NONSUICIDAL SELF-INJURY IN QUEER YOUTH

by

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Abstract

The phenomenon of nonsuicidal self-injury (NSSI) involves the deliberate harm to one's own body tissue, such as cutting or burning one's skin, in the absence of suicidal intent or a pervasive developmental delay. Some prevalence studies have indicated that gay and bisexual youth may be at an increased risk of engaging in NSSI, but these studies have had very small numbers of non-heterosexual respondents (e.g., Murray, Warm, & Fox, 2005). The current study sought to investigate more fully the phenomenon of NSSI in lesbian, gay, bisexual, transgendered, genderqueer, and heterosexual individuals. The sample consisted of 155 heterosexual people aged 19-29 and 230 lesbian, gay, bisexual, transgendered, and genderqueer people who responded to an online survey advertised across Canada. Participants replied to questions about background, gender identity, and sexual orientation, followed by questions from the Non-Suicidal Self-Injury Questionnaire (NSSI-Q), and the Center for Epidemiological Studies- Depression (CES-D) inventory. Findings indicate that there was a statistically significant difference in the rates of NSSI in the total queer sample (47%) compared to the heterosexual sample (28%). The highest rate of self-injury was in the transgendered and genderqueer sub-sample, which had a NSSI rate of 67%. This subsample also had the highest severity of self-injury. Parental reaction to coming out was statistically significantly related to rates of self-injury, while one's own reaction to identifying as lesbian, gay, bisexual, transgendered, or genderqueer had a statistically significant relationship with severity of self-injury. There was also a relationship between the severity of self-injury and having been physically attacked due to sexual orientation or gender identity or having experienced homophobic bullying. The findings suggest that sexual orientation can have an impact on self-injury; implications for theory, practice, and research are discussed.

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Acknowledgements

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Chapter 1: Statement of the Problem

Defining Self-Injury

Nonsuicidal self-injury is the intentional destruction of body tissue such as cutting or burning one's skin without the intention of killing oneself. Recent research shows that roughly 14%-17% of teenagers are intentionally harming themselves in this manner, most often by cutting their skin (Klonsky & Muehlenkamp, 2007). In addition, the rates of documented self-injury have increased in the past decade, especially among young teenagers (Hawton et al., 2003). Researchers are still working to develop a basic understanding of self-injurious behaviour but have been slowed by challenges of operationally defining self-injury. For example, some research studies include behaviours performed with suicidal intent while others separate suicidal and non-suicidal self-injury. Further, terminology has been a challenge, with self-injury, self-harm, and self-mutilation all sometimes being used interchangeably to describe similar behaviours, despite many studies noting an important difference between self-injury and self-harm.

Partly due to lack of consistency in the definition, it has been difficult for researchers to elucidate the problem through the variability of definition in research studies. Some clarity in definitional issues came in 2006 when leading self-injury researchers founded the International Network for the Study of Self-injury (INSS) and one year later, in June 2007, agreed on the following definition of nonsuicidal self-injury, which will hereafter be referred to simply as self-injury or abbreviated as NSSI:

> The deliberate, self-inflicted destruction of body tissue resulting in immediate damage, without suicidal intent and for purposes not socially sanctioned. As such, this behavior is distinguished from: suicidal behaviors involving an intent to die, drug overdoses, and

> other forms of self-injurious behaviors, including culturally-sanctioned behaviors performed for display or aesthetic purposes; repetitive, stereotypical forms found among individuals with developmental disorders and cognitive disabilities, and severe forms (e.g., self-immolation and auto-castration) found among individuals with psychosis. (Heath, Toste, Nedecheva, & Charlebois, 2008, p.139)

The list of behaviours generally included in self-injury research is cutting (including scratching and carving), burning, self-hitting or punching, self-biting, poking objects into the skin, and breaking bones on purpose (Laye-Gindhu & Schonert-Reichl, 2005; Murray, Warm & Fox, 2005; Ross & Heath, 2002; Whitlock et al., 2006). With this definition, NSSI is differentiated from suicide attempts, from more severe forms of self-mutilation such as self-castration or eye enucleation, and from stereotypical behaviours seen in people with autism or severe cognitive impairment. Self-injury is also considered to be distinct from more general risk behaviours, such as disordered eating, binge drinking, or reckless driving.

Using the Network's definition of NSSI, researchers have begun to establish the prevalence of self-injury, which ranges from 4% in adult community samples to 30-61% in clinical samples (Lloyd-Richardson, 2008). Recent research has also been investigating the reasons why a nonsuicidal person would self-injure, although this has been challenging as Suyemoto explains in her review of functional models of NSSI, "Part of the difficulty in understanding the reasons behind self-mutilation lies in the over determined nature of the behavior. It is likely that self-mutilation serves more than one function simultaneously" (1998, p.532). Because self-injury can serve multiple functions simultaneously, isolating specific causes or triggers has been difficult. Initially, self-injury was thought to be primarily an attention-seeking behaviour or a form of manipulation (Warm & Fox, 2003). However, these

ideas have been discarded, as the most commonly cited reason people give for engaging in non-suicidal self-injury is to relieve emotional distress (e.g., Klonsky & Muehlenkamp, 2007; Laye-Gindhu & Schonert-Reichl, 2005; Nock & Prinstein, 2004). The most common theory is that youth who self-injure find that translating emotional pain into physical pain can provide an emotional release which leaves them feeling calm (Murray, Warm, & Fox, 2005).

Nock and Prinstein (2004) have investigated the motives that influence engaging in self-injury and have advanced a functional model of NSSI which links functions of self-injury with a model of positive and negative reinforcement (Skinner, 1965). The model will be examined more fully in the following chapter, but in sum, these researchers theorize that self-injury most commonly serves autonomic functions, meaning the purpose of the behaviour is to regulate emotions; they cite that the top two reasons for self-injuring in their sample of adolescent psychiatric inpatients were "to stop bad feelings" and "to relieve feeling numb or empty" (Nock & Prinstein, 2004, p.588,). Besides autonomic functions, they also point to social functions of self-injury which include seeking attention or self-injuring to belong to part of a group.

