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Superficial Self-Harm Behavior: Helping Young Women Who Hurt Themselves

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SUPERFICIAL SELF-HARM BEHAVIOR:

HELPING YOUNG WOMEN WHO HURT THEMSELVES

by

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This thesis has been read by each member of the following graduate committee and by majority vote has been found to be satisfactory.

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ABSTRACT

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HELPING YOUNG WOMEN WHO HURT THEMSELVES

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Roughly 1 to 4% of the population engages in self-harm. Superficial self-harm is reported by more young women, than young men. Appropriate responses from family, friends, and other important individuals are a key ingredient in facilitating recovery. Non-therapists, such as family, friends, and school personnel often wish to assist young women who self-harm, but the problem is complex and they are often unsure of how to respond. Current studies primarily focus on the clinical interventions for self-harm, while very few have investigated the perspectives of the individuals who self-harm. This study investigated the perspectives of young women who self-harm in terms of *who* and *what* they perceive as helpful when attempting to deal with and/or reduce their self-harming behaviors. Results revealed that participants perceive their friends as the most helpful group. The most preferred helping behaviors included the following: having someone acknowledge the severity of their distress; talking about self-harm with someone who is nonjudgmental and lets them verbalize their feelings; and knowing someone is available.

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Chapter 1: Introduction

Self-harm behavior (SHB) is one of the least understood behaviors of children, adolescents, and young adults. While SHB is most frequently associated with disorders such as autism, schizophrenia, borderline personality disorder, and multiple personality disorder (Zila & Kiselica, 2001), over 6% of typically-developing teens inflict harm upon themselves (Ystgaard, Reinholdt, Husby, & Mehlum, 2003); that is, in any given teenage classroom, an average of two students self-harm (Nursing Standard, 2005).

What is Self-Harm Behavior?

SHB is socially unacceptable intentional injury upon the self without conscious suicidal intent (Alderman, 1998; Favazza & Rosenthal, 1993). There are four major elements of SHB that define the behavior as pathological (Travia, 2003). First, it is socially unacceptable (Haines, Williams, Brain, & Wilson, 1995). That is, cultural practices—such as piercing or scarring one's body for ritual or ornamental purposes—are not considered SHB. Second, it is almost always a reaction to a psychological crisis (Haines et al., 1995). Third, it leads to tissue damage. Finally, as stated above, the individual engages in the behavior without conscious suicidal intent (Favazza & Rosenthal, 1993).

Differentiating Pathological and Non-Pathological SHB

Some individuals engage in self-harming behavior for cultural reasons, believing that their acts serve a purpose from which they or their community will benefit. In many cultures, self-harming rituals and acts of asceticism and self-mortification are prominent and viewed favorably (Favazza, 1996). Often in these cases they are seen as a sign of penitence, healing, or enlightenment. For example, in Morocco, one group engages in drinking boiling water, eating spiny cacti, and other self-harming acts in an attempt to produce a psychic state believed to

create unity with God (Favazza, 1996). An additional example includes the following: during the New Year festival of the Abidji tribe of the Ivory Coast, members volunteer to participate with the purpose of driving away bad spirits. Often, participants become deeply involved in a trance-like state and plunge knives into their abdomens (Favazza, 1996). The practices of both of these groups are culturally accepted and therefore not considered pathological.

However, at the same time, incidents are reported of individuals who are mentally ill engaging in SHB for religious reasons (i.e., plucking out their eyes or castrating themselves) (Favazza, 1996). In these cases, the behavior is pathological. The most common explanations these individuals give for their behaviors include: the desire to offer a sacrifice to God (e.g., by cutting off a body part), to become like Jesus by suffering as He suffered, or that the scriptures or "God told [them] to" (Favazza, 1996, p. 26). Cleary, in these cases the behavior is pathological.

Three Types of Self-Harm Behavior

There are three types of SHB: superficial or moderate; stereotypic; and major (Simpson, 2001). Superficial or moderate SHB is the most common type and is often found in individuals with personality disorders (Favazza, 1996). It includes injuries such as superficial scratches and cuts. The second type—stereotypic SHB—seems to be biologically driven (Favazza, 1996) and is usually seen in individuals with developmental disabilities such as autism, deLange Syndrome, or Lesch-Nyhan syndrome, as well as in individuals with Tourette syndrome. It includes repetitive, often rhythmic behaviors such as biting of the hands, arms, or lips, head banging, eyeball pressing, and self-punching. Finally, major SHB is infrequent and refers to amputation of the limbs or genitals, and eye enucleation. This form is usually associated with psychosis or acute intoxication (Favazza & Rosenthal, 1993; Favazza, 1996). This study focuses on superficial or moderate SHB, specifically in young women.

Superficial Self-Harm

It is believed that superficial SHB is more common in females. However, this may be merely an assumption. Favazza (1996) writes "That the behavior *seems* more common in females may be an artifact of sampling techniques. A tremendous amount of cutting and burning, for example, goes on in prison" (p. 240). However, outside of the prison setting, the assumption that superficial SHB is more common in females is likely an accurate one, as indicated by current research (e.g., Lieberman, 2004).

In females, the most common form of superficial SHB is cutting, but burning is also quite common (Selekman, 2002). Cutting the wrists and forearms is most commonly observed, but cuts may occur anywhere on the body, including the face, genitals, and breasts. Instruments used for cutting are also limitless and range from razors, knives, and sharp stones (Jacobs, 2005) to broken glass, needles, fingernails, and food bones (Ross & McKay, 1919). Burning most often occurs with a cigarette butt, but may also occur with the repetitive friction of erasers (The Houseparent Network, 2005).

Less common forms of superficial SHB include scratching, self-punching, head banging, bone-breaking, needle-sticking, hair-pulling, interference with wound healing, excessive nail biting, ingesting sharp or toxic items, punching walls, constricting the air passage or blood flow to a part of the body, inserting objects under the skin or into body orifices, biting or abrading, and hitting the body with objects or other parts of the body.

How Common Is SHB?

Roughly 1-4% of the general population engages in SHB (Alderman, 1998; Klonsky, Oltmanns, & Turkheimer, 2003). However, this statistic is much higher during adolescence. It is estimated that 14-39% of nonclinical adolescents engage in the behavior (Lloyd, Kelley, &

Hope, 1997, as cited in Nock & Prinstein, 2005; Ross & Heath, 2002), while up to 61% of adolescent psychiatric inpatients intentionally harm themselves (DiClemente, Ponton, & Hartley, 1991). As mentioned, rates are probably higher among females during this time. Furthermore, according to Lieberman (2004), approximately 60% of elementary-aged children and 80% of middle- and high-school aged children who self-injure are female. Finally, SHB is just as prevalent as eating disorders, but (outside of sub-populations of adolescents where SHB is viewed as a right of passage and/or copy cat activity) more people go to great lengths to hide their injuries and scars because SHB is highly stigmatized (Martinson, 2000).

Who Engages in SHB?

Children as young as four have been reported to self-harm (Dubo, Zanarini, Lewis, & Williams, 1997). However, SHB typically begins in late childhood or early adolescence and can continue for 15 to 20 years (Favazza & Rosenthal, 1993). As mentioned, rates are highest among adolescents, during which time it is more common among females than males. The behavior also appears to be most common among middle and upper class adolescent girls or young women (Simpson, 2001).

Common Characteristics of People Who Self-Harm

A person who engages in superficial SHB may not be easily identifiable on the street or in a social setting. However, a number of studies have reported several commonalities among individuals who self-injure.

Victims of abuse. The majority of individuals who self-harm have been victims of physical, sexual, and/or psychological abuse (Darche, 1990; Favazza, 1996; Low, Jones, MacLeod, Power, & Dugan, 2000; Zlotnick, Shea, Pearlstein, Simpson, Costello, et al., 1996). In fact, a longitudinal study of 74 clients found a strong correlation between self-harm behavior and

childhood physical and sexual abuse (Van der Kolk, Perry, & Herman, 1991). Regarding childhood abuse, Favazza (1996) writes: “As children, self-mutilators often experience a sense of abandonment, of loneliness, and of unlovability…” (p. 77). Often accompanied by a difficulty expressing themselves, individuals with such feelings—especially females—turn these feelings inward. Such feelings often manifest themselves in behaviors reflecting self-destructiveness and/or self-hate, as may be the case with self-harm (Nock & Prinstein, 2005).

Compulsive eating and drug misuse. **T**hese individuals often compulsively eat (Favaro & Santonastaso, 2000; Matsunaga et al., 2000) and/or misuse alcohol and drugs, particularly oral drugs (Simpson & Porter, 1981). One study found that 57% of individuals who self-harm had overdosed on drugs (Favazza & Conterio, 1989). One theory suggests that the behaviors are related and part of an impulse disorder, which is explained in detail below (Favazza & Rosenthal, 1993; Lieberman, 2004).

Limited coping skills. **T**hese individuals usually have poor insight and coping skills. That is, they are “hypersensitive to environmental stressors and respond to frustration more intensely than do non-mutilators” (Shea, 1993, as cited in Favazza, 1996, p. 174).

Intense anxiety and rage. Third, in terms of anxiety and rage, adolescents who self-harm report feeling significantly more anxiety and hostility, especially prior to engaging in SHB (Ross & Heath, 2003).

Limited ability to express feelings verbally. Fourth, researchers and therapists report that adolescents who self-harm tend to have a very limited ability to verbally express their feelings (Simpson, 2001). Interestingly, individuals who self-harm also indicated this deficit on self-report surveys (Favazza & Conterio, 1989).

Negative self-image. Finally, not only do these individuals lack the coping skills needed to deal with strong emotions, they also report a negative self-image and limited emotional resiliency (Simpson, 2001).

Clinical Correlates

Superficial SHB is often clinically correlated with borderline personality disorder (BPD), eating disorders, antisocial personality disorder, depression, anxiety, post-traumatic stress disorder (PTSD), social isolation, and impulse disorders (Darche, 1990; Favazza, 1996; Klonsky et al., 2003; Levitt, Sansone, & Cohn, 2004; Wilkins & Coid, 1991, as cited in Favazza, 1996). In addition, individuals who self-harm often report early parental depravation, family disruption, physical and sexual abuse, poor adjustment to sexual development, and identity failure (Wilkins & Coid, 1991, as cited in Favazza, 1996).

Borderline personality disorder. Superficial SHB is more common in borderline personality disorder than in any other mental disorder (Favazza, 1996). The most prominent features of BPD include: an intense fear of abandonment; intense and unstable relationships; rapid mood changes accompanied by inappropriate anger; anxiety; depersonalization; psychotic-like symptoms; and an unstable, wavering self-image and sense of self. People with BPD commonly have a history of failed marriages, lost jobs, and incomplete educational experiences (Favazza, 1996). According to Favazza, “Episodic self-mutilation is so prevalent [in BPD] because it works: it ends the depersonalization and mounting anxiety. . . provides solace, stabilizes emotional swings, and so forth” (p. 250). For these reasons, superficial SHB is highly prevalent in individuals with BPD.

Antisocial personality disorder. Superficial SHB is also common among individuals with antisocial personality disorder, particularly those who are incarcerated in correctional facilities

(Favazza & Rosenthal, 1993). In fact, Ross & Mckay (1979) found that 86% of the inmates in a Canadian correctional institution for adolescent girls had carved their skin at least once; the average girl had carved her skin eight times.

