.g., wrist-cutting, burning, etc), were not pregnant, were not a resident in any facility (e.g., prisoners; jails or prisons, juvenile detention centers, nursing homes, mental health facilities, rehabilitation, etc.), spoke English, and were not an elderly person. The only identifying information obtained from the participants was the admission criteria for admittance into the study and their e-mail address to take part in the e-mail interviews. Despite participant background data such as ethnicity, location of residence, socioeconomic status, age, etc., not being requisite, collected or analyzed, during the interviews, several participants mentioned being enrolled in an institution of higher

education. One participant, for example, mentioned she was African American, another revealed she was Mexican and living in the United States, and several of the participants provided possible clues about residing outside the United States of America (e.g., going on "holiday," spelling of words such as "behaviour," stating she resides in England). The aim of this study was to understand and clarify the meaning of SIB from each of the participants' viewpoints and not to draw inferences from data that were beyond the criteria for admission into the study.

All participants were sampled from SIB message boards and chat rooms over the Internet. Seventy participants completed the initial interview questionnaire and 18 of the 70 of the participants (25.7%) engaged in further interviews. The basis for understanding SIB was drawn from the in-depth e-mail interviews of the 18 participants sampled and it was at this point that the data became saturated for significant SIB statements and theme clusters (Creswell, 2007).

Recruitment

Participant recruitment was initiated through an invitation posted on several SIB Internet message boards (e.g., Yahoo! Groups, MySpace, Self-Injury.net, Yahoo! Answers, and Facebook) to take part in a study on SIB (see Appendix C). A weblink to the researcher's website was included on the invitation to the study. The research website (SurveyMonkey.com) was used to develop an electronic questionnaire that included a consent form and a safety-precautions checklist (Appendixes B and D) that initially needed to be completed by each potential participant.

Next, after each participant completed the questionnaire, the researcher was able to log into the research website and view each of the participants' responses. Each completed questionnaire was reviewed to make sure that all participants provided permission or consent to participate in the study; had a safety-precautions plan; and that other admission criteria were met. At the end of each questionnaire, a request to participate with a follow-up contact was mentioned and those participants willing to partake in this portion of the study listed their e-mail addresses. Those who listed their e-mail address were sent clarifying follow-up questions based on their responses to the initial questions in the questionnaire. As a result, an e-mail contact took place. Those participants who did not have a safety-precautions plan were not eligible to take part in the follow-up process (Appendix D).

Data Collection and Storage

Data were initially collected through an online questionnaire consisting of 10 questions (Appendix A). Next, the consent form, safety-precautions form, and questionnaire were copied and pasted from the SurveyMonkey Website and put into a Microsoft Word document. An electronic file folder was then created for each participant on the researcher's USB flash drive (portable memory) along with the copied consent form, safety-precautions form, and questionnaire. Each night this USB flash drive was put in a security box and locked at the researcher's residence. Each participant's record was then labeled, "P.1, P.2, P.3, etc." A separate transcript was developed for each participant on a separate Microsoft Word document that included, at the top of the document, the participants' number (e.g., 1, 2, 3, etc.) followed by a colon and their e–

mail address. Below this information were the participants' number and the questions from the questionnaire. This document was then saved in the participants' electronic file folder. If the participant gave an e-mail address, after the transcript had been analyzed, the researcher developed individualized follow-up questions and sent these through e–mail to the participant to commence the e-mail interviews.

Data Analysis

Text Analysis

All data were analyzed according to a Heideggerian-hermeneutic interpretive phenomenological method (Crist & Tanner, 2003). This qualitative research methodology focuses on interpretation of the data rather than description and bracketing (Crist & Tanner, 2003; Moustakas, 1994). In the Heideggerian-hermeneutic tradition, the primary researcher became involved in a research circle where he was questioner, investigator, interpreter, and analyzer. The dialogue between researcher and participant was fostered by the e-mail-interviewing method contributing to the Heideggerian-hermeneutic interpretive phenomenological process (Crist & Tanner, 2003). Even though the use of e-mail interviewing is unique to this particular study, the field of psychology and counseling in particular are using Internet technology to provide psychological counseling services (Reese, Conoley, & Brossart, 2002).

Each transcript and all e-mail interviews were printed, and a manila file folder created for each participant with their number (i.e., P.1, P.2, P.3, etc) on the tab. Next, the researcher further analyzed the transcript using a red ink pen and noted specific themes in the document. When the data became saturated with recurring-meaning themes,

categories of meaning themes were then developed. Saturation was observed with recurrent meaning themes in at least 18 of the participants. Therefore, a separate electronic file folder was created. Then, several documents were created using categories that summed up the meaning themes. These themes were typed at the top of the paper. Afterward, the researcher went through each of the participants' transcripts and put the meaning themes into categories.

Security

The SurveyMonkey Website (http://www.surveymonkey.com/Default.aspx) uses secure-sockets layer (SSL) encryption for professional accounts and the researcher purchased this option to further ensure security of data. SSL allowed the researcher to send encrypted survey links to an audience. Therefore, the survey link and survey pages were encrypted during transmission from the researcher's account to the participants, and their responses were encrypted as they were delivered back into the Analyze section of the researcher's account on the SurveyMonkey Website. Additionally, the SSL encryption used by SurveyMonkey for this research study is also commonly used for online banking sites or sites that transmit secured information over the Internet. Therefore, the SSL encryption provided added assurance of the security of the data collected. This complies with the Health Insurance Portability and Accountability Act regulations.

Procedure

Initially, the data from the questionnaire and e-mail correspondence were organized and put into file folders labeled, "Participant 1, Participant 2, Participant 3,

etc." This information was also saved into electronic file folders on a USB flash drive. The researcher took the commentaries from the original questionnaire and transcribed them using the "copy and paste" tools of Microsoft Word, resulting in a more organized and approachable document (i.e., added space) to make notes during analysis. The researcher then read each transcript in its entirety and made notes forming initial codes. Next, the researcher created another virtual file folder on a USB flash drive documenting the core meaning themes into separate documents. Subsequently, the researcher read the notes from each transcription and put them into the core meaning theme documents. Finally, the core meaning files were read and reread to make sure nothing had been overlooked. From a phenomenological perspective, this whole process represented data analysis and representing, data managing, reading, memoing, interpreting, and classifying (Creswell, 1998, 2007).

Data Verification

According to Creswell (1998), "phenomenologists view verification and standards as largely related to the researcher's interpretation. To illustrate different conceptions of verification in psychological approaches to phenomenology, neither empirical nor transcendental phenomenologists place substantial emphasis on verification beyond the perspective of the researcher" (p. 207). Verification procedures used in this study-included clarifying research bias, member checking, and peer review (Creswell, 2007; Leech & Onwuegbuzie, 2007).

First, the primary researcher provided information to participants and clarified biases by outlining personal experiences with SIB and then conducted a wide-ranging

literature review on SIB (see chapter 2). This procedure elucidated the context and understanding the primary researcher had with SIB and provided illumination of potential bias during the interpretation process. The primary researcher's dissertation chairperson (Tiffany Rush-Wilson, PhD) participated in the peer-review process and reviewed the data as a triangulation strategy. This verification technique allows for an external check on the research process by asking questions about the research process and about the findings, being a good listener for the researcher, and taking the position of "devil's advocate" (i.e., critical examiner). In addition, the primary researcher engaged in member checking with participants. After transcription and analysis, the researcher was able to follow-up with participants and obtain their feedback and clarification on the themes and meanings that emerged from the study.

Research Questions

Seventy participants completed the initial interview questionnaire and 18 of those 70 participants engaged in further e-mail interviews. It is quite possible that this discrepancy is due to the participants being uncomfortable delving deeper into this topic. The data became saturated with the 18 participants who engaged in the e-mail interviews. Therefore, the basis for the understanding of SIB was drawn from the in-depth e-mail interviews of the 18 participants sampled (Creswell, 2007).

The aim of this section is to present the collective participant responses to each of the research questions. Subsequently, an exhaustive account of the emerging themes from the interviews is presented. Moreover, the themes that emerged are based on the

interviews in their entirety, whereas, the initial responses are based on the research questions only.