Self-injury in Lesbian, Gay, Bisexual, and Transgendered Youth

While researchers increasingly have been interested in the rates and causes of self-injury, including investigation into the relative rates of self-injury in specific populations, such as homeless youth (Tyler, Whitbeck, Hoyt, & Johnson, 2003) and youth with eating disorders (Svirko & Hawton, 2007). Few investigations of self-injury have asked any questions about sexual orientation, although three surveys of general populations (Kokaliari 2005; Murray, Warm, & Fox, 2005; Whitlock, Eckenrode, & Silverman, 2006) have included sexual orientation, and their results indicate that gay or bisexual youth may be at an increased risk of self-injury. For example, in an internet survey of youth who self-injure, Murray, Warm, and Fox

(2005) found that 22.7% of their sample identified as bisexual, over representing bisexual youth by more than 550%, given that most estimates state that bisexual young people account for 4% of the general population (Gup, 1998). However, the data gathered from these general surveys are quite limited due to the small numbers of non-heterosexual respondents; no researcher to date has gathered a specifically queer[1] sample and looked at rates of self-injury.

Because research has previously established that lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) young people experience greater emotional distress than their heterosexual, non-transgendered counterparts, self-injury might be a more significant problem in this population; suicide rates among lesbian, gay, and bisexual youth continue to be two to three times higher than for heterosexual youth (Silenzio, Pena, & Duberstein, 2007). The statistics are greater for transgendered young people, with a quarter attempting suicide (Grossman & D'Augelli, 2007). Other researchers have found that lesbian, gay, and bisexual youth have increased rates of drug and alcohol abuse, early pregnancy, eating disorders, and victimization (Moon, Fornili, & O'Briant, 2007). These higher rates of risk behaviour are suggested to emanate from the extra stress and distress faced by these youth from experiencing discrimination, leading to an increase in life challenges and difficulty in coping. A recent survey of youth across British Columbia found that queer youth continue to be at increased risk for abuse, harassment, discrimination, and stress (Saewyc et al., 2007). Nearly two thirds of the gay and lesbian teens surveyed reported having been verbally harassed at school in the previous year, while more than half had been purposely excluded by peers (Saewyc et al., 2007). Due to this

[1] The term queer and the acronym LGBTQ will be used interchangeably as short forms for lesbian, gay, bisexual, and transgendered and genderqueer people. Although queer remains a somewhat controversial term, it is a term that has largely been reclaimed by LGBT youth and is the 'label' of choice for the majority of the population being studied here (Horner, 2007).

increase in challenges and distress, it is possible that rates of self-injury will be higher in this population.

Defining the sample

Significant consideration was given to the decision to include transgendered individuals in this research along with the more traditional grouping of lesbian, gay, and bisexual people. Many research studies conducted with queer samples include only sexual orientation (LGB) and not gender identity (i.e., transgendered people), possibly because of the difficulty in obtaining a significant sample size of transgendered individuals, but also likely due to the notion that sexual orientation and gender identity are separate phenomenon that are not reductionist in nature, meaning they cannot be collapsed under a single category or encompassed in a single definition. An article by Moradi, Mohr, Worthington, and Fassinger (2009) explains how "the desire to be inclusive of marginalized groups on the one hand and the concern about glossing over important within-group variability on the other hand" creates tension in sexual minority research, and the very act of defining the population of interest can be extremely challenging.

One result of this separation between sexual orientation research and gender identity research is that very little research exists on transgendered individuals; a PsychInfo search conducted in March 2009 for "LGBT" came up with 308 results. A review of the first twenty found that only two of the twenty results were studies where the researchers had included at least one transgendered participant. Five of the twenty results were articles that used the acronym "LGBT" throughout without specifying the population further. Two of the twenty were book reviews in which the reviewer criticized the book for omitting transgendered people. The remaining eleven entries omitted transgendered people entirely from the discussion or study, despite having used the acronym "LGBT." In total, only four of the twenty entries made specific

mention of transgendered people (and two of the four were simply criticizing others for omitting them), illustrating the lack of inclusion that tends to take place in queer research.

In order not to further perpetuate the segregation and omission of transgendered people from research, the current study was specifically designed to be inclusive of variations in gender identity by including both the category of transgendered and the category of genderqueer. With the topic of self-injury, the shared experiences of discrimination, oppression, harassment, and stress that people with minority sexual orientations and minority gender identities experience makes it useful to include all these groups in the current study. This is consistent with Fassinger and Arseneau's position that lesbian, gay, bisexual, and transgendered people share common experiences of sexual prejudice and gender transgression (2007). However, in an attempt to minimize the risk of failing to recognize important within group variation, the categories of homosexual, heterosexual, bisexual, and transgendered will be analyzed separately whenever possible.

In addition to the gender categories of male, female, and transgendered, the survey also included an option of "genderqueer." This category was included following the pilot test phase of the survey when many respondents expressed frustration over having to select one of the other categories. Research in the field of sociology is also beginning to include genderqueer as an additional category separate from, but related to, transgender (e.g., Factor & Rothblum, 2008). As one author states, "the term transgender has no singular, fixed meaning but is instead currently conceptualized... as being inclusive of the identities and experiences of some (or perhaps all) gender-variant, gender- or sex-changing, gender-blending and gender-bending people" (Davidson, 2007, p. 60). However, the term genderqueer has become increasingly

popular, especially among Caucasian, North American college and university students (Davidson, 2007) and so was included as a gender category in this study.

Purpose of the Current Study

This study investigated the rates of self-injury within an internet-based sample of 385 heterosexual and gay, lesbian, bisexual, and transgendered young people aged 19-29 in Canada. Data were collected to answer the following questions:

Research Questions

1. How do the rates and severity of self-injury in the sample of lesbian, gay, bisexual, and transgendered respondents compare to those of heterosexual, non-transgendered respondents based on responses to an online survey?
2. Is there a connection between parental support of sexual orientation/ gender identity and rates or severity of self-injury?
3. Are the reasons lesbian, gay, bisexual, and transgendered people engage in self-injury different from their heterosexual, non-transgendered counterparts?
4. Does past participation in a gay-straight alliance (GSA) club in high school or similar supportive youth group influence the rates or severity of self-injury among queer youth?

The recruitment advertising targeted lesbian, gay, bisexual, and transgendered young adults aged 19-29, while a second set of ads were used to recruit the heterosexual, non-transgendered comparison group. This young adult age range is well suited to the current study for two reasons. First, intentionally selecting a young adult sample, rather than a teen sample as some previous studies on self-injury have done, provides a sufficient length of time so that the respondents may be more thoughtful about their reasons for engaging in self-injury and what, if

any, relation self-injury might have had to their sexual orientation or gender identity. Particularly by examining sexual orientation, a young adult sample is preferred to an adolescent sample as many teenagers have not had time yet to solidify their sense of self in relation to their sexual orientation or gender identity. Second, the young adult sample may be less psychologically vulnerable than an adolescent sample and will be more able to give independent informed consent, and so the young adult sample is less challenging from an ethical standpoint.