Eating disorders. Superficial SHB and eating disorders are also highly correlated. Favazza & Conterio (1989) found that 61% of individuals who self-harm "now have or at some time in the past have had an eating disorder" (p. 287). Slightly lower statistics were reported in numerous other studies. Specifically, an estimated 15-30% of both in- and outpatients with bulimia nervosa report SHB (Fichter, Quadflieg, & Rief, 1994; Matsunaga, Kiriike, Iwasaki, Miyata, Matsui, et al., 1998) and 14-59% of patients with anorexia nervosa report SHB (Favaro & Santonastaso, 2000; Nagata, Kawarada, Kiriike, & Iketani, 2000).

Depression. Superficial SHB and depression are also highly correlated. Favazza (1996) found that people who are depressed tend to turn their anger inward. He reports, "The result may be psychotic decompensation, replete with feelings of great guilt and sometimes with self-mutilation" (p. 66). Thus it appears that people with depression self-harm, at least partially, as a result of intense anger and guilt directed at the self.

Anxiety and PTSD. SHB is commonly seen in individuals who suffer from generalized anxiety disorder and/or PTSD, a form of anxiety where traumatic events are psychologically re-experienced. This is because cutting, burning, and other similar acts of self-harm quickly and effectively provide relief from feelings of extreme tension.

Social isolation. Individuals who superficially self-harm frequently report social isolation during childhood. Often they carry this sense of loneliness into adolescence and adulthood, reporting a current inability to form close relationships (Favazza, 1996).

Impulse disorders. A final clinical correlate on which many experts agree is that individuals who engage in recurrent SHB have an impulse disorder that fits into the same category as alcohol and substance abuse, shoplifting, suicide attempts, and eating disorders (Lacey & Evans, 1986; Lieberman, 2004). Lacey & Evans attribute the behaviors seen in this disorder to a "deficit in impulse control which is closely related to difficulty coping with depressive emotions and anxiety" (p. 646). Furthermore, according to Lieberman, these behaviors have two factors in common. First, these behaviors occur intermittently and are usually precipitated by an upsetting event and second, these behaviors become addictive because they are gratifying.

What Causes SHB? What is its Function?

Emotional regulation. SHB has no single universal cause. However, in the absence of alternative, healthy coping strategies, it is often an attempt to find quick relief from severe emotional distress, such as depression, anxiety, depersonalization, anger, loneliness, or troublesome sexual feelings (Favazza & Rosenthal, 1993). However, the most common reason for engaging in SHB tends to be the tension-releasing qualities it provides in the absence of more adaptive coping strategies (Haines et al., 1995; Haines & Williams, 1997).

This tension-releasing quality is also known as "the endorphin effect" (Selekman, 2002). That is, when the person harms him/herself, endorphins—a natural antidepressant—are quickly released into the bloodstream. This results in a numbing or pleasurable sensation. The individual may not experience physical pain from the injury until hours, days, or even weeks later.

Along these same lines, it is worth noting that imbalances in specific neurotransmitters such as dopamine, norepinephrine, serotonin, and Gamma Amino Butyric Acid (GABA) have been linked to various syndromes characterized by SHB (superficial or other), including Lesch-

Nyhan syndrome, deLange syndrome, and Tourette syndrome (Favazza, 1996). This concept is being investigated.

As stated above, SHB is a coping behavior. Individuals who self-harm often lack the coping skills needed to regulate their emotions, communicate effectively, and control their impulses. Lieberman explains the functions of SHB in relation to emotional regulation.

> Things happen, tensions build, and they are driven to find relief from the pressure. Self-mutilation can serve as a means to relieve intolerable emotional pain; a form of self-punishment; a way to reconnect or "stabilize" the body in response to a dissociative episode; and, almost always, a means of communicating a deep sense of anguish. Typically, students who self-mutilate are not trying to manipulate others around them; they are trying to express what they cannot put into words... (Lieberman, 2004, p. 3)

But what causes this severe emotional distress in the first place? Many children and adolescents who self-injure feel emotionally disconnected, isolated, and invalidated by the people around them. Many feel emotionally dead inside and self-harm enables them to "feel something" (Simpson & Porter, 1981, p. 437). According to Simpson and Porter, the behavior may be a request for help, "born of an almost unfathomable sense of loneliness and helplessness" (p. 438).

Environmental manipulation. SHB not only regulates emotions, but can also function as a manipulation tool when an individual lacks the skills necessary to get their needs met (i.e., communication skills). Favazza (1996) explains this concept: "People with RSM [repetitive self-mutilation] recognize and may try to exploit the particularly unsettling effect that self-mutilation has on others. Thus, the behavior may be used in an attempt to engender a caring response in a significant other and instill guilt in others for a perceived wrong" (p. 254).

Further illustrating this point, Nock and Prinstein (2005) recently proposed a theoretical model suggesting that SHB has four primary functions. The latter two functions support the theory that SHB can be used to manipulate one's environment. The four functions include: automatic negative reinforcement (e.g., "To stop bad feelings"); automatic positive reinforcement (e.g., "To feel something"); social negative reinforcement (e.g., "To avoid doing something unpleasant you do not want to do"); and social positive reinforcement (e.g., "To get attention").

Statement of Problem

Self-harm behavior (SHB) is one of the least understood behaviors of children, adolescents, and young adults. Many typically-developing young people inflict violence upon themselves. The problem is prevalent, yet there is conflicted research concerning the best ways to assist these individuals.

The literature offers numerous suggestions regarding help for individuals who self-harm (e.g., Alderman, 1998; Lieberman, 2004; Selekman, 2002). While these suggestions are thoughtful and undoubtedly useful, few are drawn from well-controlled studies. Rather, they are drawn primarily from clinical case studies (Nock & Prinstein, 2005). In addition, roadblocks involving participant recruitment, collecting reliable data, and ethical and legal issues further slow the progress of research in this area. In addition, the number of case studies for each specific type of treatment is severely limited. While case studies are valuable, there remains a lack of solid research concerning the best ways to assist individuals who self-harm.

Furthermore, the majority of the research on this topic concerns interventions within a therapeutic setting and fails to offer suggestions for families, friends, and other support systems. That is, the aforementioned studies are relevant to trained professionals within a therapeutic

setting, but there is little research concerning how parents, teachers, coaches, siblings, and peers can best assist young people in overcoming SHB. This is especially problematic given that friends and family members usually have a difficult time understanding SHB and therefore often react in counterproductive ways (i.e., with anger, disgust, despair, threats) (Costin, 2004).

Finally, recommendations for SHB interventions have been generic in nature. More research is needed to gain insight into *who* is the most helpful to people who engage in SHB, *what* is perceived as helpful, and the relative effectiveness of various helping behaviors.

Statement of Purpose

The purpose of this study was to gain insight from individuals who engage in superficial SHB. More specifically, this study attempted to identify individuals who provide support in overcoming SHB. Additionally, participants were asked to identify which helping behaviors are/were of greatest assistance to them. Also, looking at recovery status, this study sought to clarify the differences in "who" and "what" is helpful, according to young women who self-harm.

Research Questions

The specific research questions addressed include the following: According to females who report SHB, (1) who, outside of professional assistance, helps them overcome SHB; (2) what type of assistance is most helpful; (3) which helping behaviors performed by which people (helpful-behavior + helpful-person combination) do individuals who self-harm find the most helpful; and (4) do young women who are recovered from SHB differ in their feelings about who and/or what was helpful when compared to those who currently self-harm?

Importance of the Study

Present interventions relevant to SHB are generic and primarily geared toward therapeutic settings. That is, they are not applicable in the home, in social settings, at school, etc. In addition, many are not research-based. The present study is important, as it strives to refine interventions to be more specific, research based, and applicable outside of the therapeutic setting (i.e., school, home, social settings, sports practice). That is, the present study strives to assist not only the practitioner, but also family members, teachers, coaches, and other important individuals in implementing research-based interventions and helping behaviors. It aims to help important individuals (parents, siblings, peers, coaches, etc.) determine which specific helping behaviors are likely to be effective.

Chapter 2: Literature Review

The general public, as well as some mental health professionals, may perceive SHB as irrational, revolting, frightening, and baffling. Consequently, it has received relatively little attention from the psychiatric community and no clear consensus exists concerning the most effective treatment for superficial SHB. In truth, there is probably no single correct therapeutic approach.

In addition, individuals presenting with self-inflicted wounds often receive unsympathetic and inadequate treatment from healthcare professionals in emergency rooms, in psychiatric settings, and in non-therapeutic settings, such as at home or school (Favazza, 1996; Shuttleworth, 2004). For example, in emergency rooms, analgesics or anesthesia may be denied when suturing wounds (Shuttleworth, 2004). In psychiatric settings, countertransference is prevalent.

> [Frequently therapists offer] …"either harsh or indifferent treatment . . . apparently therapeutic maneuvers such as ECT [electroconvulsive therapy], high-dose medication, or even the transfer of care may on occasions be a means of getting rid of a frustrating patient or even punishing her for refractoriness." (Tantam & Whittaker, 1992, p. 459)

Given that even trained professionals are prone to responding inappropriately to SHB, it is not surprising that family members, educators, peers, and significant others tend to react counterproductively when an individual deliberately harms herself. Reactions borne from ignorance and frustration, such as yelling, threatening, or punishing, are most often intended to help, but instead only heighten the individual's distress and, in turn, intensify the behavior. Clearly, mental health professionals, families, and other significant individuals are in need of some guidelines.

Need for Controlled Research Studies

Currently, there is a need for evidence-based approaches to reduce repetitive superficial SHB in adolescents and young adults. This problem is directly tied to the lack of research-based evidence regarding the effectiveness of the various treatments for reducing repetitive SHB in this population. In fact, Burns, Dudley, Hazell, and Patton (2005) searched electronic databases for research describing randomized and clinical control trials and quasi-experimental studies of interventions for this population. Their conclusions were two-fold: first, group therapy appeared to be the only intervention that leads to a significant reduction in repetitive SHB; and second, there is a serious lack of research-based evidence on this topic. They concluded

> The evidence base for treatments designed to reduce the repetition of self-harm in adolescents and young adults is very limited…Given that deliberate self-harm among young people is a common clinical problem, further good quality treatment studies are warranted. Careful consideration should be given to process evaluation to determine which individual components of any given intervention are effective (p. 121).

Clearly, there is a need for evidence-based approaches to reduce repetitive superficial SHB in adolescents and young adults.

In spite of the lack of consensus and need for controlled research studies, the literature offers the following suggestions regarding assisting individuals who engage in SHB, in both therapeutic and non-therapeutic settings.

Therapeutic Settings

There is no consensus concerning the most effective way to reduce SHB within the therapeutic setting. Several studies report the effectiveness of group therapy (Burns et al., 2005; Wood, Trainor, Rothwell, Moore, & Harrington, 2001). But according to others, family therapy

is essential for treating SHB at any age (Costin, 2004; Selekman, 2002). However, others assert that family therapy is ineffective (Zila & Kiselica, 2001). At the same time, other experts report that the best treatment is a combination of cognitive behavioral therapy and medication (Lukomski & Folmer, in press, as cited in Lieberman, 2004). Finally, others advocate art therapy, activity therapy, and support groups (Simpson, 2001). Clearly, there is no consensus.