Ten research questions were asked of each of the 18 participants and significant statements about SIB were parceled out from each of the participants' responses. These questions were derived from the broad question underlying this study: What is the experience of SIB from the perspective of a woman who has actively engaged in this behavior? Based on the participant responses, the following synopsis is provided directly from participant- data after they emerged to answer each of the questions. The following are remarks compiled from all 18 participants:

Why do you engage or have engaged in self-injurious behavior (SIB)?

In general, the participants engage in SIB as a coping mechanism due to overwhelming emotions or lack of emotion associated with perceived trauma. The following data was taken directly from the 18 participants' included after the data emerged in reaction to this particular research question:

1. It's the only way to ease the pressure, stress, anger, and sadness
2. It's the best and quickest way for me to release emotions
3. It calms and soothes me
4. To cope with stress and depression
5. My mother taught me at a young age that [self-injury] was a proper coping mechanism
6. It can be a stress reliever
7. A form of punishment

8. A form of distraction
9. When I become overwhelmed with strong feelings, I self-injure to calm me
10. It's the control
11. I was suffering from depression and it helped me to cope
12. I use it as a coping mechanism
13. I do it to punish myself
14. To stop thinking, to stop feeling, to vent anger
15. Because I am lonely and sometimes I even do it so I can enjoy caring for the wounds afterwards
16. I find myself unable to communicate or express intense emotions in any other way
17. I am full of so much fear that I may upset or hurt others by showing how I feel that I have to just stop the emotion completely
18. It was the best way to materialize my feelings
19. The pain was very focusing
20. I tend to burn when I feel anxious about my life or have recollections of sexual abuse I encountered in the past—it helps me calm down
21. As a method of coping with difficult emotions and stressful events in my life
22. SIB started as a refocusing tool

23. When I needed to slow rapid thoughts I would injure to focus all of my attention on one thing
24. Other times I felt numb and I injured to make sure I was alive
25. To balance out what was inside of me
26. I am either so numb and emotionless for so long that bleeding reminds me I'm alive or I feel so out of control inside and cutting quiets the demons

How Often Do or Did You Engage in SIB?

The frequency of engaging in SIB was particularly variable among the participants with no common pattern emerging. The following data are taken directly from the 18 participants in the study after the data emerged in reaction to this particular research question:

1. Once a year to once per week
2. Several times per day
3. Daily, weekly, monthly…depends
4. One session a day resulting in anywhere from 1–100 cuts on my body
5. Three times a month
6. Once a month to three days straight
7. Once a day to once a month
8. Three days in a row
9. Twice a day to every two days
10. Varies on stress levels
11. Twice per week to ten times per week

12. A daily activity for me to four times per month
13. I self-harm most days—especially during stressful periods
14. Roughly every 4–7 days
15. Once or twice per month in response to stress
16. I injured for about 8 years
17. Injuring a couple of times per month
18. It comes and goes in waves. … I can do well for months at a time and then sometimes for weeks I will cut everyday

What Does Engaging in SIB Accomplish For You?

Overall, engaging in SIB was a form of affect regulation to feel more in control as well as a coping mechanism to turn the emotional pain into physical pain so it can be tolerated, as a punishment for perceived wrongdoing. The following data were taken directly from the 18 participants after the data emerged in reaction to this particular research question:

1. It makes me feel a little bit better
2. Disgusted and ashamed for doing it again
3. It distracts me from emotional pain which is intolerable to physical pain which is tolerable
4. It soothes me and sedates me
5. It calms me
6. It makes the negative emotions become manageable

7. It would remind me that I didn't do something properly and I deserved pain for it
8. It helps me feel in control of my chaotic world and not the unbearable mix of emotions that try to overwhelm me sometimes
9. It helps relieve some of the tension
10. A feeling of release, calm, reminders of existence—if I can feel pain I must be alive
11. It reduces feelings of fear and panic
12. I cut to take away the emotional pain and replace it with physical
13. I cut to stop the endless thoughts swirling around in my head and to take away the scared panicky feelings
14. It decreases suicidal thoughts
15. I cut because I can imagine all my problems are flowing out of me with the blood
16. Most important for me it diffuses the anger I feel toward myself—after cutting the anger just kind of flows away
17. I am able to achieve some form of escape by focusing on the pain I am inflicting as opposed to the situation that caused it and it allows me to punish myself and reinforce a sense of self-loathing
18. Engaging in SIB keeps me from doing much more drastic harm to myself
19. It focuses me and calms me down
20. It calms me down and allows me to feel relief

21. It distracts me from my thoughts that I can't deal with at times
22. Release of strong emotions—a way of releasing stress and a method of grounding myself and reminding myself I'm alive and I have survived painful events in my life
23. Injuring accomplished the task of setting a balance: when I felt dirty it made me less tainted, when I was "bad" it was the punishment, when I had racing thoughts it was calming
24. I can feel the tension or self-loathing or whatever may be eating at me most of that day just wash away as the blood flows from my arms and I regain control

What Is It Like For You To Engage in SIB?

In most cases, to engage in SIB functions as a way to cope with overwhelming thoughts. The feeling of engaging in SIB is a discharge of the overwhelming thoughts that results in calming their emotions and thoughts. Engaging in SIB for some who dissociate means feeling no pain, whereas those individuals who do feel pain do not seem to be in a dissociative state of mind. The following data is taken directly from the 18 participants after the data emerged in reaction to this particular research question:

1. It makes me feel better, less bad; it feels like a great release, it's a bit surreal
2. I usually think I'm so clear-headed during the act but the time I was caught the other person told me that I didn't respond and that I seemed to be out of it

3. Different situations resulted in different feelings
4. It's hard because most people don't SI, so I'm isolated and add to that being a Black women SI'ing and it's laughable how alone you feel because such a thing is considered a White thing
5. I just know that it is the only solution at the time and I don't go into it with any motive other than to get rid of the other emotions I can't control
6. It's relieving and every time it feels like I've conquered a fear and I'll live another day, at the time it is the only thing I can think of doing and it's like nothing else exists
7. It's a special secret
8. It is an adrenaline rush and a sense of empowerment and I feel in control of my actions and emotions
9. I feel strong and brave like no one can hurt me
10. It is a bit like I imagine drugs would be where you are detached from the action and can almost watch yourself performing the injurious act like a film
11. It starts with different feelings usually rage or despair
12. When I decide to cut I start to feel a little more calm because I've decided on an action that will end the bad feelings
13. Once I get the bandages on I feel safe and cared for
14. Once I start cutting I focus so much on the act of cutting that everything else starts to slip away—then as the blood flows the calm sets in

15. It started out being a relaxing thing but towards the end of my cutting I was really out of control and didn't feel pain at that point just relaxed
16. It's been a way to help get rid of the thoughts I can't cope with
17. Shameful, secretive guilty behaviour that needs to be hidden but also feels like I have been given an injection of diazepam that calms and numbs
18. Injuring is a rush like a high
19. The pain wasn't always the goal though—it was more about overcoming the pain to convince myself that I was ok again

What Method(S) Do You Usually Use?

The most popular cutting implement was a razor blade to incise the skin. Other methods such as burning and the use of a hammer to strike oneself have occurred when the individual has been engaging in SIB awhile and it reaches a more extreme point. The following data are taken directly from the 18 participants after the data emerged in reaction to this particular research question:

1. Scissors, knives, earrings
2. I usually cut myself with a razor blade
3. My main method was cutting but I also burned myself or hit myself
4. Overdoses were used as a method of self-injury a few times
5. Salting (i.e., ice and salt used together to create a burn of sorts)
6. Cutting with random objects from safety pins to knives to broken glass
7. If I am desperate for a fix it's likely I'll reach for the closest sharp object

8. I engaged in pinching, scratching, slapping but I really never thought of it as SI because it didn't leave lasting marks
9. Scalpel
10. I used to draw blood with needle and syringes
11. I burnt with a lighter
12. Slammed my arm in a sliding door
13. Punched a brick wall till I bled and experimented with sutures
14. I am constantly purging and starving myself (I also have anorexia nervosa)
15. I overdosed a couple of times although that can be perceived as suicide related
16. Bit holes inside my cheeks
17. Scratch my skin raw
18. Pull out hair on my body
19. I started with hitting
20. I started cutting with a piece from a broken piece of pottery I smashed out of anger
21. I found that I preferred glass (mirror) over anything
22. I believe that it was "hammering" that really prompted me to get help—I didn't start hammering until near the end of my self-inuring phase but that was perhaps the most brutal and I really could feel myself losing a battle
23. I used to pure acetone into the wounds or something to make it burn more and keep the scars

24. I used the metal of a hot lamp to burn my right shoulder and upper arm
25. Punching hard to cause bruising
26. I mostly cut with razors and burned with cigarettes, lighters, heated metal, at one point I used a hammer to bash my knees and thighs
27. A couple of times I used anything metal to scrape my skin raw (like a key)
28. Cutting preferably with a razor blade that even that has evolved over time because it started out with a serrated kitchen knife

Why Do You Choose One Method Over Another?