Significance of the Study

Social events in the last forty years have shaped attitudes and public policy in North America towards homosexuality in general. The Stonewall riots of 1969 in New York City, when drag queens and gay men fought back against the police raid of the Stonewall pub signalled the beginning of the gay rights movement (Carter, 2004). The start of the AIDS epidemic (Cochrane, 2004) brought homosexuality front and centre in the media and subsequent attention on combating homophobia (Clarke, 2006). Canada's legalization of same-sex marriage in 2005 brought the social movement to legalized acknowledgement of equality. Currently, the larger social institutions such as schools, community services and religious organizations in North America demonstrate a greater desire and ability to support gay, lesbian, bisexual, and transgendered youth than in the past (Schindel, 2008). Many schools now have gay-straight alliance (GSA) clubs, various communities have gay centres which often run youth groups, and there are an increasing number of websites and print resources supporting queer youth. Even with this increase of tolerance, there continues to be significant homophobia (Fone, 2000), confirmed by the suicide rate of LGB young people which continues to be much higher than their heterosexual counterparts (Silenzio, Pena, & Duberstein, 2007).

The outcome of this research focusing on non-suicidal self-injury will provide information to service providers and policy makers. For those in the community supporting queer youth, including youth group leaders, GSA club teacher sponsors, school counsellors, and others, education about self-injury including how it presents behaviourally in this population, and with what frequency, may better equip adults in leadership positions to help youth struggling with self-injury. However, before approaching the issue of how to treat or prevent self-injury in queer youth, we first must establish if self-injury is a concern in this specific population.

Given research showing that queer youth experience more harassment, less connectedness, and more general distress (Saewyc et. al., 2007), it is not surprising that preliminary studies such as the internet survey by Murray, Warm, and Fox (2005) indicate that queer youth may be at an increased risk for engaging in non-suicidal self-injury. Beyond examining if the rates are higher in this population, it is also important to investigate if the reasons for engaging in self-injury are similar to heterosexual, non-transgendered individuals, since knowing the reasons behind the behaviour is a crucial step towards preventing self-injury. It is important for service providers and other adults working with all youth to become aware of the problem as a first step towards helping youth develop healthier coping skills.

Chapter 2: Literature Review

Since the mid 1990s, there has been a steady growth in the body of literature on the topic of nonsuicidal self-injury (NSSI). The majority of studies focus on issues relating to prevalence rates, methods of harm, and functions of self-injury. The task of establishing consistent prevalence rates has challenged researchers, with rates in non-clinical samples varying widely from 4% in a recent adult sample (Klonsky, Oltmanns, & Turkheimer, 2003) to 56% in a recent pre-teen sample (Hilt, Cha, & Nolen-Hoeksema, 2008). Preliminary research has shown that some groups of adolescents are at higher risk for engaging in NSSI, with gay, lesbian, and bisexual teenagers among them (e.g., Murray, Warm, & Fox, 2005). This chapter will review the scope of the current research on NSSI, relevant aspects of research on sexual orientation, and some key issues pertaining to internet based research in general and with the LGBTQ population in particular.

Nonsuicidal Self-Injury

Research on self-injury has been slowed partly due to "semantic obfuscation" (Prinstein, 2008, p.1); it has taken many years for researchers to tease out terms for discrete but related phenomena. Researching self-injury is problematic because studies sometimes refer to both the type of self-injury typified by cutting or scratching one's body without any suicidal intent, and the type of self-injury done when one cuts his or her wrists or ingests pills with specific suicidal intent. Only recently have researchers tried to separate the two distinct yet related types of behaviours by referring to the former as nonsuicidal self-injury (NSSI). In addition to referring to self-injury both with and without suicidal ideation, library research using the key word "self-injury" in Psych Info and Medline further reveals articles on behaviours such as head banging,

seen in people with various developmental disabilities such as autism. Further complicating the body of research, the terms self-harm and self-mutilation are also used, though self-harm has generally come to mean a broader scope of harmful behaviours including binge drinking, suicide attempts, and eating disorders (e.g., Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003), while self-mutilation has generally been dropped for the more sensitive term of self-injury. Through the confusion of terminology, a standard definition has now emerged in North America whereby nonsuicidal self-injury has come to be defined as intentional and direct physical injury done to the self without suicidal intent and in the absence of a pervasive developmental delay (Favazza, 1996). This definition gained support in 2007 when the International Network for the Study of Self-injury (INSS) coined a similar definition. A consistent list of behaviours included in the definition of self-injury has begun to emerge with the most commonly included being banging and hitting self, hair pulling, pinching, cutting, biting, scratching, burning, and carving (Klonsky & Olino, 2008). The lack of a consistent list of behaviours plays a role in the variations in prevalence rates and makes cross-study comparison difficult.

Lifetime rates of self-injury among adult populations have been as low as 1-4% (Klonsky, Oltmanns, & Turkheimer, 2003) whereas rates in high school and college populations tend to fall around 14-20% (Laye-Gindhu & Schonert-Reichl, 2005; Rodham & Hawton, 2009; Whitlock, Eckenrode, & Silverman, 2006), and one study examining the rates in an exclusively pre-teen female population were found to be 56% (Hilt, Cha, & Nolen-Hoeksema, 2008). These rates suggest that even though some variation in rates comes from differing lists of injurious behaviours, another source of variation is due to the fact that NSSI rates may be currently on the rise, with rates being highest in current early adolescent populations (e.g. Klonsky & Muehlenkamp, 2007). The prevalence rates of NSSI have been found to be higher in adolescent

clinical populations, reaching 80% in some studies, including Nock and Prinstein's study of adolescent inpatients of a psychiatric hospital (2004). Age of onset in community samples seems typically to be found to be around age 12 to 14 (Klonsky & Muehlenkamp, 2007; Rodham & Hawton, 2009), although researchers studying a female sample of 10 to 14 year olds found the age of onset to be age 10 (Hilt, Cha, & Nolen-Hoeksema, 2008). Several studies suggest that youth between the ages of 18 to 25 are in the highest risk group for engaging in NSSI, indicating that even if the onset of the behaviour is younger, it is at this age that self-injury may be most common and when studies find the highest overall rate of injury (Rodham & Hawton, 2009).