Group therapy. According to some, group therapy is the only intervention that leads to a significant reduction in repetitive SHB (Burns et al., 2005). Additional support for this approach was offered by a randomized trial involving group therapy for adolescents who repeatedly engaged in SHB. In this study, participants who took part in group therapy had more favorable outcomes when compared to those who received routine care alone in terms of SHB frequency, school attendance, need for routine care, and behavioral disorders (Wood, et al., 2001).

In group therapy, clients interact with other individuals who self-harm. The goal of the group approach is "to learn to identify and practice more adaptive means of meeting [one's own] needs than self-harm. [Clients] learn new skills, particularly communication skills, and may find greater self-understanding through sharing common experiences and common fears" (Tantam & Whittaker, 1992, p. 460).

Dialectical behavior therapy. Dialectical behavior therapy (DBT) also appears to be quite successful in reducing SHB (Favazza, 1996). Numerous randomized control trials suggest that DBT reduces SHB, especially in patients with borderline personality disorder (Harvard Mental Health Letter, 2002).

DBT combines cognitive-behavioral, supportive, and insight-oriented treatments. The main purpose of the therapy is to prevent certain destructive behaviors while encouraging alternative, more productive behaviors.

DBT approaches SHB as a maladaptive problem-solving behavior used by persons with low distress tolerance and inadequate coping skills. It involves both individual and group treatment. The individual treatment has three main focuses: first, it focuses on replacing SHB by using more adaptive problem-solving strategies; second, it focuses on individual goals, such as mending or developing interpersonal relationships, dealing with past trauma, or financial and career stability; third, it focuses on avoiding behaviors that interfere with progress, such as missing sessions, lying, drug abuse, and antisocial acts.

While the individual portion of DBT focuses on problem-solving strategies, goals, and interfering behaviors, the group portion of DBT focuses on interpersonal skills, emotional regulation, distress tolerance, and self-management (Favazza, 1996).

Cognitive therapy. Cognitive therapy may effectively reduce superficial SHB in some individuals (Favazza, 1996; Walsh & Rosen, 1988). This may be because cognitive therapy aims to alter the distorted thinking patterns believed to precipitate SHB. Specifically, clients learn to monitor and challenge their destructive thought patterns. Walsh & Rosen (1988) summarize four basic thought patterns that cognitive therapy aims to challenge: first, “self-mutilation is acceptable;” second, “one’s body and self are disgusting and deserving of punishment;” third, “action is needed to reduce unpleasant feelings and bring relief;” and fourth, “overt action is necessary to communicate feelings to others” (p. 156).

From within this paradigm, it is believed that individuals who engage in superficial SHB are deficient in social, relationship, and communication skills (Favazza, 1996; Walsh & Rosen, 1988). Therefore, as an essential part of recovery, they must learn to think differently about their relationships and ways of communicating. In cognitive therapy, the therapist works with the client on developing and reinforcing these skills.

Family therapy. Several experts emphasize the importance of involving family members when working with individuals who self-injure (Costin, 2004; Tantam & Whittaker, 1992). Undoubtedly, the reactions of family members to SHB are likely to influence the course of the behavior. Therefore, it is important to work with family members in order to demystify the behavior and develop non-reinforcing, helpful responses to SHB (Costin; Tantam & Whittaker).

However, many of the families in which SHB is present are disturbed (Tantam & Whittaker, 1992). Therefore, while it is important to cover family issues, involving family members may not always be the best option (i.e., if a parent is too emotionally unstable to handle the situation appropriately; or if the harm to other members outweighs the benefits).

Behavior therapy. The majority of the literature on reducing SHB through behavioral techniques is irrelevant to patients who engage in superficial SHB because it focuses on patients who engage in stereotypic and major SHB (i.e., people with mental retardation, schizophrenia, or other forms of severe psychosis who head bang endlessly, sever limbs, remove eyeballs, etc). Unfortunately, reduction of superficial SHB is "strikingly absent from the behavioral literature, with the exception of DBT [dialectical behavior therapy]…" (Favazza, 1996, p. 312).

Also, the use of behavioral techniques with individuals who engage is superficial SHB can be tricky. This is primarily because the self-harming behavior itself is negatively reinforcing (e.g., it relieves tension). However, several suggestions have been offered. For example, in psychiatric settings, nursing staff should minimize positive reinforcement by responding to self-inflicted wounds neutrally. In addition, behavioral contracts, desensitization (e.g., learning to cope with unpleasant feelings in incremental steps), and rewards for abstaining from the behavior have been suggested (Walsh & Rosen, 1988). However, the literature on these suggestions is also nearly nonexistent (Favazza, 1996).

Medication. Currently, there are no specific medications that are indicated solely for the treatment of superficial SHB. Most often the drugs found to effectively reduce SHB were originally prescribed to treat an underlying psychiatric condition. Nonetheless, there are a number of effective medications.

For example, drugs used to increase the activity of the brain's neurotransmitter serotonin—selective serotonin reuptake inhibitors (SSRIs)—have been consistently successful in reducing superficial SHB (Favazza, 1996). In fact, SSRIs appear to be the only consistently effective medication.

Nonetheless, a small number of case studies report the effectiveness of other drugs. However, these medications are usually only effective for specific types of SHB, for SHB occurring only as part of specific mental disorders, or when combined with other forms of treatment.

For example, stimulants, such as amphetamines, are sometimes successful in reducing chronic SHB (Favazza, 1996). Additionally, anticonvulsant agents such as topiramate may improve SHB in patients with bipolar disorder and borderline personality disorder (Cassano Lattanzi, Pini, Dell' Osso, Battistini, & Cassano, 2001). In addition, Hough (2001) found that low doses of the antipsychotic olanzapine are effective in reducing SHB when combined with other forms of treatment. Finally, opiate antagonists such as naltrexone have been effective in reducing the various forms of SHB in individuals with mental retardation (Buzan, Dubovsky, Treadway, & Thomas, 1995), but ineffective for reducing cutting and burning (Favazza, 1996).

A number of other drugs have been tried unsuccessfully. Major tranquilizers and other antipsychotics are helpful only in the treatment of delusional parasitosis (when the belief that

insects are invading the skin results in an attempt to dig them out); minor tranquilizers are also ineffective and may actually increase SHB (Gardner & Cowdry, 1985).

The reports on these drugs are scarce and should be interpreted with skepticism. It appears as though SSRIs are the only consistently effective medication for treating superficial SHB. All other reports of psychotropic intervention should be interpreted with caution.

In general. Regardless of the type of therapy, clients report that several factors contribute to the reduction of SHB. Specifically, when asked in a follow-up study to identify the factors that most contributed to their recovery, recurrent cutters reported the following: first, acquiring the ability to verbally express feelings; second, learning to use constructive behavior; and third, the control of psychosis (Nelson & Grunebaum, 1971). Learning to verbally express feelings and behave constructively was usually achieved with the help of an accepting therapist. Furthermore, these individuals reported that gaining insight about the origin of their cutting behavior was not helpful. Regardless of the therapeutic approach, these factors should be considered.

Outside the Therapeutic Setting

The literature offers several suggestions for families, friends, and other significant individuals when interacting with individuals who self-harm. However, these suggestions are *not* based on research studies that evaluate helping behaviors in non-therapeutic settings. Most suggestions are based on practitioners' knowledge and their experience counseling with individuals exhibiting SHB. Professionals offer the following suggestions to assist families and friends who interact with individuals exhibiting SHB.

- Empathize. Acknowledge the severity of the person's distress. Learn to empathize. Often the behavior is rooted in an early lack of empathic connection with significant others (Costin, 2004).

- Talk. Know that in order for the behavior to stop, the person must be able to talk about the feelings connected to them. This removes the secrecy surrounding the behavior and helps the person find new ways to deal with their strong feelings (Alderman, 1998; Costin, 2004; Lieberman, 2004).
- Listen. Listen without judging or accusing (Alderman, 1998; Lieberman, 2004).
- Be available. Most people who hurt themselves do it in private. Statements such as "I see that you are having a hard time and I am here for you if you want to talk about it," are the most appropriate (Alderman, 1998; Costin, 2004; Lieberman, 2004).
- Focus on helping the person understand the function their behavior serves (Costin, 2004).
- Focus on helping the person find new ways to meet their needs (Costin, 2004).
- Treat the wound the same way you would treat an accidental injury (i.e., help dress the wound, offer empathy, offer to talk about what happened) (Costin, 2004).

Professionals list the following cautions, behaviors to avoid, when friends and family interact with individuals who self-harm.

- Don't yell, ground, threaten, or punish (Costin, 2004).
- Don't get caught up in *why* the person hurts themselves (Costin, 2004).
- Don't accuse the person of being *bad, attention-seeking*, or *manipulative*. These stigmatizing terms "have no explanatory value but do subtly devalue the [person's] distress" (Tantam & Whittaker, 1992, p. 459).
- Don't react with overt fear, anger, or anxiety (Tantam & Whittaker, 1992).
- Don't free the person of responsibility by blaming others for their dysfunction (Tantam & Whittaker, 1992).

- Don't discourage the behavior. Alderman (1998) gives the following advice.

> When we maintain the right to choose, our choices are much more powerful and effective...Telling an individual not to injure herself is both aversive and condescending. Because SHB is used as a method of coping and is often used as an attempt to relieve emotional distress when other methods have failed, it is essential for the person to have this option (p. 3).

The Importance of Social Supports

The literature distinguishes between two types of social support: emotional and instrumental (Smith & Anderson, 2000). Emotional support refers to behaviors that communicate to the individual the s/he is loved and/or cared for, while instrumental support refers to practical, tangible behaviors that provide assistance (e.g., lending money, giving a ride) (Smith & Anderson, 2000). Numerous studies suggest that a weak social support system (emotional and instrumental) intensifies the likelihood of self-harm, while a strong social support system reduces the risk of self-harm (Kelly & McKenna, 2004; Pattison & Kahan, 1983).

As mentioned, a lack of social support serves as a predisposing factor for self-harm. Studies involving cohorts of people who self-harm (Pattison & Kahan, 1983), institutionalized, mentally-ill individuals transitioning into the community (Kelly & McKenna, 2004), and adults with depression (Dennis, Wakefield, Molloy, Andrews, & Friedman, 2005), all support this claim. For example, one study involving older adults with depression compared those who were high-risk for self-harm with those who were low-risk for self-harm. The study found that individuals who self-harmed (high-risk) "were more likely to have a poorly integrated social network…" (Dennis et al., 2005, p. 1). Additional studies support this finding among various cohorts of people who self-harm (Pattison & Kahan, 1983; Kelly & McKenna, 2004).

Therefore, it is imperative for professionals, parents, educators, and others to consider the nature of the young person's social support network. That is, two means of assistance should be employed when assisting the individual who self-harms: first, parents, teachers, and others should do their best to serve as a means of social support themselves; and second; they should attempt to assist the individual in establishing and/or strengthening their own network of social supports (e.g., providing a mentor).

What Is Missing in the Literature?

SHB is a prevalent problem, yet there is limited and conflicted research concerning how to best assist people who struggle with it. Even more, there have been virtually no solid, well-controlled studies on how families, educators, or other significant people can assist individuals who engage in superficial SHB.

More research is needed to gain insight into the perceptions of the self-harming individuals themselves. Specifically, according to the individual who has harmed herself, *who*, besides the therapist, is the most helpful, and *what* particular behaviors and/or reactions does she perceive as helpful.