Generally, the sight of blood appears to initiate a calming affect as well as serving as a visual cue for both relief and a sign that one has verified proof of their pain. The following data are taken directly from the 18 participants after the data emerged in reaction to this particular research question:

1. The habit I guess
2. It's the fastest way to get blood
3. Cutting makes me bleed and I love the sight of blood
4. Once I stole syringes from my mother and used them to take my blood—this was very satisfying to me
5. Overdoses are out of curiosity and the need to hurt myself in a more permanent way
6. Burning is a way of torturing myself because the burns are third degree
7. Cutting was the only one that made me feel like I had accomplished my task of hurting myself

8. Seeing the blood was what I needed at that point
9. Convenience—it's what I have always done
10. I prefer safety pins because they are just the right amount of pain and a strangely soothing scratching noise
11. Cutting was the most effective and burning was too painful and hitting a bit violent—I had a friend in high school who had done it and I guess I got the idea from there
12. The amount of relief I get from it and how visible the damage will be (the less visible—the more appealing)
13. I find cutting with a razor to be the best because I am able to keep my cuts sterile and free from infection which is harder with burns—it also allows for blood loss—the sight of blood being calming and a visual cue that says you have succeeded and this is proof of your pain
14. Starvation is also good because it can be undetected for a short period until too much weight is lost and hospitalization is necessary
15. The only time I hit or scratch is when cutting is not an option (like when I'm at work)
16. Glass is sharper and makes you bleed more and quicker without having to press as hard and with little effort—with glass the skin doesn't pull apart it slides open and it doesn't hurt as much either in my opinion
17. I resorted to hammering because I did not want any more scars but I wanted to feel pain—hammering felt like you were going into shock

almost and all it left was a nasty bruise that you could easily lie about if someone happened to see it

18. Burning forms fairly intense scabs and I can pick at them after I burn
19. Burning was punishment and cutting was for fun and both were for stopping racing thoughts
20. Cutting was when I felt dirty
21. I need to see blood—the more the better and nothing else gives you blood quite like cutting

When Are You Most Likely to Engage in SIB During the Year?

The majority of the participants maintained that it was easier to hide their scars during the fall and winter months. Alternatively, they may have been more prone to engaging in SIB during times of stress regardless of the time of year. The following data are taken directly from the 18 participants after the data emerged in reaction to this particular research question:

1. About everyday but the worst is around Christmas, my birthday, when I get a new job, winter and spring, no specific time of the year is worst then the rest
2. Important event days, (e.g., dates of my friends deaths or their birthdays)
3. Anniversaries of significant events that caused distress to me at that point in my life
4. Whenever the pressure builds, it can happen anytime during the year

5. Winter hands down—it's easy to hide the cuts and everyday feels just like the last
6. I'm not sure it ever changed—it is more related to stress
7. Holidays—especially if family and during periods of stress
8. When my father is sick (he has an illness related to serving in Vietnam)
9. When I have to decide what I want to do with my life
10. In relation to work or study choices which are likely precursors to my future failures
11. Winter because it is such a hard time of the year and because wounds are easier to hide but I probably cut just as much during the other seasons
12. During high school it was because of the stressors and other people
13. During the school year because it's more stressful
14. When I feel unsupported emotionally or feel abandoned by people I care about
15. If I feel that I have not lived up to my high expectation of myself
16. I injured all year
17. November, December, January, and February were trigger months because of their association with other events, early Spring

How Do You Think You Could Stop Engaging in SIB?

Addressing the underlying issues for one's SIB, creating an alternative coping mechanism for managing their emotional pain, establishing a support system, and mostly being committed to discontinuing to engage in SIB are the suggestions the participants

had for refraining from SIB. The following data was taken directly from the 18 participants after the data emerged in reaction to this particular research question:

1. Establishing a firm social support network, being somewhat comfortable with emotions, and being emotionally open and willing to confide in peers
2. Finding another outlet but I just can't find any outlet that gets rid of my emotional pain as quickly
3. I stopped because I found medication for schizophrenia
4. Years of therapy would probably be useful though I did know everything the therapists suggested but I didn't know how to apply it
5. I don't know, I'm in therapy and have been given alternatives but nothing works as quick as this [SIB]—I hope that once I've dealt with underlying issues this will go away
6. I think to quit this you'd have to be fully committed and have a real reason to quit and I think I would need someone to support me
7. It sounds silly but for me it was a spiritual thing and I made the decision to stop letting it have control and commanded it out of my life
8. Developing a support system would help although telling people is very difficult
9. Personally I think I have to find some sort of contingency within myself in the world—a sound sense of identity and develop a contentment with life that could perhaps provide some peace and acceptance within myself

10. I think the only way I will ever quit is by the willpower that comes from wanting with all my heart to quit
11. I don't think any of the alternatives my therapist has suggested work, the thing that truly stopped me from SIB was when my brother was paralyzed in a car accident
12. I have tried to go to counseling provided through my university but I have found it to be extremely unhelpful, so far I have stopped injuring but it was mostly because when I got a real job I had responsibilities and couldn't afford to be hospitalized

What Does Engaging in SIB Mean to You?

From participant accounts, SIB is a way to cope and control emotions. The following data was taken directly from the 18 participants after the data emerged in reaction to this particular research question:

1. A punishment
2. It's a way of dealing when the pain of life gets too overwhelming
3. It means I can manage my emotions
4. It's a way I can be in complete control of my body
5. It means a release, relief, and pain personified
6. Confusion
7. It means I'm obviously not capable of handling my life in a normal health way
8. Prevention from me doing something worse

9. Ashamed
10. A reliable old friend
11. A taboo coping method
12. It's a coping method
13. It's something I can consistently do to alleviate the pain or anxiety I face at times
14. It is a means by where I cope with the effects of abuse I suffered for many years
15. Failure and regression
16. SIB = dark empty hole
17. It means I am a survivor
18. Anything that causes bodily harm and is not suicidal

Can You Identify Any Uninviting/Significant Events That May Have Happened To You During Your Lifetime?

A large number of the participants had been abused (e.g., sexually, physically, emotionally) at a young age. Many other of the participants were sexually molested, raped, come from divorced parents, and had an alcoholic father. The following data was taken directly from the 18 participants after the data emerged in reaction to this particular research question:

1. Many things—the loss of people I loved when I was a kid, emotionally abused all my life at home, being bullied at school, being manipulated, raped

2. Gang-raped
3. I have an alcoholic father who was emotionally unavailable to me my whole life, I was sexually abused at the age of 4 by a relative, there was emotional/psychological abuse by my father from around the age of 10 to adulthood, my father use to self-injure in front of us, my father tried to blow-up the house
4. My parent's divorce
5. I remember everyday that any form of abuse—whether sexual, physical, emotional occurred
6. I was molested when I was 4 and 5 by a family friend's child and by a sibling
7. Sexually assaulted by boys
8. I've had things happen from childhood to the present that has made my self-esteem non-existent
9. My parents moved around a lot when I was younger and I went to 12 different schools
10. My parents divorcing
11. University stress, actually getting depression and having to cope with it is probably the most disturbing thing that has ever happened to me
12. Physical and emotional abuse by mother from a young age, sexual abuse at 15, marriage breakdown at 24

13. Two emotionally distant parents who never seemed to have any negative emotions and I was sexually abused as a child
14. I found my uncle in his bed after a fatal stroke
15. I grew up with an alcoholic father, parents divorcing at an early age, mother living far away and never seeing us except once every other year
16. Encountering racism in a rich white school, remarriage of both parents, step siblings added to the family, I was sexually abused and come from a home with an alcoholic father
17. Childhood sexual abuse from 5 to 16 years old
18. Domestic violence rape death of a parent at a very young age
19. When I was 5 I was violently attacked and molested by my babysitter's son when she wasn't home, when I was 14 a "friend" raped me
20. A friend sexually assaulted me, in college a frat brother of a guy I was seeing raped me
21. My brother was very aggressive with me growing up and was physically and sexually inappropriate
22. I have been relocated more times than I can count so I never knew people long enough to make friends and I was molested just before my teen years by a camp counselor
23. I was raped three times throughout my young adult years

Themes Identified

The purpose of this study was to understand the meaning of SIB from the perspective of the individual participants sampled through Internet-e-mail interviews. All participants were sampled from SIB message boards and chat rooms located on the Internet. An initial questionnaire reflecting the research questions was provided after consent criteria were satisfied and each participant could volunteer their e-mail address to partake in the internet e-mail process. Eighteen out of the 70 participants choose to participate in the e-mail process. This questionnaire provided the foundation for the in-depth questioning. Each of the participants' remarks was analyzed for admission criteria (e.g., consent to participate, completion of the safety precautions, and e-mail address for following-up interview). After the individuals were determined to have met the admission criteria, the researcher provided detailed follow-up questions based on their remarks in the initial interview questionnaire reflecting the research questions. As a result, the researcher tailored each follow-up question based on each of the participants' individualized responses.