The research reports that the majority of young people who self-injure do so once or a few times; a minority subgroup of research participants self-injure on a frequent and/or repetitive basis (Whitlock, Eckenrode, & Silverman, 2006). This finding is supported in a study by Klonsky and Olino (2008) who used latent class analysis to identify clinically distinct subgroups of self-injurers. They analyzed data from 208 people who engaged in at least one incident of NSSI and in the four groups they identified, only one group, making up roughly 11% of their sample, was characterized by frequent and repetitive self-injury. Another one of the groups, comprising 17% of the sample, were notable for also using more than just one method of self-injury, even if the actual acts of self-injury were relatively rare occurrences; however, all the participants in Klonsky and Olino's study were first year university psychology students who may represent a distinct group of self-injurers compared to the general population.

One correlate of self-injury that researchers have identified is childhood abuse (Klonsky & Muehlenkamp, 2007). In their study of 2875 college students, Whitlock, Eckenrode and Silverman (2006) found that sexual abuse was significantly related to engaging in self-injury a single time while emotional abuse was significantly related to both single and multiple incidents

of self-injury. Physical abuse was unrelated to self-injury in their population. In a meta-analysis of 40 studies, Klonsky and Moyer (2008) found that the relationship between self-injury and childhood sexual abuse was small (mean weighted aggregate phi coefficient =.23) and the authors concluded that sexual abuse might best be conceptualized as a proxy risk factor, with depression, anxiety, and/or self-derogation being the connecting link. Corroborating findings linking emotional abuse with self-injury, Murray, Warm, and Fox's study (2005) found that when asked if they had ever engaged in self-injury as a response to emotional abuse, 85% of their sample of adolescent self-injurers endorsed this question.

A consistent finding in the research on self-injury has been the comorbidity of self-injury and eating disorders. In Murray, Warm, and Fox's (2005) study of adolescent self-injurers, 30% of their sample reported having a history of anorexia and more than 25% reported a history with bulimia. Likewise, 28% of the self-injurers in Whitlock, Eckenrode, and Silverman's study (2006) were found to have disordered eating. A large scale review examining the connection between eating disorders and self-injury in 26 studies found that the occurrence of eating disorders among people who self-injured ranged from 54% to 61% (Svirko & Hawton, 2007). The authors use the data from the studies to establish a model whereby predisposing factors such as personality traits or early trauma experience combine with two or more pathological processes, including affect deregulation, a self-criticising cognitive style, or impulsivity to produce the combination of an eating disorder and self-injury. Klonsky and Muehlenkamp also state in their study that the connection between self-injury and eating disorders is that both are pathological coping responses to negative emotions, and so the underlying connection is depression, anxiety, or other overwhelming feelings (2007).

One new area of research has been on how internet use impacts certain behaviours. A recent survey of over 1600 adolescents in China investigated the connection between nonsuicidal self-injury experiences and internet addiction. These researchers conducted an odds ratio and found that teenagers who met their criteria of being moderately or severely addicted to the internet (roughly 10% of their total sample) were two times more likely to have self-injured than those who had 'normal' rates of internet use (Lam, Peng, Mai, & Jing, 2009). The authors hypothesize that both internet addiction and self-injury can be considered part of the impulse control disorders. While rates of internet addiction are still unknown, it is possible that advertising and conducting an entirely internet-based study on self-injury may result in biased results by capturing a slightly higher degree of young people addicted to the internet. It is difficult, however, to determine if similar results would be found with North American youth as this was the first study of its kind.

One of the most challenging questions for self-injury researchers is why are so many young people purposely causing themselves pain? What drives someone to burn or cut his or her own skin? Initially, researchers and clinicians alike believed that self-injury was primarily an attention-seeking behaviour, a notion reflected in the fact that the only mention of self-injury in the Diagnostic and Statistical Manual IV-Text Revision (American Psychiatric Association, 2000) is as a symptom of borderline personality disorder, a disorder frequently associated with an excessive need for attention. However, recent research has found that while attention seeking may be the primary function for some who self-injure, it is not the most common self-reported reason.

Researchers investigating the functions of self-injury have found consistent data showing that affect regulation, not attention-seeking, is the most commonly cited reason for self-injury on

self-report measures (Klonsky & Muehlenkamp, 2007). Affect regulation is the attempt to control emotional feelings by either increasing or decreasing the intensity of emotion being felt. People who self-injure will often say that hurting themselves helps to relieve emotional distress. In one study of adolescents, the most commonly endorsed item for the reason for self-injury was "I felt very unhappy or depressed" (Laye-Gindhu & Schonert-Reichl, 2005), while in another study of adolescents it was "to stop bad feelings" (Nock & Prinstein, 2004). Similarly, an internet survey of adolescents who self-injure found the most common emotion prior to injury was depression while the most common emotion immediately following injury was calm (Murray, Warm, & Fox, 2005).

To bring some unity to the reasons for self-injury, Nock and Prinstein (2004) developed a functional model of self-injury, called the four-function Model. This model, shown below, links functions of self-injury with B.F. Skinner's model of positive and negative reinforcement, where positive reinforcement is the addition of something pleasurable (such as being paid) and negative reinforcement is the removal of something aversive (such as turning off an alarm clock) (Skinner, 1965). The four-function model states that non-suicidal self-injury has autonomic or social functions which are maintained by positive or negative reinforcement. Autonomic functions include affect regulation and are most commonly maintained by negative reinforcement; affect regulation is the efforts one takes to maximize positive moods and minimize negative moods. An example of how this relates to a person who self-injures would be someone who cuts his or her arms to make the scared/hurt/depressed feelings subside (therefore negatively reinforcing the behaviour). The most commonly cited reasons for self-injury among adolescent samples in the literature fall into this category. Autonomic functions have also been

tied to positive reinforcement, with some people stating that they self-injure in order to feel *something*- even if it is pain (Nock & Prinstein, 2004).