Chapter 3: Methods

Participants

Participants included 96 females between age 18 - 46 years (mean = 21.8, median = 20, *SD* = 4.9). Participants were individuals who reported presently engaging in, or formerly engaging in, superficial SHB, but not stereotypic or major SHB (participants indicating stereotypic and/or major SHB were excluded). In addition, all participants self-reported being free from severe psychological disturbances that often co-occur with more severe forms of SHB, specifically autism, schizophrenia, and multiple personality disorder (participants self-reporting these disorders were excluded).

Participants were recruited from three online support forums: http://gabrielle.self-injury.net/; http://buslist.org/phpBB/; and www.shardforum.co.uk. These websites host members who seek support for managing and/or reducing their self-harm. Members of the communities on these sites post messages seeking and/or offering support; they may also participate in live, online conversations through typed, posted messages. No compensation for participation was provided.

Forty-seven of the participants were from 24 different states within the United States; 32 were from England; 5 were from Canada; 3 were from Australia; 1 was from Singapore; 1 was from New Zealand; and the remaining 7 were from various European countries. Eighty-eight of the participants were Caucasian; 7 were other; and 1 did not specify.

Eighty-six of the participants reported harming themselves within the past year; 10 reported being recovered, as determined by the self-report that the participant had not harmed herself within the past year. In addition, the reported mean length of time harming oneself was 7 years (median 6 years; *SD* = 4.4 years; range=1 - 24 years).

Finally, participants reported the most frequently occurring form of self-harm as cutting, with 98 percent of the sample cutting at least several times weekly. Other forms of self-harm included, in descending order: scratching; picking skin so it becomes wounded or cannot heal; burning; biting, biting nails excessively short, banging the head, inserting items under the skin, and eating sharp or toxic items.

Procedures

Initially, the survey was reviewed by five licensed psychologists from BYU's Counseling Psychology and Special Education (CPSE) Department and licensed psychologists from BYU's Counseling and Career Center. Reviewers provided feedback in regard to the survey's content, particularly the type of questions and the potential of the survey to gather the identified information.

Next, permission to conduct research was obtained from the three online support group forums: http://gabrielle.self-injury.net/; http://buslist.org/phpBB/; and www.shardforum.co.uk Once letters of permission were obtained, all materials were be sent to Brigham Young University's (BYU) Institutional Review Board (IRB).

Upon the completion of IRB approval, moderators from each of the three aforementioned websites were notified that the survey was ready for posting. A web-link to the survey was then listed on each of the three aforementioned online support forums. The link posted on each site was accompanied by an explanatory message, as well as a message soliciting participation.

Prior to administering the surveys, informed consent was obtained from all participants. The informed consent form informed participants of the details of the study, risks, and benefits. It provided contact information for the primary investigator as well as BYU's IRB Chair.

Participants were informed that anonymity would be assured. Appendix A contains the participant's research consent form.

Informed consent was obtained through clicking on an "I agree" statement indicating that the individual had read and understood the consent form, desired to participate at her own free will, was female, and was at least 18 years of age. Online participants were not allowed to access the questionnaire until they clicked on the "I agree" statement, which was placed at the bottom of the informed consent document. Clicking on the "I agree" statement connected participants to the survey.

In addition, two screening questions were included at the end of the online survey with the purpose of eliminating participants who have a history of major and/or stereotypic SHB, or who have been diagnosed with schizophrenia, autism, or multiple personality disorder/dissociative identity disorder. Surveys from participants who self-reported the presence of any these behaviors or diagnoses were excluded.

Measures

Appendix B explains the questions and variables associated with the questionnaire. The questionnaire is included in Appendix C.

Research Design

As the questionnaire included both close-ended and open-ended questions, this study may be classified as a within-stage, mixed model design. It was both qualitative and quantitative. In addition, the present study was both retrospective and prospective. That is, the survey investigated the perspectives of individuals who no longer self-harm, as well as the perspectives of individuals who continued to self-harm at the time of participation.

Data Analysis

For each of the questions, descriptive statistics were generated, including mean and standard deviation, median and interquartile range, and modes and ranges. Since there was no reference point with which to compare these data (using single sample t-tests), this initial study described the responses as a first step.

Several *t*-tests or non-parametric analogues were used to test for differences between recovered vs. non-recovered self-harming subjects. Results were evaluated and considered significant if *p* were less than or equal to .05.

Chapter 4: Results

Demographic Data

The sample (n = 96) was composed of female participants from around the world. Forty-seven participants resided in 24 states within the United States, 32 resided in England, 5 in Canada, 3 in Australia, 2 in Scotland, and 1 participant in each of the following countries: Singapore, Austria, Netherlands, New Zealand, Slovenia, Sweden, and Switzerland. The sample was 91.7% Caucasian (n = 88), 7.3% non-White (n = 7); one participant did not specify her race/ethnicity. Participants ranged from 18 to 46 years of age (M = 21.8, SD = 4.9). In addition, 41.7% (n = 40) of the participants had completed at least some college and 30.2% (n = 29) were students who worked part-time. These demographics, though limited, appear to be somewhat representative of the general population of young women who self-harm (Simpson, 2001).

Profile of Self-Harming Behaviors

Only 10.4% (n = 10) of sample met the "recovered" criteria, indicating that they had not engaged in any form of self-harm within the past 12 months. Participants reported harming themselves for lengths of time ranging from 1 to 24 years (M = 7, SD = 4.4). The most frequently occurring form of self-harm reported was cutting, with 97.9% (n = 94) of participants reporting a history of cutting and 36.5% (n = 35) reporting cutting at least several times weekly. Other forms of self-harm included, in descending order: scratching, picking skin so it becomes wounded or cannot heal, burning, biting, biting nails very short, head banging, hair pulling, inserting items under the skin, and eating sharp or toxic items.

What is Helpful

Eighty-six percent (n = 83) of participants reported that having someone acknowledge the severity of their distress is helpful; 83% (n = 80) reported that talking about self-harm with

someone who is nonjudgmental and lets them verbalize their feelings is helpful; and 81% (*n* = 78) of participants reported that knowing someone is available is helpful. On the contrary, 99% (*n* = 95) of participants reported that being grounded, threatened, or punished in some way is not helpful.

Who is Helpful

On a scale ranging from extremely harmful to extremely helpful, participants rated their perceived helpfulness of the following individuals: mother, father, friend(s), significant other, sibling(s), teacher(s), athletic coach, religious leader, and school psychologist/counselor. Refer to Appendix C for bar graphs depicting perceptions of participants rating these individuals' perceived helpfulness.

Participants rated their friends as the most helpful group. Fifty-nine percent (*n* = 57) of participants rated their friends as *minimally helpful* or better (e.g., as *minimally*, *somewhat*, or *extremely helpful*), indicating the tendency for participants to perceive their friends as the most helpful group of individuals in terms of dealing with their self-harm.

In addition, the most frequently occurring helpfulness rating for each potential helper included the following: 20% (*n* = 19) rated their mothers as *somewhat harmful*; 28% (*n* = 27) rated their fathers as *neutral*; 27% (*n* = 26) rated their friends as *somewhat helpful*; and 38% (*n* = 36) rated their sibling(s) as *neutral*. A helpfulness rating of *N/A* was the most frequently occurring response for teacher(s), athletic coach, religious leader, and school psychologist/counselor. Table 1 provides a summary, listing individuals' helpfulness ratings.

Table 1

Percentage of Participants Describing Perceived Helpfulness of Specific Individuals

	Helpful			Neutral	Harmful			NA
	Extremely	Somewhat	Minimally		Minimally	Somewhat	Extremely	
Mother	4	12	7	16	11	20	12	17
Father	3	4	5	28	10	21	8	20
Teacher	5	9	6	32	2	3	5	36
Friend(s)	11	27	21	18	7	2	2	11
Siblings	3	3	10	38	8	8	5	24
Signifi-cant other	9	21	11	12	6	1	7	31
Athletic coach	0	1	1	23	1	1	1	72
Religious leader	6	5	2	21	2	2	2	59
School psych or school counselor	8	12	11	12	5	6	3	41

Note. $N = 96$.

Who-What Combination

A follow up question was asked of participants who answered *yes* to the question of whether a particular behavior is/was helpful. This question asked *who* they most preferred to perform that helping behavior.

One of these questions asked "…who would you most prefer to have directly ask(ed) you how they might be helpful?" Almost half, 41.4% (12 of 29) reported that they would most prefer their friend(s) to ask this question.

When asked "…who is/was the single most helpful person to talk about 'why' with you?" 41% (23 of 56) responded that they would most prefer to talk about *why* they harm themselves with a mental health worker, doctor, or social worker; 32% (18 of 56) said they would prefer having this discussion with their friend(s).

In addition, out of those participants who responded *yes* to whether "talking about it with someone who is nonjudgmental and lets you verbalize your feelings" is/was helpful, 37% (25 of 67) reported they would most prefer this type of discussion with a mental health worker, doctor, or social worker; 34% (23 of 67) reported they would most prefer this type of discussion with a friend.

When asked "…who is the single most helpful person to stay with you?" 42% (15 of 36) responded friend(s) and 25% (9 of 36) responded significant other/ex-significant other.

When asked "…who is the single most helpful person to have available?" 41% (n = 59) responded that they would most like to know that their friend(s) is/are available, and 19% responded that they would most like to know that their partner/ex-partner is available.

Finally, when asked who was most helpful in acknowledging the severity of participant's distress, 28% (15 of 53) responded that they would most like their friend(s) to acknowledge the

severity of their distress, while 19% (10 of 53) responded a preference for a mental health worker, doctor, or social worker to acknowledge the severity of their distress.

Perspective of Recovered versus Non-Recovered

Only 10% (n = 10) of this sample met the "recovered" criterion, indicating that they had not engaged in any form of self-harm within the past 12 months. Statistical tests revealed only one significant difference between the recovered and non-recovered participants. Women that had recovered were less likely to attend church (U = 281.5, p=.045). There were no differences between the two groups on any other *demographic, who,* or *what* variable.

CHAPTER 5

Discussion

Summary

In terms of *who* is helpful, participants rated friends as the group of people perceived as the most helpful, with 59% (57 of 96) rating their friends as *minimally helpful* or better (e.g., *minimally*, *somewhat*, or *extremely* helpful). Participants rated the helpfulness of all other individuals predominantly within the *neutral* to *extremely harmful* range. This finding indicates that, aside from their friends, participants perceived others as either having no impact on their self-harm behaviors, or, even worse, as exacerbating these behaviors. These findings make sense, given that many women who self-harm have borderline personality disorder (BPD), and a key feature of BPD involves the need to feel nurtured and supported. It also makes sense in that therapeutic approaches consistent with those of dialectical behavior therapy (DBT)—which involves validation, empathy, and a radical acceptance of things as they are "in the moment"—have been quite effective in treating patients with BPD (Swenson, Sanderson, Dulit, & Linehan, 2001).

In terms of helping behaviors (e.g., "what"), participants expressed their beliefs that each of the following is helpful: having someone acknowledge the severity of their distress; talking about their self-harm with someone who is nonjudgmental and encourages expression of feelings; and knowing that someone is available. On the contrary, only one participant reported that punitive measures such as being grounded, threatened, or punished were helpful. This finding is consistent with the theory that self-harm is a means of tension-reduction in the face of overwhelming feelings of anxiety (i.e., the endorphin effect) (Selekman, 2002). The notion that

being grounded, threatened, or punished exacerbates the problem makes sense, in that punitive behaviors frequently serve to increase tension, anxiety, and anger.