After rereading the text of each participant transcript thoroughly, seven themes became saturated based on the research questions and participant replies: stress and coping, control, affect regulation, perceived trauma, addiction, punishment, and rejection. In order for a theme to be identified the researcher determined that a majority of responses endorsing a particular theme would determine its appearance in the study. The minority of the participants' remarks that did not merge on the major themes identified were noted as "discrepant findings."

Verification procedures used in this study-included clarifying researcher bias, peer review/debriefing, transcripts reviewed by dissertation chair/advisor, and member checking (Creswell, 2007; Leech & Onwuegbuzie, 2007). The following seven themes were salient based on the results:

Theme 1: Stress and coping. The greater part of the theme clusters revealed engaging in SIB to be a method of coping with stress (i.e., indirectly or directly). The following exemplars were documented from the participants:

1. It is a method of coping with unresolved problems and feelings
2. To relieve stress, it means that I figured out a way to cope, self injury is a way to help relieve the pain I am feeling
3. Self-injury is a negative way of coping with pain, to me it means that I am incapable of coping with trauma is a healthy way
4. I use it as a "coping mechanism" when things feel out of control in my life
5. Burning is a way to cope with this recollection of past abuse
6. It's just that some of us don't quite find the right way to cope
7. A method of coping with difficult emotions and stressful events in my life
8. It is a means by where I cope with the effects of the abuse I suffered for many years
9. It is how I coped and still cope with intense emotions or stress
10. I think that children are too busy trying to survive that normal events in growing up and maturing are missed out and it leaves gaps in a person's ability to cope

11. It relieves the pressure, it is a way to cope, it is a stress relief, it's been a way to help get rid of the thoughts I can't cope with
12. I let the stress control my cutting, a way from the pain or stress in my life
13. The fact that I cannot deal with emotions and overcome them is directly linked to my inability to overcome past pain
14. It is embarrassing but it is a way I cope
15. It is an indirect result of stress when coupled with an individual who has
16. never been equipped with the coping mechanisms that normal individuals
17. are taught earlier in life
18. I am able to achieve some form of escape by focusing on the pain I am inflicting as opposed to the situation that caused it
19. It is a simple feeling of escape and release

Theme 2: Control. Control is a function of SIB and is used as a mechanism of taking control of the pain and keeping people from hurting them. Therefore, only they could hurt themselves. Ultimately it is a way to take away the emotional pain by causing physical pain. The following exemplars were noted:

1. It means that I have control
2. I do it to control my emotions
3. Makes me feel in control
4. Usually it's the control
5. It lets me be in control of what I want to feel
6. A controlled pain

7. It makes me feel in control
8. It's a method of control—not the unbearable mix of emotions that try to overwhelm me sometimes
9. It means I can control and get rid of my emotions
10. I have control—I can do this and you can't stop me
11. A sense of control
12. Physical pain reminds me that I am in control
13. I was looking to gain control (anticipatory or reactive) over negative feelings
14. Abuse is something that happens to you that you are unable to control and so in response to that individuals may seek self-injury as something they may exert control over
15. I believe if I would have been able to talk about things that happened to me as they happened to people who actually cared about my well-being I would have been able to express the right amount of emotion needed for that event and I wouldn't need to worry about losing control of any emotions

Theme 3: Affect regulation. A significant number of the participants indicated engaging in SIB was a way to manage or regulate their emotions. The following validate this trend:

1. There is a huge connection between the need to regulate my emotions and my cutting—I simply can't handle that much emotion

2. SIB was a way of regulating my own emotions and feeling in control of something
3. It distracts me from my emotional pain which is intolerable to physical pain which is tolerable
4. I just can't find any outlet that gets rid of my emotional pain as quickly
5. It means I can manage my emotions
6. When I become overwhelmed by strong feelings I self-injure to calm down
7. I don't go into it with any motive other than to get rid of the other emotions I can't control
8. It reduces feelings of fear and panic
9. I cut to stop the endless thoughts swirling around in my head and to take away the scared panicky feelings
10. It diffuses the anger I feel toward myself
11. I originally started cutting because I could not control my anger
12. To alleviate the pain or anxiety I face at times
13. I also have great difficulty handling my emotions and [self-injury] for me is a way of focusing on something other than this emotion

Theme 4: Perceived trauma. According to the sample drawn for this study, the data revealed a history of trauma in the form of emotional abuse, sexual abuse, physical abuse, or any combination as the underlying origin of the participants' motivation to engage in SIB. As a result, engaging in SIB acted as a coping mechanism to alleviate the

stress of intense emotions due to past trauma. The following exemplars were documented:

1. The fact that I cannot deal with emotions and overcome them is directly linked to my inability to overcome past pain
2. Emotional abuse all my life at home, being bullied at school, manipulated, and raped
3. I was gang-raped 9 years ago, but I started cutting before that, I also have an alcoholic father who was emotionally unavailable to me my whole life, I was molested as a child, I was sexually assaulted, my parents divorced at the same time
4. I was a victim of statutory rape as a teenager, I was sexually abused at the age of four by a relative as well
5. There was emotional/psychological abuse from my father from around the age of ten to adulthood and a little beyond
6. I was molested from 2 to 13 by my stepfather
7. I remember every day the form of abuse—whether sexual, physical, emotional occurred
8. I remember everything, and back in the SI days, I used to do nothing but sit and reflect upon those things—I was sexually abused by two boyfriends, I was molested when I was 4 and/or 5 by a family friend's child and by a sibling
9. As a child I was abused—emotionally, sexually

10. Parents emotional abuse, rejected by peers, abusive first boyfriend, cancer, raped, sexual assault
11. Emotional abuse and I was molested as a young child
12. Childhood sexual abuse, rape/sexual assault, emotional abuse, physical and emotional abuse by mother from very young age
13. Sexual abuse at 15
14. History of sexual abuse, rape
15. Sexual abuse as a child, rape as a teenager
16. Childhood sexual abuse (5 years–16 years) and domestic violence rape
17. Death of my mother while a young child
18. Being abused as a child for 11 years, being raped as a child and an adult, a miscarriage
19. I always want to say no to this, because I do not believe myself to have suffered trauma, regardless of what my therapist says. She tells me that the way my parents treated me was emotionally and verbally abusive and that that traumatized me. Maybe I just do not want to accept that. If I allow myself to be honest I can see a connection

Theme 5: Addiction. Several participants noted experiences of SIB to have an addictive quality (i.e., craving) where they became dependent on SIB to help them cope with their stress. The following exemplars are documented:

1. It's like an addiction
2. It means addiction

3. It got addictive
4. It is a bit like I imagine drugs would be
5. You are aware that it is wrong and harmful but you crave the high or escape so much that you ignore the fact that you will later have feelings of remorse and have to hide evidence of your dirty secret
6. I figured it was a better alternative than people who abuse drugs
7. I think it can be addicting
8. Yes, it can be addictive
9. Yes, that feeling can become addictive
10. I kept doing it because it turned into an addiction
11. Gives me a little bit of a high

Theme 6: Punishment. SIB as a form of punishment was a running theme among the participants. The following exemplars were documented:

1. A punishment
2. I need to punish myself for all those things I blame myself for
3. I punish myself for what's been done to me
4. I need nobody to hurt me, I can do it well on my own
5. It initially began as a way of punishment
6. It is a way to punish myself
7. I feel punished for things I feel guilty about
8. A form of punishment for a job not well-done
9. When I feel I need a punishment

10. I've done it as a form of punishment
11. To punish myself for something I did
12. Once I hurt myself and I feel like I've been punished enough
13. Because I'm angry and want to punish myself
14. I do it to punish myself
15. I know that I believe I need to be hurt and since there is no one around to hurt me anymore, I have to do it myself

Theme 7: Rejection. The participants' feelings of rejection were related to engaging in SIB as a way to manage their thoughts and feelings. The following exemplars were documented:

1. The only truly traumatic event in my lifetime occurred in my last two years of high school wherein all my closest friends rejected me because of a dispute over a boy and it made me feel unwanted and that was when I began to SI
2. The main reason I began cutting was the group of friend that I was in. There was a leader who controlled everything; who we dated, who we spoke to; what we did in the evenings after school and such. If one person in the group made her mad, the rest of the group was mad at that person as well because you always had to be on her side of things. After a while, you started living your life around her and not living your own life for yourself. After 3.5 years I finally stood up for myself

and left the group, but by that time I'd already been cutting for a year and knew that worked so I kept it and used it ever since

3. Adolescence is a time where you are questioning yourself a lot, and I did not have the privilege of an adult mentor to guide me through it. My parents are both emotionally absent. I have never been comfortable with expressing extreme emotion, and likewise my emotional development is still quite stilted. I should also say now that I, like much of the literature I have read in regards to S.I., had a physically present but emotionally/spiritually/parentally absent father

Discrepant Findings

Discrepant findings were defined as the minority of the participants' remarks that didn't merge on any of the major themes identified (e.g., stress and coping, control, affect regulation, perceived trauma, addiction, punishment, rejection) and under the minority count (i.e., ≤ 8).

Counseling and psychotherapy

Noteworthy dialogue during some of the interviews revolved around the use and effectiveness of counseling from the participants' perspective. The majority of the participants claim that counseling and psychotherapy were ineffective:

1. Severely ineffective. I first contacted a counselor at my high school, and then a counselor at my university. I found them to be, in layman's terms, entirely too mushy and sentimental. I had contacted my university counselor in regards to self-injury as well as some anxiety, depression, and

homicidal ideation. I felt that there was a significant therapeutic barrier that existed, in that I sensed her disgust with certain aspects of my childhood, such as the pyromania and torturing/killing of animals. She asked to see my injuries even after my explicit denial of her request within the first 10 minutes of the interview, without any attempt to establish rapport. It was not so much the timing of the request as was the tone she made the request. I gave a scathing indictment of her, the nobility of her profession, and the noticeable lack of nobility in her practice, and left after the interview. I did not return.

2. I really do not feel therapy has been very effective for me. The therapy I experienced while at my Hospital Stay at Two Rivers was probably most effective, primarily because individuals whose life experiences reflected my own, which drew us together and allowed a safe environment to express ourselves, surrounded me. Outside the hospital, therapy has proven useless.

3. In my experience, I felt as if the counselors I have sought help from have treated me as incompetent. I would consider myself as someone who is intelligent, and to have him or her seemingly treat me as incompetent made it difficult to be honest with them. If I view a counselor as incompetent, I will maneuver the conversation away from the real issues. Honestly, I need a competent counselor who treats me as an intellectual. I love to learn and love to think about things. I do not think

the counselors tapped the best way I express myself, which is through writing. I can express my feelings through writing much better than what I can express in words. I needed someone to challenge me rather than just someone to talk to every week.

4. I think the fact that they did not approach the sessions on a more intellectual basis made it feel as if were dumbing things down. It is a struggle for me to relate to people on an emotional level and to just divulge my emotions openly. To a certain extent, my brain works best with logic, and although I am not sure how I would react if confronted my own illogical actions, I would like to think that I would recognize the cognitive dissonance in my own actions and seek to change those actions. The activities or assignments they gave seemed childish and irrelevant to the issues with which I was struggling. I viewed them as one more thing to do in my life.

5. I know counselors/therapists see many clients during the day. However, when they have my file in front of them and ask me a question that is clearly in the chart, it makes it feel as if they are wasting my time. If they are ill prepared, I will be less likely to take them seriously. If they expect me to do their petty activity, I think it is fair that I should expect that they be prepared. It is easy to tell whether a counselor will challenge me or not in steering them off the real issues. They often get off track themselves. I have had conversations about grammar with a psychiatrist when we were

supposed to be discussing medication issues. It is frustrating when they cannot stay on task and that is their job. I think the fact they do not recognize that in certain situations I was forced to be there hurts my view of them too. It makes it more difficult for them to win my respect, but I think it would cause me to respect them more if they did acknowledge that.

6. I do not think any type of counseling has ever been effective. My brother's accident made me realize I needed to stop.

7. I have been in therapy for 8 months now and I do not see much of a change. My therapist says she sees progress, but I do not. If I were to quit therapy now, I would be in almost the same place I was when I began. The only real difference would be that I am not so afraid of therapy anymore. For me, the biggest benefit has been an enormous [sense] of relief at not being alone with this anymore. No one I know in real life knows about my self-injury. The thought of talking about it was terrifying and the thought of seeing a therapist added to that was nearly enough to push me over the edge. However, she was so patient and gentle (and unrelenting) that it was okay. I still have problems talking to her, but I am not terrified anymore. Knowing there is someone I can trust to discuss my SI with takes a huge weight off my shoulders. As far as my SI goes though, I am still not willing to give it up completely, although I am willing to try to go without for longer periods. Therefore, I guess there is some improvement.

8. Therapy has proved ineffective for me. I have been in clinics, locked wards, mental health centers, group therapy, individual therapy, art therapy, relaxation courses, cognitive-behavioral therapy courses and none of it helped because none of it can change me and the hate I have for myself.

Conversely, several participants indicated that counseling and psychotherapy was effective for them:

1. I think that, by and by from the knowledge I have gleaned of current attitudes of mental health professionals from literature, is fine and on the right track. Current therapists dealing with self-injurers are advised to not show disgust in their tone or manner, and to attempt to normalize it as another human being's right to a coping mechanism. I would appreciate a mental health professional were I to seek help again, to attempt to mold her technique around the patient. For example, a more emotional self-injurer may be well suited to the more sentimental approaches of the first counselor, whereas I would not. Other than that however, I think current care providers are being instructed with good information.
2. I was in counseling for many years. The therapist I had for most of the time was actually a self-injury specialist. When I went to S.A.F.E. Alternatives, they gave me his name as a contact when I left the hospital. I saw him for 5 ½ years. He was affective for me because I did not feel dirty or morbid or disturbed when I talked to him about it. He understood a lot

and knew what not to say. It was the small things that count and he understood that. He was just a great therapist in general and helped me with many issues. He kept our counseling personal yet held respectful boundaries.

3. Counseling was very useful to me in understanding that I was in no way to blame for the abuse. However, it is difficult to break free from the notion that I caused my father to hate me so much that he abused me. The only thing my therapist seems to not get is how people can stand to hurt themselves. The thing is, I do not think there is any way to understand it unless you have actually been there. Besides, I like that she does not understand that. It forces me to see things from a different perspective. She understands enough about all the reasons behind it to be effective. I think that is the most important thing—to understand why someone would intentionally hurt himself or herself, even if you cannot understand how. Of course, it is important that professionals do not think that people who SI are freaks, or suicidal, or to[o] cowardly to be suicidal. However, I do not think all the understanding in the world could make me give up SI. I have exchanged e-mails with other people who SI. While it is comforting to know that I am not alone, it does not make me want to stop. This is about how I feel about myself, not how others feel about me.
4. My therapist is very attentive, and is working with me to meet certain goals. Right now, it is not so good. We are doing ACT (Acceptance and

> Commitment Therapy). We have been talking about willingness to feel emotions and how it is ok to do so. This is causing an extreme amount of stress and discomfort and confusion and I've engaged in SIB 4 times in 4 days now (definitely the most consecutive times I've done it as an adult). I am scared the emotions will never stop. I am almost to the point of stopping therapy altogether, but do not want to let my therapist down. Anyway, I can tell therapy is effective. I just cannot connect that world with this one.