	Positive Reinforcement (PR)	Negative Reinforcement (NR)
Autonomic (A)	APR	ANR
Social (S)	SPR	SNR

***Figure 1*. Four-function model**

In contrast, social functions of self-injury, meaning reasons for self-injuring that involve other people, are more commonly tied to positive reinforcement, including attention-seeking or letting someone know how unhappy he or she is. The reverse is also encountered, where social functions are tied to negative reinforcement such as escaping punishment or an undesirable task. An example of this would be a young person who cuts herself in an attempt to avoid being forced to go to school. In their study of 108 adolescent psychiatric inpatients, Nock and Prinstein (2004) found that the autonomic functions, both positively and negatively reinforced, were the most frequently endorsed reasons for self-injuring: 1). "to stop bad feelings" and 2). "to relieve feeling numb or empty." Statistical support for this classification model by Nock and Prinstein was strong in their study: they had a strong goodness of fit finding, 21 of the 22 items loaded significantly onto the proposed factors, and the internal consistency of each factor's alpha coefficients ranged from .61 to .85 (Nock & Prinstein, 2004). Subsequent researchers have established further support for this model (e.g. Klonsky & Olino, 2008). Given such a long list endorsed by participants in other studies for the reasons behind their self-injurious behaviour,

this model's strength is that it serves as a classification device for categorizing different types of self-injurers based on the primary function of self-injury. For example, the study conducted by Laye-Gindhu and Schonert-Reichl (2005) lists a full twenty-nine reasons youth endorsed self-injury, ranging in diversity from "I was high or drunk" to "I was bored" to "It stopped me from killing myself." Often people self-injure for multiple reasons, making it a challenge for any conceptual model to adequately capture the diversity in reasons for self-injury, but this model helps conceptually to categorize common functions.

Researchers have found gender differences in self-injury. Self-injury was thought initially to be more prevalent in women, but recent research indicates that the rates frequently are similar between genders depending on what type of behaviour is being included in the definition of self-injury (Rodham & Hawton, 2009). While more recent and large-scale studies have found that men and women have similar rates of self-injury, gender differences in the behaviour appear to be in both the method (e.g., cutting, pulling, etc.) and functions of self-injury (Heath et. al., 2008; Klonsky & Muehlenkamp, 2007). One study that surveyed 424 high school students found that girls were more likely to report cutting themselves while boys were more likely to report hitting or punching themselves (Laye-Gindhu & Schonert-Reichl, 2005). The primary reasons each group gave for self-injury were also different, with girls endorsing emotional reasons such as, "I did not like myself" and, "I felt very unhappy or depressed," and boys endorsing some more social reasons such as, "I wanted to be noticed" and, "It helped me join a group." In their survey of college students, Whitlock, Eckenrode, and Silverman (2006) also found that women were more likely to scratch, pinch, or cut themselves, while men were more likely to punch an object with the intention of hurting themselves.

A distinction should be drawn between non-suicidal self-injury and suicide attempts. The early research on self-injury assumed that most incidents of self-injury were suicidal in nature, and that people who self-injured were necessarily experiencing suicidal intention, and the conflation of the two ideas continues, especially in research based in the UK (e.g., Skegg et al., 2003). While research generally shows that people who self-injure have higher rates of suicidal ideation than non-self-injurers (Klonsky & Muehlenkamp, 2007), a growing body of research supports important phenomenological distinctions between suicide and self-injury. A typical suicide attempt has the purpose of ending life, while a typical act of self-injuring has the purpose of coping with, and thereby continuing to engage in, life. For example, 41% of the adolescents who self-injured in one study stated that they had done it because "it stopped me from killing myself" (Laye-Gindhu & Schonert-Reichl, 2005). Because of the importance of understanding this distinction, the Network has placed at the forefront of their definition of self-injury, "The deliberate, self-inflicted destruction of body tissue resulting in immediate damage, *without suicidal intent* [italics added] and for purposes not socially sanctioned" (Heath, Toste, Nedecheva, & Charlebois, 2008, p. 139). Whitlock, Eckenrode, and Silverman (2006) found that 34% of those who had self-injured had also seriously considered or attempted suicide, a percentage that illustrates the significant number of people (66%) who self-injure in the absence of any suicidal ideation. Because people who self-injure tend to have higher levels of depression and emotional distress than other people, Klonsky and Muehlencamp advise that, "it is essential to routinely assess the intent or motivation underlying the self-injury" (2007, p. 1049).

Throughout this discussion on the reasons for self-injury, the link of depression has emerged several times. Depression impacts a significant number of youth, with some research estimating as many as one in five teenagers will experience a major depressive episode before

graduating from high school (American Psychological Association, 2003). Even the most conservative estimates of teenagers diagnosed with depression stand around 5-6% (Costello, Erkanli, & Angold, 2006). A large national study of depression in the United States found lifetime rates of depression in 15-25 year olds to be 16% (Kessler, 1994). Depression is more common among self-injuring youth compared with established prevalence rates reported in community samples. For example, Andover and colleagues (2005) studied 47 undergraduates who had a history of self-injury and 41 matched controls; they found that the self-injury group had significantly higher rates of depression than the control group. Similarly, a team of researchers in Australia studied a group of inpatient adolescents who self-injured and in their sample, 20 of their 38 teens (53%) had a diagnosis of depression or dysthymia (Swannell, Martin, Scott, Gibbons, & Gifford, 2008). A study of more than 5000 university students found that 32% of those students who had self-injured were depressed, compared to 11% of those students who had never self-injured (Gollust, Eisenberg, & Golberstein, 2008).

Maladaptive responses to depression include over use of alcohol, tobacco use, and other risk behaviours (Schwinn, Schinke, & Trent, 2010). Self-injury is most often a way of regulating difficult emotions, and so the link between depression and self-injury as another maladaptive coping response is well consistent. The most commonly endorsed reasons for self-injury tend to be statements such as to alter low mood or release thoughts of depression (Warm, Murray, & Fox, 2003). Both self-harm and depression were found to be more common in street youth than in non-street youth (Ayerst, 1999). This is also supported by research illustrating the temporal connection between emotional regulation and self-injury, such as the Murray, Fox, and Warm study (2005) which found that the most common emotion before self-injury was depression while the most common emotion after self-injury was feeling calm.

Gender Identity and Sexual Orientation

LGB specific minority stress: Research on the difficulties faced by lesbian, gay, bisexual, and transgendered (LGBT) individuals is developing. Researchers have coined the term minority stress as "the excess stress individuals from stigmatized minority groups experience as a result of being part of that group" (Berghe, Dewaele, Cox & Vincke, 2010, p. 155). They go on to explain that this stress comes from three sources: external events such as discrimination, the expectation of such events, and the internalization of negative societal messages regarding sexual orientation or gender identity. These stressors can result in a variety of negative mental health outcomes (Berghe et al., 2010). A survey of more than 30,000 youth in grades 7-12 across British Columbia conducted in 2003 found that LGBT youth continue to be at increased risk for abuse, harassment, discrimination, and tend to be less connected to family or school. Nearly two thirds of the gay and lesbian teens surveyed reported having been verbally harassed at school in the previous year, while more than half had been purposely excluded by peers (Saewyc et al., 2007).