The two main helping behaviors noted by participants included someone acknowledging the severity of their distress and someone encouraging verbalization of their feelings. This finding is consistent with the hypothesis that individuals who self-harm have a difficult time verbalizing their feelings. The young women who participated in this study apparently recognized this as challenging and expressed the importance of this need to verbalize their feelings with a trusted other. These findings also support basic counseling theory and the elements necessary to build rapport and therapeutic relationships (Corey, 2005).

In terms of *who-what* combinations (e.g., person + helping behavior), participants indicated a preference for mental health workers/doctors/social workers, friends, or partners/ex-partners to perform certain helping behaviors. Summarizing this feedback, first, mental health workers/doctors/social workers were the most frequently listed group of individuals with whom participants said they would like to "talk about why," as well as the second-most frequently listed group of individuals whom participants said they would most prefer to have "acknowledge the severity of [their] distress." Finally, mental health workers/doctors/social workers were the most frequently listed group of individuals with whom participants stated they would most like to engage in the following: "talking about it with someone who is nonjudgmental and lets you verbalize your feelings."

The results of this study also suggest that, in addition to mental health workers, friends have the potential of playing a significant role in an individual's management of and recovery from self-harming behaviors. Participants indicated that, more than anyone else, they would prefer their friends to directly ask how they might be helpful; that they would most prefer to

know that their friends are available; and they would most prefer their friends to acknowledge the severity of their distress. In addition, friends were chosen as the second-most preferred group of people (only to mental health workers/doctors/social workers) when participants were asked with whom they would most prefer to talk in a nonjudgmental way while allowing them to verbalize their feelings. Finally, friends were also second only to mental health workers/doctors/social workers when participants were asked with whom they would most prefer to "talk about why." While there is currently no research concerning the effects of friendship on self-harm, multiple studies suggest that friendship/positive peer support promotes pro-social behavior in young people (e.g., Barry & Wentzel, 2006; McGuire & Weisz, 1982). Specifically, the affective quality, stability, and frequency of interaction in a friendship are correlated with the frequency of pro-social behavior in young people (Barry & Wentzel, 2006). Furthermore, positive friendships have to potential to counter some of the intense, negative emotions frequently associated with self-harm, such as social isolation and loneliness (Favazza, 1996).

Finally, partners/ex-partners also appear to play a significant role in the management of self-harm in young women. Specifically, "partner/ex-partner" was the most common response to the question, "…who is the single most helpful person to stay with you?" It was also the most popular response to the question about *who* participants preferred as being *available* to them.

In summary, it appears that, aside from mental health and medical professionals, young women who self-harm would most prefer their friends to help in the following ways: (1) by acknowledging the severity of their distress; (2) by directly asking how they might be helpful; and (3) by being available.

These findings are consistent with past research in several areas. First, past research indicates that many young people who engage in superficial self-harm have a limited ability to

verbally express their feelings (Simpson, 2001), possess limited coping skills (Shea, 1993, as cited in Favazza, 1996), and report a sense of social isolation, loneliness, and inability to form close relationships (Favazza, 1996). It appears that on some level participants recognize these weaknesses and are aware of the means by which other individuals can be used to compensate and/or increase their skills. That is, participants appear to recognize the appropriateness of discussing feelings with others, as this behavior doubles as a coping strategy and way to increase one's ability to effectively express oneself.

Furthermore, past studies report that individuals who self harm find it helpful to develop coping skills, particularly in verbally expressing their feelings and learning to use constructive behavior (Nelson & Grunebaum, 1971). The results of this study are clearly consistent with these claims. However, in Nelson and Grunebaum's (1971) study, participants most frequently reported that learning to verbally express feelings and behave constructively were achieved with the help of an accepting therapist. In the present study, mental health workers (which were not part of the original research questions) were actually written in as the most preferred helpers on numerous open-ended questions; this occurred in several areas. This is a potentially valuable finding, particularly for those who work with youth in school settings (school counselors and school psychologists). More efforts should be taken to educate and prepare school-based mental health workers to work with youth exhibiting SHB.

Although almost 75% of mental health services are provided in the public school setting (Burns & Hoagwood, 2002), after graduating many individuals do not have medical insurance and/or the monetary resources to obtain mental health services. Thus, almost by default, it appears that friends may be the single most valuable and available resource for many young people who self-harm.

Finally, while participants expressed a preference for their friends, helping behaviors need not be limited solely to friends. Influential adults whom the individual respects, such as parents, teachers, coaches, siblings, and others, may be able to assist in steering behaviors and attitudes in a positive direction (e.g., by acknowledging distress, etc.) while avoiding judgment and punitive measures that tend to increase anxiety. Efforts aimed at providing parents and support personnel with basic information about self-harm would provide a greater net of support for effective intervention, particularly instructions for assisting individuals in the development of healthy coping skills.

Limitations

This study contained several weaknesses. First, the majority of participants (89.6%) failed to meet the criteria for recovery, indicating that they had engaged in self-harm at least once within the past 12 months. As a result, this particular sample may be viewed as less-than-ideal for gaining insight into *who* and *what* is truly helpful, given that these individuals continue to harm themselves. Perhaps an exclusively recovered sample would reveal more useful findings.

Second, it may be argued that Internet support forums attract a very specific group of people (Mathy, Kerr, & Haydin, 2003), specifically people who are computer-literate and/or falling within an SES category allowing for computer ownership. Consequently, the sample obtained may not be entirely representative of individuals who self-harm. If this is the case, then the data gathered from this study do not generalize to the population of young women who self-harm. At the same time, however, it can be argued that an Internet sample is more generalizable than a local sample due to the broad range of cultures from which participants can be drawn (Birhbaum, 2004).

Second, participants may have provided false responses on the screening questions used to exclude individuals with certain psychiatric disorders and/or histories of non-superficial self-harm. These questions were included in order to ensure that the population sampled most accurately represented individuals who engage in superficial self-harm, rather than stereotypic and/or major self-harm. This was important, as these forms of self-harm represent very different underlying pathology (Simpson, 2001; Favazza, 1996; Favazza & Rosenthal, 1993). If numerous participants did in fact provide untruthful responses, then the data gathered is not representative of the population in question—that is, young women who engage in superficial self-harm in the absence stereotypic and/or major self-harm.

Third, it was impossible to verify whether each participant was truly older than 18 years of age. Although participants were initially required to report an age of 18 or older in order to participate, a few participants reported ages of 17 or younger. These surveys were excluded from the study.

Fourth, the participants were primarily Caucasian. Consequently, the results may be minimally generalizable to populations of non-Caucasian women who self-harm. At the same time, however, participants were drawn from numerous countries around the world. So while this study represents a variety of cultures, it fails to represent cultures composed of primarily non-Caucasian individuals.

Finally, some participants may have responded more than once. Participants may have been uncertain if their electronic information was entered and may have completed the questionnaire more than once to ensure their data actually entered the system. The data were examined for response sets that appeared to have come from the same individual (e.g., two consecutive surveys that provided the same age, location, and response pattern). Approximately

twenty of these were found and discarded. However, the possibility of duplicate responses remains.

Suggestions for Future Research

Given that this study consisted of primarily Caucasian participants, future studies could investigate superficial self-harm among non-Caucasian populations. Specifically, it could look at how the nature of self-harm and its surrounding consequences differ between cultural groups (i.e. prevalence, stigma). Subsequent treatment implications and helping behaviors could then be investigated. To accomplish this, future Internet surveys could solicit specific ethnic and/or cultural groups (e.g., African Americans, Latin Americans) through culture-specific websites and/or even create culture specific websites to unite these populations.

Future research may also investigate current interventions and how mental health professionals assist individuals who self-harm. Investigating strategies of practitioners and the effectiveness of intervention, based on both the perspective of the therapist and the perspective of the client. Additionally preparing school-based mental health professionals (school counselors, school psychologists and social workers) with researched based interventions to more effectively assist adolescents and children would be of great value.

References

Alderman, Tracy (1998). Self-inflicted violence: Helping those who hurt themselves. *Self Help Magazine.* Retrieved September 16, 2004, from http://www.selfhelpmagazine.com/articles/depress/violence.html

Barry, C. M., & Wentzel, K. R. (2006). Friend influence on prosocial behavior: The role of motivational factors and friendship characteristics. *Developmental Psychology, 42*(1), 153-163.

Berk, L. E. (2003). *Child development* (6th ed.). Boston: Pearson Education, Inc.

Birnbaum, M. H. (2004). Human research and data collection via the Internet. *Annual Review of Psychology, 55,* 803-832.

Burns, J., Dudley, M., Hazell, P., & Patton, G. (2005). Clinical management of deliberate self harm in young people: The need for evidence-based approaches to reduce repetition. *Australian and New Zealand Journal of Psychiatry, 39,* 121-128.

Burns, B. J., & Hoagwood, K. (2002). *Community-based treatment for youth: Evidence based interventions for severe emotional and behavioral disorders.* New York: Oxford University Press.

Buzan, R. I., Dubovsky, S. L., Treadway, J. T., & Thomas, M. I. (1995). Opiate antagonists for recurrent self-injurious behavior in three mentally retarded adults. *Psychiatric Services, 46*(5), 511-512.

Cassano, P., Lattanzi, L., Pini, S., Dell' Osso, L., Battistini, G., & Cassano, G. B. (2001). Topiramate for self-mutilation in a patient with borderline personality disorder. *Bipolar Disorders, 3,* 161.

Corey, G. (2005). *Theory and practice of counseling & psychotherapy* (7th ed.). Belmont, CA: Brooks/Cole.

Costin, C. (2004). Interventions and strategies for families and friends of the self-harming patient with an eating disorder. In J. L. Levitt & R. A. Sansone (Eds.), *Self-harm behavior and eating disorders: Dynamics, assessment, and treatment* (pp. 195-210). New York: Brunner-Routledge.

Darche, M. A. (1990). Psychological factors differentiating self-mutilating and non-self mutilating adolescent inpatient females. *Psychiatric Hospital, 21*(1), 31-35.

Dennis, M., Wakefield, P., Molloy, C., Andrews, H., & Friedman, T. (2005). Self-harm in older people with depression: Comparison of social factors, life events, and symptoms. *The British Journal of Psychiatry: The Journal of Mental Science, 186,* 538-539.

Diamond, M., & Hopson, J. (1999). *Magic trees of the mind: How to nurture your child's intelligence, creativity, and healthy emotions from birth through adolescence.* New York: Plume.

DiClemente, R. J., Ponton, L. E., & Hartley, D. (1991). Prevalence and correlates of cutting behavior: Risk for HIV transmission. *Journal of the American Academy of Child and Adolescent Psychiatry, 30(*5), 735-739.

Dubo, E. D., Zanarini, M. C., Lewis, R. E., & Williams, A. A. (1997). Childhood antecedents of self-destructiveness in borderline personality disorder. *The Canadian Journal of Psychiatry, 42*(1), 63-69.

Favaro, A., & Santonastaso, P. (2000). Self-injurious behavior in anorexia nervosa. *The Journal of Nervous and Mental Disease, 188*(8), 537-542.