It appears that when the personality of the therapist does not correspond to the personality of the client, therapy increases its chances of being ineffective for those who engage in SIB. Several of the negative therapist factors that seem to be mismatched with the clients included attitude, tone, inability to relate to the client and genuinely understand where the client was coming from, and what they were going through emotionally. This did not seem to have been conveyed properly to the client and the clients felt like they were not being understood. Likewise, feeling understood, molding counseling and psychotherapy techniques to the client, and knowing what not to say were the positive attributes of an effective counseling and psychotherapeutic experience.

Summary

The sample consisted of 18 females who were at least 18 years of age or older who had engaged in SIB. No contextual data was obtained (e.g., ethnicity, location of residence, precise age, socioeconomic status, educational status, marital status) about participants as the researcher did not want any potential inferences to influence the study.

The participants were recruited from SIB chat rooms, message boards, and Internet forums through online Internet technology. The researcher located SIB message boards through the *Google* search engine and then contacted the SIB Website moderator to place a posting for an SIB study. Those participants willing to participate went to the SurveyMonkey research Weblink to begin the study. E-mail interviews were asynchronous and used to get at the essence of SIB for each of the participants.

Several themes emerged from the data: SIB as a way to cope and control emotions, a way to cope with overwhelming emotions from perceived trauma, a method to regulate one's affect to feel more in control, and a means to turn emotional pain into physical pain.

Chapter 5 provides an interpretation of the results, strengths, limitations, implications for social change, recommendations, and conclusions. It includes an explanation of how the findings of this study can influence social change as well as the results it may have for researchers and clinical practitioners, the limitations of the study, and how the distinctiveness of this study can contribute to move the field forward.

CHAPTER 5: INTERPRETATIONS AND CONCLUSIONS

Overview

SIB among adult females who were 18 years of age or older were interviewed to discover the meaning it had for them. SIB has a high-prevalence rate and is a strategy to call attention to oneself as well as a plea for help. The act of SIB typically suggests underlying psychological distress in an individual (Hilt, Cha, & Nolen-Hoeksema, 2008). This study added richness to the SIB literature not copied by any other existing study on the topic by going directly to the participants and obtaining their personal perspectives with SIB based on their very personal circumstances, an online study, the use of an e-mail interviews, and the selection of a unique sample, because the majority of participants would not have participated in face-to-face interviews. Several key questions were examined to understand the meaning and phenomenon of SIB for each participant (e.g., Why do you engage or have you engaged in SIB? What does engaging in SIB accomplish for you?).

This study used a qualitative research methodology rooted in a Heideggerian-hermeneutic phenomenological-human science approach using a sample ($N = 18$) of adult females (18 or more years old) who had engaged in SIB. The use of Internet technology (i.e., SurveyMonkey, e-mail, SIB Websites, SIB message boards) and e-mail interviews were implemented to uncover the meaning of SIB for each participant. Accordingly, an exhaustive examination of the research questions and themes revealed four prevailing core-meaning units in relation to the meaning of SIB (affect regulation, control, perceived trauma, stress and coping, punishment, rejection).

Interpretation of Findings

Based on the research questions and findings revealed in chapter 4, the results of this study aligned with previous and current research on SIB suggesting affect regulation, depression, and trauma are common underlying factors (Gratz, 2006; Gratz & Chapman, 2007; Heath, Toste, Nedecheva, & Charlebois, 2008; Hilt et al., 2008; Nock & Mendes, 2008; Prinstein, 2008; Shaw, 2006; Suyemoto, 1998; Weierich & Nock, 2008; White-Kress et al., 2004; Yates, 2004; Yates, Tracy, & Luthar, 2008; Yip, 2005; Zila & Kiselica, 2001;). Moreover, given that the overall premise of this particular qualitative-phenomenological research was to establish the meaning of SIB for those who have engaged in SIB (Camic et al., 2003), the following are the conclusions drawn from this research study.

Meaning-Function of Self-Injurious Behavior

In general, the meaning of SIB for this sample was a method of coping with stress (indirectly or directly) and emotions (positive or negative) as a way to regulate and control affect from perceived historical trauma. This was derived from several recurrent meaning themes: SIB as a way to cope and control emotions, the accomplishment of being more in control by turning the emotional pain in physical pain by engaging in SIB, SIB is a way to cope with overwhelming thoughts and bring one to a calmer state of mind, the sight of blood itself had a calming affect and acted like a visual cue for both relief and a sign of verification of the emotional pain.

The vast majority of the participants' indicated addressing the underlying issues, learning alternative ways of coping, establishing a support system, and being committed to stopping their engagement in SIB could have a therapeutic effect.

Heideggerian-Hermeneutic Phenomenological-Human Science Interpretation

Heidegger pictured Dasein as a futural being (1926/1962) and from this sample, the person with self-destructive tendencies does not have a positive horizon of future possibilities, nor does the person have a positive sense of self-understanding on which to build from a positive past history. Since the self as Dasein is historical, this is a place to start in the reconstruction of the self. Heidegger's Being-toward-death does not have the meaning it does for her, nor does she seem to have a positive sense of authenticity, but it would be good to have a strong value on being-in-the-world each day that is engendered by Being-toward-death. In other words, she is unable to comprehend life's possibilities within the existential realization that death is always already a part of her. If she genuinely understood this, she would make the most out of her possibilities life has to offer each and everyday. From a therapeutic standpoint, it would be important to get her sense of the world, outlook, and then to try to reconstruct her historical self in a more positive sense.

Implications for Social Change

As noted in chapter 1, the rationalization to conduct research on the phenomenon of SIB was evident through its pervasiveness in our society and the limited number of studies explaining the SIB experience with any degree of certainty directly from the experience of the individual's point of view (Kadison & DiGeronimo, 2004; Wester &

Trepal, 2005; Whitlock et al., 2006). This study supports and contributes to social change through research on the phenomenon of SIB. As a result, critical factors were explicated in chapter 4 that underlie SIB (e.g., affect regulation, coping, stress, trauma) and present a foundation for future research on assessment, evaluation, prevention, and intervention strategies for SIB. This study gave those individuals' who would not normally participant in a face-to-face interview due to fear and anxiety a voice and opportunity to discuss their experiences with SIB. The study also referenced emitic and etic perspectives of the data.

Secondly, it is quite possible that a future study could build upon the results of this study and examine the various components of SIB so prevention programs and treatment modalities could be developed to create a healthier society. Third, participants indicated specific psychotherapeutic features (e.g., a nonjudgmental attitude, not using a complacent method of counseling, respecting their intelligence) that enhanced the counseling process, particularly the ability of the therapist to convey to them an understanding of SIB as attention needing rather than attention seeking.

Further, this study provided a basis for future research that considers the role of coping, stress, and trauma as hypotheses to be examined empirically among those who engaged in SIB. In addition, given the overwhelming amount of early childhood trauma indicated by the participants, examining and empirically testing the role of such hypotheses as the emotional security theory (Crockenberg & Langrock, 2001; Davies & Cummings, 1994; Davies & Woitach, 2008; Goeke-Morey, Cummings, & Papp, 2007) could enhance future research in the SIB field. Keep in mind, the emotional-security theory "postulates that, within the emotion-laden context of interparental conflict, a

prominent goal for children is maintaining a sense of protection, safety, and security" (Davies & Woitach, p. 269). As a result, it is probable that the observation by a child of marital conflict could create stress and lead to the coping mechanism of SIB.

Another premise worthy of testing in the field of SIB is to more closely examine the attachment-SIB relationship across the life-span (Bowlby, 1969). If attachment's primary function is affect regulation and both attachment and affect regulation functions are tied into the right hemisphere of the brain (Allen & Land, 1999; Joseph, 1992; Schore, 1994, 2000, 2001, 2003a), future research should consider the role of these functions in SIB when developing prevention and treatment options. Here there is the potential for depathologizing SIB by using the term *attachment* in prevention, intervention, and future research.