Impact of LGBT minority stress: LGBT young people are at an increased risk for facing minority stressors, and the impact of this stress is also well documented in research. LGBT participants in the 2003 BC survey were found to have higher rates of homelessness, suicidal ideation, and stress Saewyc et al., 2007). Other researchers have found that lesbian, gay, and bisexual youth have increased risk of drug and alcohol abuse, early pregnancy, and eating disorders (Moon, Fornili, & O'Briant, 2007). While very few studies exist on transgendered people specifically, there are a few studies which found that transgendered youth and adults are more at risk than non-transgendered people for a range of difficult circumstances, from higher rates of becoming homeless and/or engaging in the sex trade industry, being victims of

workplace discrimination and hate crimes, and having their parental rights denied (Burdge, 2007). Given these extra stressors in the lives of young gay, lesbian, bisexual and transgendered people, it would not be surprising to discover that self-injury is also an issue of concern with this population.

GSA and school climate research: One of the research questions that will be analyzed in this study is if the presence of a gay-straight alliance (GSA) club in high school has an impact on rates or severity of self-injury. The first school club to identify itself as a gay-straight alliance club was in Massachusetts in 1989 (Schindel, 2008). There are currently more than 3000 GSA clubs registered with the Gay, Lesbian, and Straight Education Network (GLSEN) in the United States alone. Due to the relatively recent emergence of such clubs, research studies on their impacts on school climate and homophobia are only just beginning to appear. One qualitative study interviewed fifteen GSA club leaders and found that being a part of a GSA club led to increased feelings of empowerment (Russell, Muraco, Subramaniam & Laub, 2009). A study investigating the impact of school climate on outcomes for LGB students found that a positive school climate (defined by items such as "adults in my school care about me and how well I do in school") and a low level of homophobic bullying, had moderating impacts on negative outcomes for LGB youth, including depression, suicidality, drug use, and school difficulties (Birkett, Espelage, & Koening, 2009). A GSA club can be an important role in creating a positive school climate and reducing levels of homophobic bullying. As this body of literature develops, it will be interesting to see if the rates or severity of self-injury vary based on the presence of a GSA club or participation in a GSA club.

Nonsuicidal Self-Injury and Sexual Orientation

Some preliminary research studies indicate that lesbian, gay, and bisexual people are at increased risk of engaging in self-injury. An internet survey of youth who self-harm (Murray, Warm, & Fox, 2005), had higher than expected numbers of bisexual respondents (22.7% of their sample of 128 teens), which may indicate that bisexual youth are at greater risk of self-injuring, although their published study did not indicate if these bisexual youth were men or women. They also did not investigate any further the subsample of bisexual teens aside from stating that the rates of self-injury were high. Similarly, a questionnaire on self-injury administered to more than 2000 first-year psychology students in the United States found that either identifying as bisexual or being unsure of one's sexual orientation were factors in increasing one's chances of engaging in self-injury, but again, no further analysis of the data was conducted with regard to sexual orientation (Whitlock, Eckenrode, & Silverman, 2006). Finally, a dissertation abstract published in 2005 also identifies sexual orientation (including homosexuality and bisexuality) as being correlated with nonsuicidal self-injury, in their sample of female college students (Kokaliari, 2005).

One very recent study which was published during the time period when the current study was being conducted examined a variety of indicators of emotional distress among LGBT youth in Boston, including rates of nonsuicidal self-injury (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009). Their LGBT sample consisted of 24 males and 79 females. They found that 42% (n=10) of the male LGBT group and 14% (n= 11) of their female LGBT group had self-injured in the past year. Through mediation analysis, they discovered that levels of perceived discrimination attenuated the elevated risk of self-injury for the LGBT boys by 57% (Z-score 4.16, $p < 0.0001$), but did not have an impact on the self-injury rates for the girls. They did find,

however, that perceived discrimination accounted for elevated levels of depression for both boys and girls identifying as LGBT.

All three of these studies were specifically looking at prevalence rates, methods of injury, and functions of self-injury in general populations and only included mention of sexual orientation impacting the rates, and none captured sizeable gay, lesbian, or bisexual subgroups. Two other studies examine more closely the relationship between sexual orientation and self-injury. The first such study is published under the title of, "Sexual orientation and self-harm in men and women," and examines questionnaire data from a birth cohort of 1019 adults in New Zealand, administered when the cohort was age 26 (Skegg et al., 2003). This study found that any degree of same-sex attraction increases the likelihood of self-harm, and in contrast to the earlier studies that found the highest rates in bisexual individuals (Murray, Warm, & Fox,2005; Whitlock, Eckenrode, & Silverman, 2006), this study found that the greater degree of same-sex attraction led to an increasing chance of self-injury (i.e., the highest rates were in homosexual individuals). However, the large original sample only yielded data on 8 gay men and 9 lesbians. In addition, the authors use self-harm to mean both nonsuicidal self-injury and suicide attempts, thus confounding the data and conclusions. The results section of the article does not clearly separate the two distinct phenomenon, and the questionnaire did not ask sufficient questions on non-suicidal self-injury to obtain any information beyond the rates.

The final study of note is a qualitative study out of the UK which used interview data from sixteen lesbian and bisexual-identified women who self-injure; the authors analyzed the transcripts using interpretative phenomenological analysis (IPA) to elicit themes (Alexander & Clare, 2004). The authors clearly state that they only interviewed women whose self-injury was non-suicidal in nature. Quotes from the women interviewed illustrate both the similarities to

heterosexual people who self-injure as well as some differences. Some of the themes that emerged were: self-injury as a response to bad experiences (either in childhood or adulthood), invisibility and invalidation, feeling different, and coping through self-injury. One question the authors asked was if the participants felt there was a connection between their sexual orientation and their self-injurious behaviour, and the authors conclude that indeed, the extra discrimination and stress that came from a homophobic and/or heterosexist society was identified as a factor by the women. They state, "that self-injury can be understood as a coping response that arises within a social context characterized by abuse, invalidation, and the experience of being regarded as different or in some way unacceptable" (Alexander & Clare, 2004, p.70).