Favazza, A. R. (1996). *Bodies under Siege: Self-mutilation and body modification in culture and psychiatry*. Baltimore, MD: The Johns Hopkins University Press.

Favazza, A. R., & Conterio, K. (1989). Female habitual self-mutilators. *Acta Psychiatrica Scandinavica, 79,* 283-289.

Favazza, A. R., & Rosenthal, R. J. (1993). Diagnostic issues in self-mutilation. *Hospital and Community Psychiatry, 44*(2), 134-140.

Fichter, M. M., Quadflieg, N., & Rief, W. (1994). Course of multi-impulsive bulimia. *Psychological Medicine, 24,* 591-604.

Gardner, D. L., & Cowdry, R. W. (1985). Alprazolam-inducted dyscontrol in borderline personality disorder. *American Journal of Psychiatry, 142*(1), 98-100.

Haines, J., & Williams, C. L. (1997). Coping and problem solving of self-mutilators. *Journal of Clinical Psychology, 53*(2), 177-186.

Haines, J., Williams, C. L., Brain, K. L., & Wilson, G. V. (1995). The psychophysiology of self mutilation. *Journal of Abnormal Psychology, 104*(3), 471-489.

Harvard Mental Health Letter. (2002, August). Dialectical behavior therapy. Author, *19*(2), 1-3.

Hough, D. W. (2001). Low-dose olanzapine for self-mutilation behavior in patients with borderline personality disorder. *Journal of Clinical Psychiatry, 62*(4), 296-297.

The Houseparent Network (2005). *Glossary/definitions to common residential childcare terms.* Retrieved August 18, 2005, from http://www.houseparent.net/Glossary-Definitions.htm

Jacobs, B. (2005). *Adolescents and self-cutting (self-harm): Information for parents.* Retrieved August 22, 2005, from New Mexico State University, College of Agriculture and Home Economics Web site: http://cahe.nmsu.edu/pubs/_i/I-104.pdf

Kelly, S., & McKenna, H. (2004). Risks to mental health patients discharged into the community. *Health, Risk, & Society, 6*(4), 377-385.

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

Lacey, J. H., & Evans, C. D. H. (1986). The impulsivist: A multi-impulsive personality disorder. *British Journal of Addiction, 81,* 641-649.

Levitt, J. L., Sansone, R. A., & Cohn, L. (Eds.). (2004). *Self-harm behavior and eating disorders: Dynamics, assessment, and treatment.* New York: Brunner-Routledge.

Lieberman, R. (2004). Understanding and responding to students who self-mutilate. *Principal Leadership Magazine, 4* (7). Retrieved September 1, 2004, from http://www.naspcenter.org/principals/nassp_cutting.html

Low, G., Jones, D., MacLeod, A., Power, M., & Dugan, C. (2000). Childhood trauma, dissociation, and self-harming behaviour: A pilot study [Abstract]. *British Journal of Medical Psychology, 73,* 269-278.

Martinson, D. (2000). Self-injury. *Focus Adolescent Services.* Retrieved September 16, 2004, from http://www.focusas.com/SelfInjury.html

Mathy, R. M., Kerr, D. L., & Haydin, B. M. (2003). Methodological rigor and ethical considerations in internet-mediated research. *Psychotherapy: Theory, Research, Practice, Training, 40*(1), 77-85.

Matsunaga. H., Kiriike, N., Iwasaki,Y., Miyata, A., Matsui, T., Nagata, T., et al. (1998). Multi impulisivity among bulimic patients in Japan. *International Journal of Eating Disorders, 27,* 348-352.

McGuire, K. D., & Weisz, J. R. (1982). Social cognition and behavior correlates of preadolescent chumship. *Child Development, 53*(6), 1478-1484.

Nagata, T., Kawarada, Y., Kiriike, N., & Iketani, T. (2000). Multi-impulsivity of Japanese patients with eating disorders: Primary and secondary impulsivity. *Psychiatry Research, 94*, 239-250.

Nelson, S. H., & Grunebaum, H. (1971). A follow-up study of wrist slashers. *American Journal of Psychiatry, 127*(10), 1345-1349.

Nock, M. K., & Prinstein, M. J. (2005). Contextual features and behavioral functions of self mutilation among adolescents. *Journal of abnormal psychology*, *114* (1), 140-146.

Nursing Standard. (2005). Self-harm inquiry reveals alarming rates. *Author, 19*(29), 8.

Pattison, E. M., & Kahan, J. (1983). The deliberate self-harm syndrome. *American Journal ofPsychiatry, 140*(7), 867-872.

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

Ross, S., & Heath, N. L. (2003). Two models of adolescent self-mutilation. *Suicide and life threatening behavior, 33*(3), 277-287.

Ross, R. R., & McKay, H. B. (1979). *Self-Mutilation.* Lexington, MA: Lexington Books.

Selekman, M. D. (2002). Adolescent self-harm. *American Association of Marriage & Family Therapy*. Retrieved September 16, 2004, from http://www.aamft.org/families/Consumer_Updates/Adolescent_Self_Harm.asp

Shuttleworth, A. (2004). New guidelines for the treatment and management of people who self harm. *Nursingtimes, 100*(41), 49.

Simpson, C. (2001). *Self-mutilation* (Report No. EDO-CG-01-10). Greensboro, NC: ERIC Clearinghouse on Counseling and Student Services. (ERIC Document Reproduction Service No. ED465945)

Simpson, C. A., & Porter, G. L. (1981). Self-mutilation in children and adolescents. *Bulletin of the Menninger Foundation, 45*(5), 428-438.

Smith, D., & Anderson, R. (2000). Social support, risk-level and safety actions following acute assessment of suicidal youth. *Journal of Youth and Adolescence, 29*(4), 451-465.

Swenson, C. R., Sanderson, C., Dulit, R. A., & Linehan, M. M. (2001). The application of dialectical behavior therapy for patients with borderline personality disorder on inpatient units. *Psychiatric Quarterly, 72*(4), 307-324.

Tantam, D., & Whittaker, J. (1992). Personality disorder and self-wounding. *British Journal of Psychiatry, 161*, 451-464.

Travia, T. L. (2003). Self-inflicted violence: Examining a tension-reduction mechanism in an outpatient internet derived sample. *Dissertation Abstracts International, 54* (9), 4640. (UMI No. 3103193)

Van der Kolk, B. A., Perry, J. C., & Herman, J. L. (1991). *Childhood origins of self destructive behavior* [Abstract]. *American Journal of Psychiatry, 148*(12). 1665-1671.

Walsh, B. W., & Rosen, P. (1988). *Self-mutilation: Theory, research, and treatment.* New York: Guilford.

Wood, A., Trainor, G., Rothwell, J., Moore, A., & Harrington, R. (2001). Randomized trial of group therapy for repeated deliberate self-harm in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(11), 1246-1253.

Ystgaard, M., Reinholdt, N. P., Husby, J., & Mehlum, L. (2003). Deliberate self harm in adolescents [Abstract]. *Norske Laegeforening. Tidsskrift, 123*(16), 2241-2245.

Zila, L. M., & Kiselica, M. S. (2001). Understanding and counseling self-mutilation in female adolescents and young adults. *Journal of Counseling and Development, 79*(1), 46-52.

Zlotnick, C., Shea, M. T., Pearlstein, T., Simpson, E., Costello, E., & Being, A. (1996). The relationship between dissociative symptoms, alexithymia, impulsivity, sexual abuse, and self-mutilation [Abstract]. *Comprehensive Psychiatry, 37*(1), 12-16.

APPENDIX A

Consent to be a Research Subject

Introduction
This research study is being conducted by Katie Ryan, a graduate student at Brigham Young University, to determine what young women who currently engage in, or formerly engaged in, self-harm behaviors (SHB), such as cutting, burning, scratching, or self-hitting, believe are the best ways to help them overcome SHB. You were asked to participate because you currently engage in SHB, or have engaged in SHB in the past, are female, and over the age of 18.

Procedures
After consenting to participate, you will be lead to a questionnaire which will take approximately 10 minutes to complete. Questions will include details about your demographics, your own personal views about who has been helpful to you in dealing with SHB, and your descriptions about the ways the important people in your life have been helpful to you.

Risks/Discomforts
There are minimal risks for participation in this study. However, you may feel emotional discomfort when answering questions about your behaviors and personal beliefs.

Benefits
There are no direct benefits to participants. However, it is hoped that through your participation researchers will learn more about SHB and how people who engage in SHB feel they can be best helped.

Confidentiality
All information provided will remain confidential and will only be reported as group data with no identifying information. No identifying information will be attached to your questionnaire. All data will be kept in a locked storage cabinet and only those directly involved with the research will have access to it. After the research is completed, the questionnaires will be destroyed.

Participation
Participation in this research study is voluntary. You have the right to withdraw at anytime or refuse to participate entirely without consequence.

Questions about the Research
If you have questions regarding this study, you may contact Katie Ryan at (801) 362-1701, k_ryan25@hotmail.com.

Questions about your Rights as Research Participants
If you have questions you do not feel comfortable asking the researcher, you may contact Dr. Renea Beckstrand, IRB Chair, (801) 422-3873, 422 SWKT, renea_beckstrand@byu.edu.

1. You must agree to the below statement in order to take this survey.

[ ] I have read and understood the above consent and desire of my own free will to participate in this study. I am female and at least 18 years old.

APPENDIX B

SHB Questionnaire: Questions and Associated Variables

Variable	Question & Response
Perspective of recovered	[Item 11] Do you currently engage in SHB? (Yes, No)
Perspective of non-recovered	[Item 13] How long has it been since the last time you intentionally hurt yourself? (Less than 1 year, over 1 year) [Less than 1 year were considered non-recovered.]
Helping behaviors (*What?)*	[Items 16, 18, 20, 22, 24, 26, 28] Helpfulness of the following: verbalizing feelings to non-judgmental person; talking about "why;" having someone stay with you; knowing someone is available; having someone directly ask you how they might be helpful; having someone acknowledge the severity of your distress; being grounded threatened, or punished. (Helpful? Yes; No; Never happened but would be helpful; Never happened, would NOT be helpful) [Item 30] Are there other things people have done to help you? …what did they do? (Open-ended) [Item 31] Is there anything you wish the important people in your life would do, or would have done, to help you overcome SHB that they have not done or did not do? If yes, what do you wish they would do…? (Open-ended) [Item 32] Is there anything that people do/did with that you wish they would NOT have done or would stop doing? If yes, what did they do? (Open-ended)
Helpful people (*Who?)* Most helpful people Unhelpful people	[Item 15] Please indicate how helpful each of the following people were/are to you in reducing your self-harm. Mother, father, teacher, friend, sibling, significant other, coach, religious leader, school psychologist/counselor, other. N/A, extremely harmful, somewhat harmful, minimally harmful, neutral, minimally helpful, somewhat helpful, extremely helpful. (Check boxes) [Item 17, 19, 21, 23, 25, 27, 29, if "Yes] If you checked yes, who….? (Open-ended) [Item 30] …Who was involved? (Open-ended)

APPENDIX C

SURVEY

This is a survey for young women ages 18 and older who presently engage in, or previously engaged in, self-harm behaviors (SHB), such as cutting, burning, scratching, or self-hitting. It is a survey about how you feel others could help you, or could have helped you, in dealing with SHB. The purpose is to find out who is/was helpful to you, the specific ways they help(ed) you, and the ways that you think they could be, or could have been, more helpful. Your responses could help others to know how to best help people deal with SHB. Please answer the questions as thoroughly as you can. Thank you for your participation!