An additional idea for future research is early prevention strategies to increase emotion-focused coping (Olff et al., 2007). Because the critical time frame of attachment is within the first 2 years of life, and given emotion-focused strategies are underdeveloped in young children (Schore, 1994), future longitudinal and cross-sectional research should seek to understand the effects of early prevention and the rate and intensity of occurrence of SIB, type of attachment, and affect regulation strategies used for the sample studied. It is probable that early intervention and prevention strategies could decrease the prevalence of SIB when they address both attachment and affect regulation coping strategies before a person becomes more resistant and hardwired into an individual coping-strategy repertoire.

Moreover, this study revealed psychotherapeutic variables that may be of interest for further examination and clinical training. In the counseling process, several of the participants who engage or have engaged in SIB found therapists that demonstrated a nonjudgmental attitude, did not use a complacent method of counseling, could fully understand why they engage in SIB, and conveyed to them an understanding of SIB as attention needing rather than attention seeking to be more effective than those who did not demonstrate these qualities. This aligns with the therapeutic-alliance research (Baldwin, Wampold, & Imel, 2007; Hawley & Weisz, 2005; Karver et al., 2008; Lambert, & Barley, 2001; McLeod, & Weisz, 2005; Shirk, & Karver, 2003; Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007; Wampold, 2007; Zuroff, & Blatt, 2006). Therefore, future research should experimentally examine these variables with a larger and more representative sample to determine the significance of these variables in the counseling process among those who engage in SIB.

Due to the nature of this study using e-mail interviews, those participants who would not have likely participated in face-to-face interviews were given a chance to tell their personal experiences with SIB. This was the first research study to use a Heideggerian-hermeneutic phenomenological-human science approach using Internet e-mail interviews. Additionally, this study was also unique in that the participants were not enticed by extra credit for a college course, financial gain, or inhibited by the sometimes anxiety-provoking, typical face-to-face interviewing process.

Recommendations for Action

The results of this study revealed that the meaning of SIB for the participants sampled was a method for coping with stress (indirectly or directly) and emotions (positive or negative), and as a way to regulate and control affect from perceived historical trauma. Consequently, the aim was to provide this information to those professionals, researchers, and the public who serve this population either directly or indirectly and to broaden the possibilities for future research and interventions. These findings will be disseminated through publication (e.g., peer-reviewed journal, general-audience paperback book), professional conferences, and workshops.

Recommendations for Further Study

It is crucial that a prospective research agenda for SIB takes into account a developmental lifespan perspective: focuses on prevention, incorporates early assessment and intervention, and integrates multicomponent and multidisciplinary treatment modalities to contribute to a healthier society. The majority of participants in this study and other studies have noted perceived traumatic backgrounds, especially in childhood: research should investigate the epidemiology and etiology of SIB in the United States and the world with the intent of providing more precise data than currently exists (Weierich & Nock, 2008; Whitlock et al., 2006). For that reason, a variety of investigative fields (e.g., community, education, epidemiologists, medical, psychology, public health, religious, sociologists, spiritual) and environments (e.g., community, home, school, work) is necessary to provide further data and perspectives for a comprehensive cross-discipline research agenda.

Secondly, the findings of this research study revealed that an SIB research agenda should incorporate the fields of affect regulation, coping, and stress in a cross-discipline research approach, especially, across the lifespan using an integrative developmental psychopathology approach (Cicchetti & Cohen, 2006; Cicchetti & Rogosch, 2002; Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001; Connor-Smith, Compas, Wadsworth, Thomsen, & Saltzman, 2000; Nock & Mendes, 2008; Schore, 1994, 2000, 2001, 2003a, 2003b). This type of cross-discipline approach considers widespread multifactors that could have an impact on both healthy and abnormal development across environments, for example, community, home, school, and work.

Next, the early detection of a person who may engage in SIB would be a valuable preventative tool, in particular, because the majority of individuals that engage in SIB typically have comorbid psychopathology, difficulty with affect regulation, and possibly perceived trauma underlying their need to engage in SIB (Glassman et al., 2007; Pearlman & Courtois, 2005). In addition, the field of emotional intelligence could scientifically inform the development of standardized psychological instruments that may reveal a pattern of emotional intelligence scores of school-age individuals who are most likely to engage in SIB and need preventative intervention (Mayer & Salovey, 1995, 1997; Mayer et al., 2004; Salovey & Mayer, 1990). Therefore, the aim of future SIB assessment and prevention research would be to develop a standardized measure of emotional intelligence that could be used as part of an early-prevention model of SIB with younger populations.

Future research should design studies that sample the male population to determine the presentation, epidemiology, and etiology of male SIB. Most research on SIB tends to focus solely on the female population (Gratz et al., 2002). Therefore, assessment, prevention, and treatment of males who engage in SIB could not only fill a gap in the literature but also contribute to a healthier society.

Moreover, the research agenda presented aligns with the specialty field of health psychology, a psychological discipline that typically encompasses the areas of stress, coping, affect regulation, and its impact on health (Belar, 2008). Furthermore, the subjects of spirituality and religion in relation to health have become more accepted by the behavioral sciences and should not be ignored in a research agenda on SIB (Gange-Fling & McCarthy, 1996; Miller & Thorsen, 2003; Wagner, 2008).

Researcher Reflections

This section presents an outline of the weaknesses and strengths of the study. Additionally it details the benefits and areas for improvements as well as the personal reflections of the researcher.

Limitations of the study

Several limitations of this study are noted. First, a small, nonrandom, purposive sample was used for this study ($N = 18$). Therefore, these results are not generalizable (Gay & Airasian, 2003). Secondly, the participants sampled were all female. The use of Internet technology for interviewing the participants provided less in-depth and real-time dialogue compared to a face-to-face interview resulting in the inability in real-time to explore the subject matter more at length as it developed. The lack of visual cues or body

language from a face-to-face interview was a restriction of using the e-mail interviewing method.

This study sampled individuals who were 18 years old or older and no specific age was collected for each participant. In addition, geographic location, socioeconomic status, race, or religious affiliation data were also not collected. Data for this study were collected through several Websites and therefore were limited to those individuals who frequented those Websites at the time this study was running. As a result, the current findings may reflect the uniqueness of the participants who were on those particular Websites who chose to participate in this study rather than a true representation of the characteristic female who engages in SIB. Further, there were no strict validation procedures to make sure that everyone who participated in this study was at least 18 years of age. For example, even though the consent form asked if the person was at least 18 years of age, there was no mechanism to strictly validate the participants' true age.

Strengths

Conversely, this study contains several notable strengths. Many of the participants interviewed indicated their motivation to participate in this study was due to the non-face-to-face nature of the interviewing procedure. Many individuals who engage in SIB hide their scars and the fact that they engage in such behavior. Therefore, the e-mail-interview method was able to give these participants a voice to discuss what SIB is like for them. Although the results of this study are not generalizable, it did focus on the individual participant and what it is like for each participant to engage in SIB and differs from large random sampled studies that are generalizable (Gay & Airasian, 2003).

Personal Reflections

The researcher's preconceived notions may have had an impact on this study's outcome. The researcher is a licensed school psychologist who has encountered adolescent females who have engaged in SIB. As a result, preconceived notions based on his prior experience with adolescents who engage in SIB may have influenced the interpretive findings of this study. Additionally, because a thorough literature review was required by Walden University before the researcher could collect data, it is feasible that the researcher developed preconceived notions from the literature and developed a bias unconsciously that may have influenced both the research and interview questions.

As a result of this study, the researcher's viewpoints have been altered. The findings of this study reveal and confirm outcomes found within the literature review in chapter 2 substantiating that SIB is a coping mechanism and a strategy to regulate affect (Gratz & Chapman, 2007; Nock & Prinstein, 2004; Schore, 2003a; Suyemoto, 1998; Yates, 2004). This study not only reaffirms the literature but also establishes a genuine foundation for future research based on each individual that was given a voice in this study. In a sense, the data were compared with previous SIB research outcomes and verified identical SIB themes that emerged from this study (e.g., affect regulation, trauma).

Conclusion

The question of the meaning of SIB has been answered. Based on the participants sampled, the meaning of SIB is a method of coping with stress (indirectly or directly) and emotions (positive or negative) as a way to regulate and control affect from perceived

historical traumatic event(s). This study filled the gap in the literature by going to the individual's themselves who had engaged in SIB and provided them with an opportunity to express their personal experiences with SIB through Internet e-mail interviews. This study was unique in that it used Internet technology to obtain participants (i.e., SIB message boards) and provided them with a means where the individual may have felt comfortable expressing their experiences through an e-mail interview.