One limitation of this study is that all women interviewed had to live in or near London where the interviews took place and all the participants were Caucasian. The age range sampled was broad, ranging from 18-50. Also, the authors were limited by the small sample size to discussing general themes that emerged, rather than broadly examining in what ways self-injury in lesbian and bisexual women may differ from straight women in terms of function, method, or age of onset. For example, one point of interest would be to explore if the gender-based differences in method and function of self-harm found by Laye-Gindhu and Schonert-Reichl (2005) are similar to this population or not.

In addition to these studies that looked specifically at sexual orientation and self-injury, it is worth noting features from research specifically on self-injury and speculating as to how it might relate to lesbian, gay, bisexual, or transgendered youth. Some of the reasons for self-injury given in other studies may have particular salience for young people questioning their sexual orientation and struggling with internalized homophobia or overwhelming distress. Examples of relevant reasons for self-injury are "to punish myself" (Klonsky & Muelenkamp,

2007), having "difficult family relationships" (Murray, Warm, & Fox, 2005), and "I wanted other people to see how desperate I was" (Laye-Gindhu & Schonert-Reichl, 2005). It would be informative to see if such reasons are endorsed more frequently by youth dealing with the added complication of realizing they are lesbian, gay, bisexual or transgendered.

There are now several studies examining rates and functions of self-injury which exist for a predominantly heterosexual sample (e.g., Laye-Gindhu & Schonert-Reichl, 2005; Whitlock, Eckenrode, & Silverman, 2006); the addition of a similar survey focusing on an LGBT sample will help illuminate how this population is similar to or different from existing samples. It would be particularly interesting to have some transgendered voices added to this body of research, as those voices to date have not been included.

Internet-Based Research

Arguably, one of the most efficient ways to reach a sizeable sample of lesbian, gay, bisexual, and transgendered people in order to find out if they have engaged in any nonsuicidal self-injurious behaviour is via the internet. Murray, Fox, and Warm used this method in order to reach teens that self-injure and they were able to capture data from 128 adolescents (2005). The use of the internet to collect survey data provides greater anonymity for participants, greater access to populations, direct data entry, lower cost, effective use of contingency questions, and can have a wide geographical reach (Sue & Ritter, 2007). Research has shown that internet samples can be as robust as other types of samples, provided some safeguards are put in place such as the oversampling of or specifically targeting economically disadvantaged people (Mathy, Kerr, & Haydin, 2003). Samples of hard to reach participants, such as gay and lesbian people or people who self-injure, can be more robust and equally representative to Gallup Poll samples or US demographic samples when found via block sampling on the internet (Mathy, Shillace,

Coleman, & Berquist, 2002). Many researchers have looked for differences between surveys administered in person, via mail, or over the internet and have failed to find statistical differences (Richman, Kiesler, & Weisband, 1999). The internet-based survey provides a compelling alternative to the current practice of surveying the convenient sample of college students. For the purposes of the current study, the internet-based survey is well suited to reaching enough young people to supply a sample large enough to provide greater power and to be more confident in conclusions.

Conclusion

There remain many gaps in this still-emerging body of literature on nonsuicidal self-injury, with one being a clear picture of the phenomenon of NSSI within the gay, lesbian, bisexual, and transgendered community. We do know that self-injury is becoming increasingly common among young people and is most frequently caused by an attempt to cope with overwhelming emotions such as stress or depression. Researchers have found that LGBTQ youth are at risk for experiencing harassment and depression, and some preliminary studies indicate that self-injury rates might be higher in the LGBTQ population.

Chapter 3: Methods

The current quantitative study examined nonsuicidal self-injury (NSSI) in lesbian, gay, bisexual, and transgendered young people through the use of survey data to examine rates of self-injury and other factors relating to this behaviour. Specifically, the four questions that were investigated in this study are:

1. How do the rates and severity of self-injury in the sample of lesbian, gay, bisexual, and transgendered respondents compare to those of heterosexual, non-transgendered respondents based on responses to an online survey?
2. Is there a connection between parental support of sexual orientation/ gender identity and rates or severity of self-injury?
3. Are the reasons lesbian, gay, bisexual, and transgendered people engage in self-injury different from their heterosexual, non-transgendered counterparts?
4. Does past participation in a gay-straight alliance (GSA) club in high school or similar supportive youth group influence the rates or severity of self-injury among queer youth?

Survey Design

This cross-sectional study involved developing and administering an online survey that was advertised to Canadian lesbian, gay, bisexual, heterosexual, and transgendered people aged 19-29. The purpose of the survey was to sample sufficient LGBT respondents to determine the extent of self-injury in this population. The survey was also advertised to heterosexual, non-transgendered individuals aged 19-29 so that their responses can serve as a comparison group. Using an online survey rather than a paper and pencil form increased the number of people in the population who had access to responding to the survey. Even at the higher estimates,

homosexual people account for fewer than 10% of the population (Bagley & Tremblay, 1998; Laumann, Gagnon, Michael & Michaels, 1994), and transgendered people for fewer than 1% (Olyslager & Conway, 2007), so it was important for the survey to reach as many potential respondents as possible. Issues of confidentiality and frank responding were also an advantage. The benefits of using the survey design also included its low cost, design flexibility, and expeditious data collection.

The survey was designed and hosted on the site SurveyMonkey.com, a commercial product widely used among researchers for its flexibility and simple custom templates (Creswell, 2009). Skip logic was built in to ensure participants did not need to reply to irrelevant questions, and certain questions were coded as "required," meaning a participant could not continue until that question was answered. Coding questions as being required was not done to every single question in order to minimise frustration and attrition in the survey, but it was included for key questions such as sexual orientation, gender identity, and experiences with self-injury. To ensure question clarity and the proper functioning of technical aspects of the survey, it was piloted on a small group of individuals of various sexual orientations and gender identities who were between the ages of 30-40, and thus over the age limit for the survey but otherwise similar to the target population. The pilot test provided feedback on ease, function, and clarity of the survey, and modifications were made where necessary.