Please complete this survey only once. Also, if you took this survey on another website, please do not take it again. Thanks!

Demographic Questions
These questions will help us with our research. You may skip any question you do not feel comfortable answering. However, we encourage you to answer all of these questions as it will help us to understand the characteristics of women who self-harm.

2. Age: _____

3. What is your location? (Please include country and city. If you are in the United States, list city and state.) _____

4. What is your ethnic heritage (or race)? _____

5. How often do you attend church or other religious ceremonies?
[ ] 1 time or less per year [ ] 2-8 times per year [ ]Almost monthly [ ]Almost weekly or more

6. How would you categorize your current economic situation?
[ ] I am *very* comfortable [ ] Good [ ] I just about get by [ ] I am struggling everyday

7. What is your level of completed education?
[ ] Did not graduate from high school
[ ] Graduated high school
[ ] Some college
[ ] Bachelor's degree
[ ] Graduate degree
[ ] Other (please specify) _____

8. What is your mother's level of completed education?
[ ] Did not graduate from high school
[ ] Graduated high school
[ ] Some college
[ ] Bachelor's degree

[ ] Graduate degree
[ ] Other (please specify)

9. What is your current occupation?
[ ] Unemployed
[ ] Student, not working
[ ] Student, working part-time
[ ] Student, working full-time
[ ] Part-time job
[ ] Full-time job
[ ] Stat-at-home mother
[ ] Other (please specify) _____

10. What is your current living situation?
[ ] I live alone [ ] I live with others

Self-Harm Questions
The rest of the questions will ask you about your behaviors and feelings related to self-harm.

11. Do you currently engage in SHB?
[ ] Yes
[ ] No, I no longer engage in SHB

12. How many years have been hurting yourself? If you no longer harm yourself, for how many years did you hurt yourself? _____

13. How long has it been since the last time you intentionally hurt yourself?
[ ] Less than 1 year
[ ] Over 1 year

14. How did/do you harm yourself and how often (on average)? If you no longer harm yourself, check the box that applies to your *former behavior*. If you still harm yourself, check the box that applies to you now.

	Never	**Several times per year**	**Several times monthly**	**Several times weekly**	**Once daily**	**Multiple times daily**
Cutting						
Burning						
Scratching						
Picking skin so it becomes wounded or cannot heal						
Self-hitting						
Head-banging						

Hair pulling						
Biting nails *very* short						
Eating sharp or toxic items						
Biting self						
Inserting items under skin						
Other (please specify) _____						

15. Please indicate how helpful or harmful each of the following people were/are to you in reducing your self-harm.

	N/A	Extremely helpful	Somewhat helpful	Minimally helpful	Neutral	Minimally harmful	Somewhat harmful	Extremely harmful
My mother								
My father								
Current or former teacher(s)								
My friend(s)								
My siblings								
Significant other (boyfriend/girlfriend or spouse)								
Current or former athletic coach								
Current or former religious leader								
Current or former school psychologist or school counselor								
Other (please specify) _____								

Questions 16-34 ask you whether you find/found various things helpful in dealing with and/or reducing your self-harm. They also ask about who you think has been helpful or harmful.

16. Talking about it with someone who is nonjudgmental and lets you verbalize your feelings:

	Yes	No	Never happened, but would be helpful	Never happened, would NOT be helpful
Helpful?	[ ]	[ ]	[ ]	[ ]

17. If you checked yes, who is/was the single most helpful person to talk with?

_____

18. Talking about "why" you harm yourself:

	Yes	No	Never happened, but would be helpful	Never happened, would NOT be helpful
Helpful?	[ ]	[ ]	[ ]	[ ]

19. If you checked "Yes" for number 18, who is/was the single most helpful person to talk about "why" with you?

_____

20. Having someone stay with you:

	Yes	No	Never happened, but would be helpful	Never happened, would NOT be helpful
Helpful?	[ ]	[ ]	[ ]	[ ]

21. If you checked "Yes" on number 20, who is/was the single most helpful person to have stay with you?

_____

22. Knowing someone is available:

	Yes	No	Never happened, but would be helpful	Never happened, would NOT be helpful
Helpful?	[ ]	[ ]	[ ]	[ ]

23. If you checked "Yes" on number 22, who is/was the single most helpful person have available?

_____

24. Having someone directly ask you how they might be helpful:

	Yes	No	Never happened, but would be helpful	Never happened, would NOT be helpful
Helpful?	[ ]	[ ]	[ ]	[ ]

25. If you checked "Yes" on number 24, who would you most prefer to have directly ask(ed) you how they might be helpful?

_____

26. Having someone acknowledge the severity of your distress:

	Yes	No	Never happened, but would be helpful	Never happened, would NOT be helpful
Helpful?	[ ]	[ ]	[ ]	[ ]

27. If you checked "Yes" on number 26, it is/was most helpful to you when which person acknowledges/acknowledged the severity of your distress?

_____

28. Being grounded, threatened, or punished in some way:

	Yes	No	Never happened, but would be helpful	Never happened, would NOT be helpful
Helpful?	[ ]	[ ]	[ ]	[ ]

29. If you checked "Yes" on number 28, who is/was the most helpful person to ground, threaten, or punish you?

_____

30. Are there other things people have done to help you? If "No", skip this question. If "Yes", what did they do? Who was involved?
What did they do? _____
Who was involved? _____

31. Is there anything you wish the important people in your life would do, or would have done, to help you overcome self-harm that they have not done, or did not do? If "No", skip this question.
If "Yes", what do you wish they would do (or would have done)? _____
Who do you wish would do this (or would have done this)? _____

32. In terms of dealing with your self-harm, is there anything that people do/did that you wish they would NOT have done or would stop doing? If "No", skip this question.
If "Yes", what do they do? (Or what did they do in the past?) _____
Who does/did these things? _____

33. Have you ever been diagnosed with any of the following: schizophrenia, autism, or multiple personality disorder/dissociative identity disorder?
[ ] Yes
[ ] No

34. Sometimes individuals can hurt themselves, causing major harm to their body, such as injuring their eyes (popping out their eye or mutilating their eye) or even in extreme cases, amputating a limb.

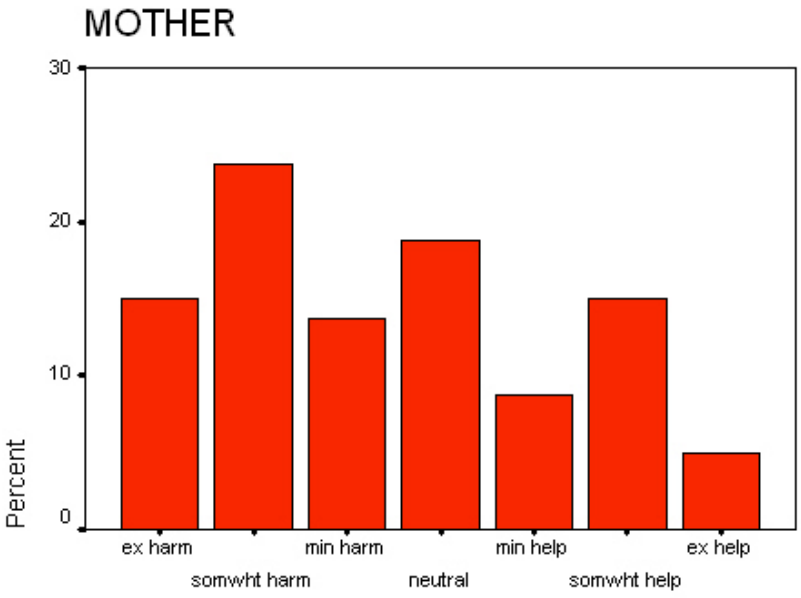
Have you caused serious injury to your body such as these two examples?
[ ] No
[ ] Yes, please explain

_____

Thank you for your participation!

APPENDIX D

Bar Graphs of Participants' Perceptions of Individuals' Helpfulness



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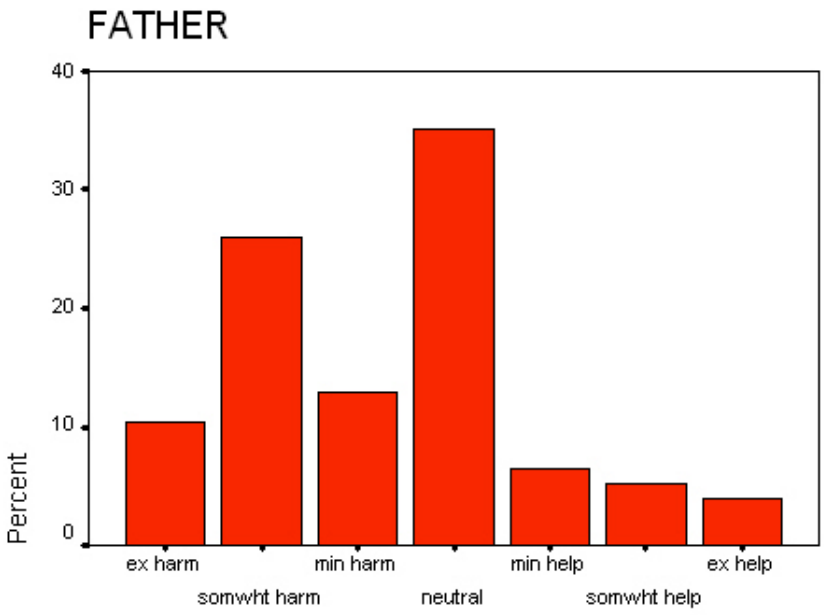

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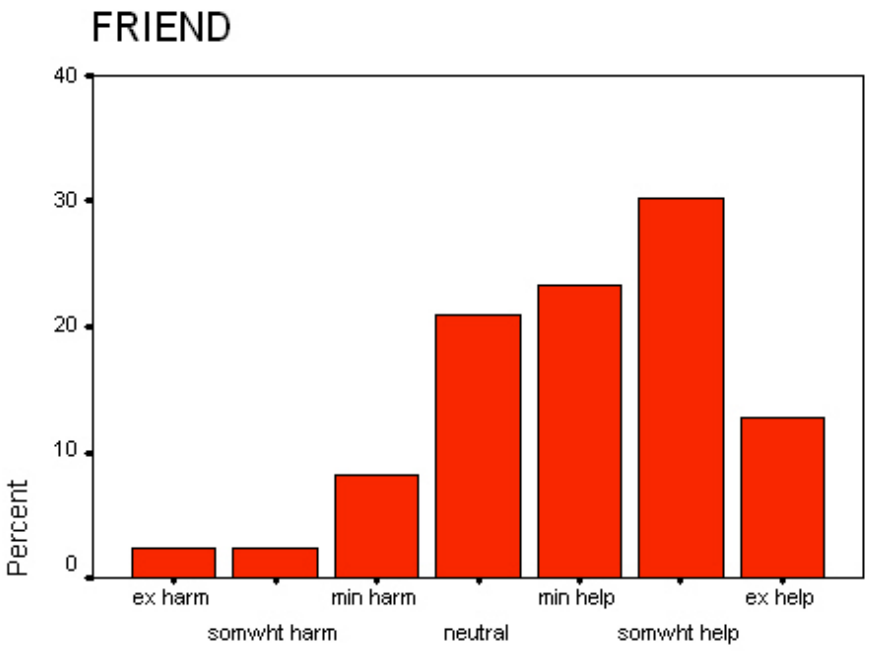