As a result, the participants did not have to come face-to-face with the researcher for an interview. The population sampled may have been distinctive in this respect as most of the participants' indicated they had difficulty expressing their personal experiences with SIB with someone and have a tendency to conceal the fact that they self-injure. A second aim is to bring about social change by providing information to society on the escalating and puzzling phenomenon of SIB. Ultimately, the intent of this research was to uncover the meaning for each of the participants' and then to distribute these findings to the public, research, and professional communities, contributing to social change through prevention, intervention, general knowledge, and research.

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APPENDIX A

INTERVIEW GUIDE

Participant (#)_____ Date:_____

1. Why do you engage or have engaged in self-injurious behavior (SIB)?

2. When is the last time you engaged in SIB?

3. What method do you use when engaging in SIB (e.g., cutting, burning, etc.)?

4. When are you most likely to engage in SIB?

5. Why do you think you engage in SIB?

6. Why do you think some people engage in SIB and others don't (i.e., what is the purpose)?

7. What does it mean to you when you engage in SIB?

APPENDIX B

CONSENT FORM

The Meaning of Self-Injurious Behavior: A Phenomenological Investigation

Walden University

You are invited to participate in a dissertation research study on *self-injurious behavior* (SIB). This particular study will examine the *meaning* of SIB and will be conducted through online-email correspondences only. Criteria and parameters for inclusion into the study are:

- At least 18-years of age
- Female
- Have a history of self-injurious behavior (e.g., wrist-cutting, burning, etc)
- Cannot be pregnant
- Cannot be a resident in any facility (e.g., prisoners, juvenile detention centers, nursing homes, mental health facilities, rehabilitation, etc.)
- Cannot be non-English speaking
- Cannot be an elderly individual (65+)

Confidentiality but not anonymity will be provided to each participant. What's more, participation in this study is voluntary and you may discontinue at any time. Please read this consent form, check mark your willingness to participate in this study, and feel free to ask any questions you may have before participating in this study. If you meet the criterion and decide to participate in this study, when referring to others during the email correspondences please refer to people you have been acquainted with by their initials only (e.g., MJ, TC, etc) and not actual names.

This study will be conducted by William (Bill) Hosmer, Doctoral (PhD) Candidate at Walden University.

Background Information:

The purpose of this study is to better understand the meaning of self-injurious behavior among adult females from their perspective.

Procedures:

All participants who agree to join this study will take part in electronic-email interviews conducted through the Internet. After all forms have been electronically signed/ "clicked", the researcher will send you a couple of questions to begin the interview. After

you have completed these questions you will send them back through email to the researcher. The researcher will inquire, question, and provide follow-up questions. Email correspondence interviews could range from 15-minutes to 2-hours in there entirely. Interviews do not have to be completed in one day. When the researcher determines that enough information has been provided, he will send you an email stating that the interview has been completed.

These interviews will ask a range of personal questions in regards to your own experiences with SIB. Please be aware that these personal questions may cause challenging emotional feelings for you. Therefore, a "safety procedure" document will be required to electronically sign/check as well (Appendix B).

Those agreeing to participant in this study will check mark their willingness to participate on the proper forms.

Voluntary Nature of the Study:

Your participation in this study is strictly voluntary and you may withdraw at anytime during this study.

Risks and Benefits of Being in the Study:

There are several known risks for you by partaking in this study:

- RISK: Use of online-electronic communication (i.e., email) cannot guarantee strict confidentiality.
- RISK: Due to the content of the interviews, difficult emotions may arise for you and the need to seek a mental health professional may be necessary
- BENEFIT: To assist researchers and mental health professionals in establishing a better and more complete understanding of self-injurious behavior for the individual person
- BENEFIT: If a more complete understanding of SIB can be obtained, this study can contribute to enhanced mental health support in the future

Compensation:

None.

Confidentiality:

All information is confidential. Information that is published or disseminated for others to read will not contain the individuals name but "Participant 1, Participant 2, etc." All transcripts and questions of the participants' identifying information will be kept in a locked-fire proof filing box. Keep in mind that only the researcher will have access to these records.

All interviews will be saved onto a Microsoft Word document through a "cut and paste" procedure. All transcripts will be available to the researcher and his dissertation committee (i.e., professors) to analyze. Keep in mind that transcriptions sent to the researcher's dissertation committee will not contain the names of the participants but "Participant 1, Participant 2, etc." only. The transcripts will be destroyed within 5-years from the completion of the study.

Contacts and Questions:

The researcher conducting this study is William (Bill) Hosmer. The researcher's advisor is Tiffany Rush-Wilson, PhD. Feel free to ask any questions you may have at this time. If you have questions later, you may contact William (Bill) Hosmer at (802) 584-3696, whosm001@waldenu.edu or Dr. Tiffany Rush-Wilson at (416) 729-8265, trushwil@waldenu.edu. The Research Participant Advocate at Walden University is Dr. Leilani Endicott, you may contact her at 1-800-925-3368 extension 2393 or email at Leilani.Endicott@waldenu.edu if you have questions about your participation in this study.

Statement of Consent:

I have read the above information. I have asked questions and received answers. I consent to participate in the study and meet the following criteria:

(1) I am at least 18-years of age
(2) I am female
(3) I have a history of self-injurious behavior (e.g., wrist cutting, burning)

Place a check mark or "X" in one of the following:

☐I voluntarily on my own will agree to participate in this study on self-injurious behavior

☐I voluntarily on my own will do not agree to participate in this study on self-injurious behavior

APPENDIX C

INVITATION TO PARTICIPATE IN RESEARCH

This is an invitation to participate in a RESEARCH study on Self-Injurious Behavior/SIB (e.g., wrist cutting, burning, etc.). This study will consist of in-depth interviews through email correspondence involving the meaning of self-injurious behavior. Participation has the potential of contributing to the understanding of self-injurious behavior and the possibility of assisting others who engage in SIB by future research and interventions.

Taking part in this study is strictly voluntary and you can discontinue at anytime. All information is confidential. However, you must meet the following criteria: (1) at least 18-years of age; (2) female; and (3) have a history of self-injurious behavior (e.g., wrist cutting, burning, etc).

If you are interested, please follow the link on this Website entitled "SIB Research" and begin the introduction to see if you qualify.

Thank you for your time and cooperation,

Bill Hosmer

Bill Hosmer, M.Ed., C.A.S.
PhD student, Walden University
This research was approved by WALDEN UNIVERSITY

APPENDIX D

SAFETY PRECAUTIONS CHECKLIST

Due to the nature of the interviews for this study that may bring up disturbing emotions, it is imperative that each participant has an "emergency plan" in place before the start of the first interview. Such a plan will contain the following:

- Having a means of communication (i.e., telephone, cell phone)
- Having the following phone numbers in close proximity to call for support:
  - "9-1-1"
  - Local/closest hospital emergency room
  - A mental health professional (e.g., licensed psychologist, licensed mental health counselor, licensed social worker, licensed psychiatrist) in/near the area that you live who can be on "stand by", or you can have access too, during the time of your participation in this study

Please check mark the following indicating that you have an "emergency plan" in place complete with phone numbers, names of professionals, and place to go to in case of an emergency:

☐ Yes, I do have an "emergency plan" as indicated as above

☐ No, I do not have an "emergency plan" and I will have to develop one before I can participate in this study

CURRICULUM VITAE

William R. Hosmer

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Education

2009	PhD., Walden University; Minneapolis, MN Major: Psychology Specialization: Research & Evaluation Dissertation Title: The Phenomenology of Self-Injurious Behavior
2000	C.A.S. Edinboro University of Pennsylvania, Edinboro, PA Specialization: School Psychology
1999	M.Ed. Edinboro University of Pennsylvania, Edinboro, PA Major: Psychology Specialization: Educational Psychology Thesis Title: Parent Training
1995	B.A. Notre Dame College, Manchester, New Hampshire Major: Psychology

Professional Experience

2003–Present	School psychologist, Blue Mountain Union School District, Wells River, Vermont 05081
2000–2003	School psychologist, Clymer Central School District, Clymer, New York
1996–1998	Special education tutor, Manchester School District, Manchester, New Hampshire

License/Certification

2006	School psychologist II license #002648489 State of Vermont, Department of Education
2000	School psychologist permanent certification #002648489 New York State, Department of Education