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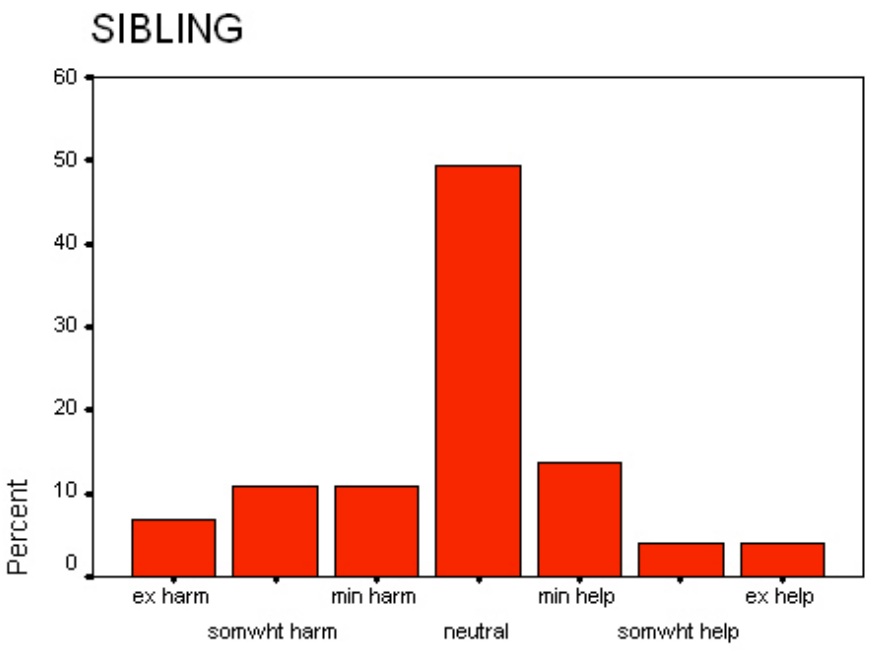

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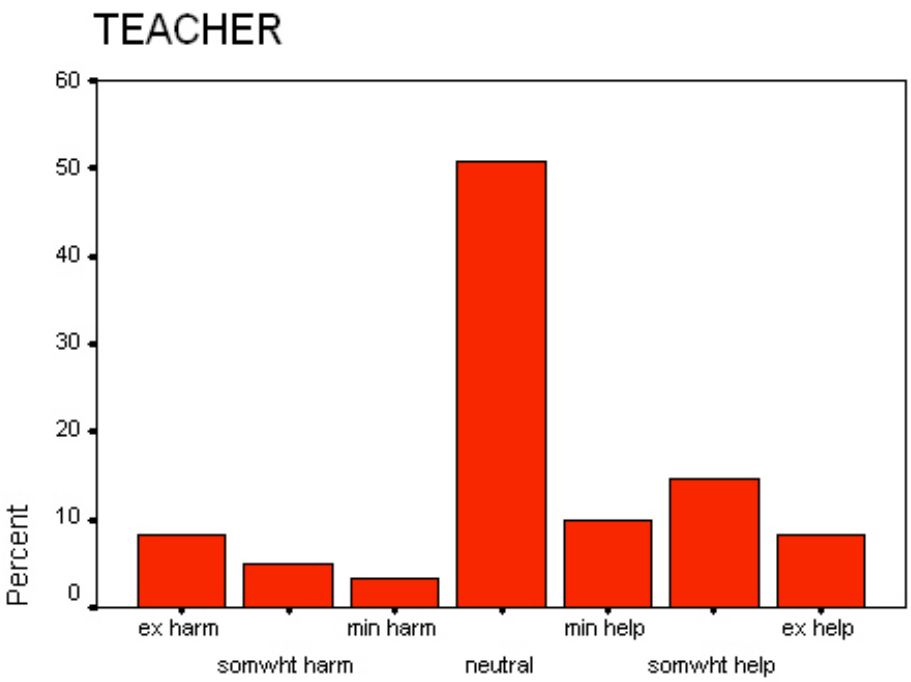
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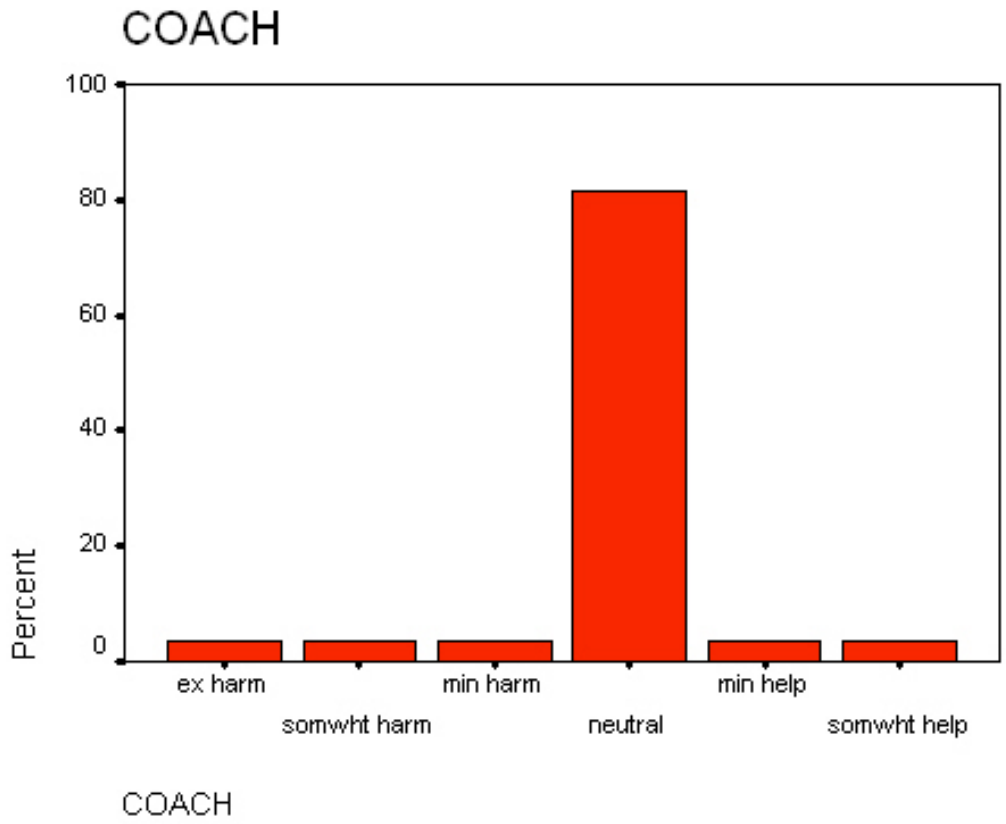
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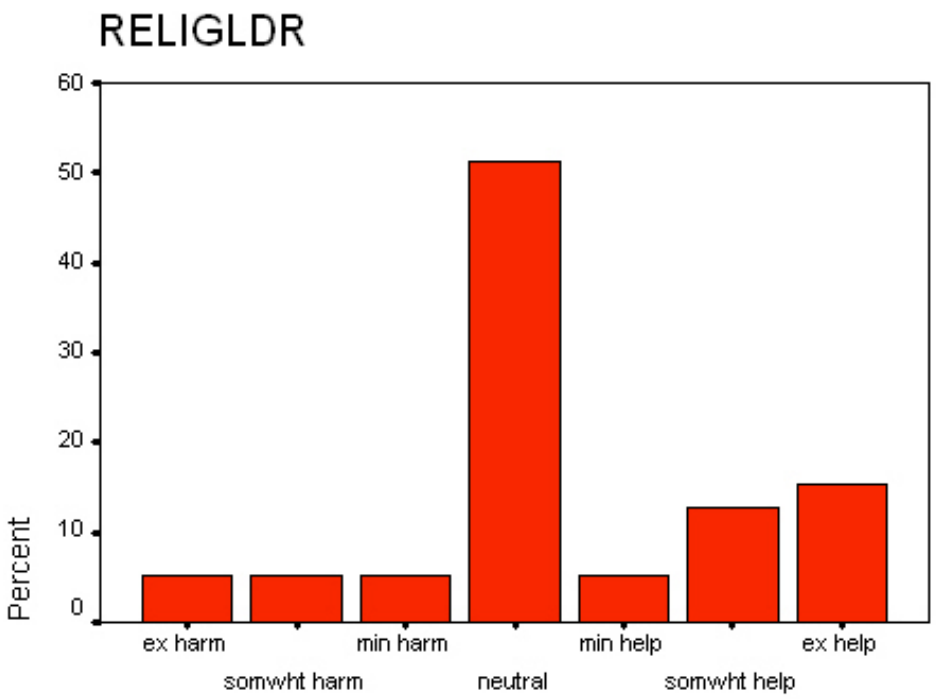

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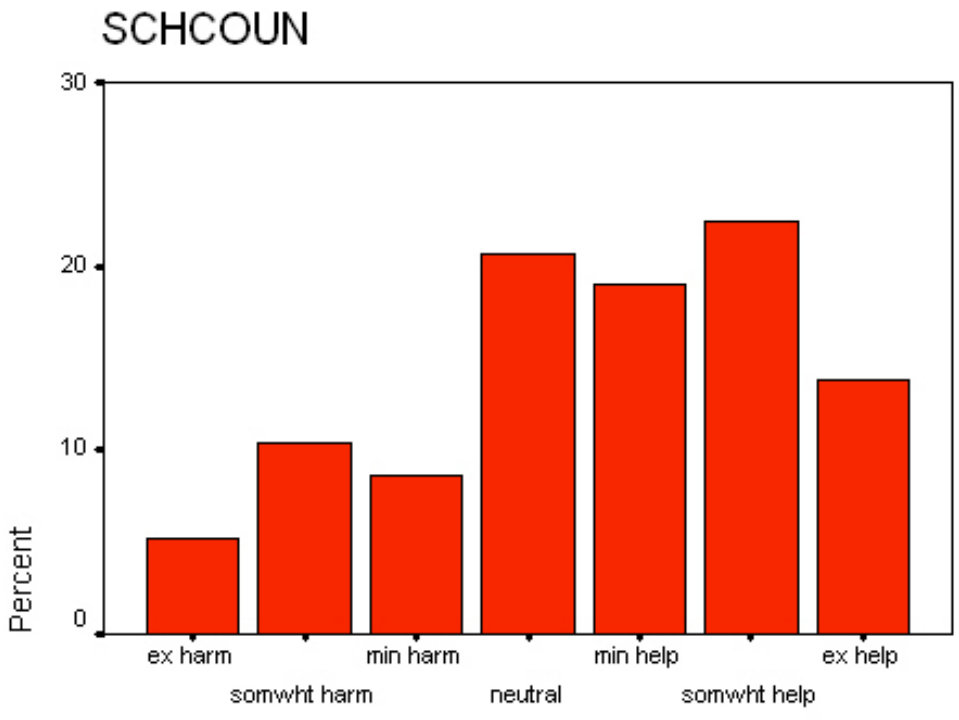

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