Sample and Population

Setting and participants. Participants were heterosexual people and lesbian, gay, bisexual, and transgendered individuals aged 19-29 who were recruited primarily from BC, although the survey was advertised on some websites which have a national audience (e.g. xtra.ca, a site developed to disseminate news of interest to LGBT people with an emphasis on

Montreal, Ottawa, and Vancouver). Due to the global nature of the internet, some participants from other countries may also have responded to the survey advertisement, but only people who confirmed that they lived primarily in Canada were included in the data while the rest were directed out of the survey, thanking them for their interest. People who stated that they were under 19 or over 29 were also directed out of the survey. The age group of 19-29 was selected due to the nature of the research questions. Thus far, the research indicates that the peak age for self-injuring is 18 to 25 years old (Rodham & Hawton, 2009). In addition, the average age of "coming out to self" (realizing one's own sexual orientation) has been found to be around age 17 for men and age 19 for women, although the ages drop to 16 and 15 respectively when the sample is limited to individuals aged 19 to 24, indicating perhaps that the average age of coming out has lowered in recent years (Grov, Bimbi, Nanin, & Parsons, 2006). A sample that is over 18 but under 30 should have both had time to reflect on their teenage experiences, identify their sexual orientation or gender identity and deal with some coming out issues, and yet not be challenged by the memory problems inherent with retrospective studies.

Sample size. A power analysis determined that a minimum of 100 queer participants were needed, with an additional 100 heterosexual, non-transgendered individuals required for comparison. These groups were further divided into a minimum of 50 each of queer men, queer women, straight men, and straight women. The survey remained open until the final group to be collected reached over 50 respondents.

Ethical considerations with the sample. This study received approval from the University of British Columbia's Ethics Review Board (see Appendix A). There were a few key ethical considerations with this research project, the first of which was ensuring no participants suffered harm from participating in the survey. Because participants who have never engaged in

self-injury were not required to be answering any further questions on the subject due to the survey's built-in "skip logic," the survey was not anticipated to have negative impact for those with no history of self-injury. Skip logic means that the response given to a particular question will determine which question follows. In this case, if respondents chose the response indicating they had never self-injured, they were skipped over all subsequent questions on self-injury.

For participants who do have a history of self-injury, it is possible that answering several questions on the behaviour could increase its salience in participant's mind and result in a negative outcome. To guard against harm, the survey ended with information on a variety of sources of community support, including counselling, for the participants (see Appendix C). These safeguards are consistent with previous research on self-injury (e.g., Laye-Gindhu & Schonert-Reichl, 2005; Murray, Warm, & Fox, 2005). The informed consent page informed participants that some of the survey questions may trigger uncomfortable feelings and emphasised that participants can quit the survey at any time (see Appendix B).

Privacy was also an important consideration, both in ensuring the survey data collected was secure, but also in guaranteeing that the participants' anonymity was maintained. To this end, participants were invited to contact a dedicated email address after completing the survey if they wish to be entered into a draw for a gift certificate; this way, identifying information (email address) was not tied in any way to survey responses. The survey itself did not ask participants to provide identifying information such as name or province of residence. As required by the UBC Ethics Review Board, the informed consent page outlined that the host website, surveymonkey.com, was a website based in the United States, making it subject to the Patriot Act, but because the survey did not collect personal information, only the computer's IP address and not the specific user was identifiable.

A final ethical consideration is in how the data is disseminated. There is an important discourse on conducting research on vulnerable populations. The research must have a strong ethical foundation so that the results are not used in such a way as to further marginalize or weaken the population being studied. It will be important to report any results carefully, in such a way as to not focus exclusively on the vulnerabilities but rather on the strengths of queer young people. Similarly, this is why the current study breaks away from a pattern of excluding transgendered people from queer studies, thus further marginalizing them and limiting the scope of knowledge on this important population.

Recruitment of participants. Participants were recruited from several areas via the internet. Poster advertising was planned but not conducted due to the success of internet-based advertising. Email recruitment took place through list serves for queer university groups across BC. The survey was advertised online in banner ads at websites targeting a gay or lesbian audience. Social media such as Facebook advertising was also used, as were advertisements on Craigslist.ca pages for major cities across Canada. Most advertisements specify the target audience (e.g. queer individuals aged 19-29), that participants are needed for an online survey, and that anyone completing the survey will be entered into a draw for a $100 gift certificate. Other advertisements, such as some on Facebook and Craigslist, did not specify that individuals need to be queer, in order to attract a heterosexual, non-transgendered comparison group. Some word of mouth advertising also took place across Canada. None of the advertisements stated that the topic of the survey was self-injury in order to avoid recruiting a potentially biased sample.

Measures

The on-line survey was comprised of three sections. The first section included demographic information as well as questions on sexual orientation, gender identity, and various

experiences related to having an LGBT identity (see Appendix E). This section used skip logic so that someone who identified as being heterosexual and non-transgendered was forwarded on to the second section. LGBT participants were asked a series of questions about coming out, experiences with harassment, and contact with supportive groups like a GSA club in high school. These questions were developed specifically for this study based on existing literature, including past studies on self-harm, sexual orientation, and research on conducting successful online surveys.

The second section of the survey consisted of items from the Non-Suicidal Self-Injury Questionnaire (NSSI-Q) developed by Dr. Janice Whitlock (2008) (see Appendix F). Dr. Whitlock gave permission to use her full survey of 65 questions (personal communication, March 4, 2008). Specifically, the NSSI-Q questions cover the topics of method of self-injury, reasons for self-injury, first self-injury experience, help-seeking behaviour around self-injury, extent and frequency of self-injury, time since most recent incident, and other issues. Items in the questionnaire were developed by Dr. Whitlock and Dr. Favazza after a thorough review of the literature, existing surveys on self-injurious behaviours, and interview data from self-injurors and mental health providers (Whitlock, Eckenrode, & Silverman, 2006). No psychometric data has yet been published on the NSSI-Q.

Following the NSSI-Q, the Center for Epidemiologic Studies Depression Scale (CES-D) was administered to all participants, not only those with a history of self-injury, to assess current levels of depression in the various survey participants (see Appendix G). The CES-D is a 20-item measure of depression that has internal consistency rates of .84 to .90 (as measured by Cronbach's alpha) and test-retest reliability of .51 to .67 in 2-8 week intervals. Concurrent validity measures found it to correlate between .5 to .8 with the Hamilton scale. The Hamilton

Depression Rating Scale was first published in 1960 and has been considered to be the "gold standard" for the assessment of depression (Bagby, Ryder, Schuller, & Marshall, 2004). Following the CES-D, a single open-ended question was included, asking participants who identified as LGBTQ and who had experienced self-injury to comment on if they saw a connection between the two, and if so, to please describe the connection as they saw it. In sum, participants were led through a welcome page, informed consent information, demographic questions, questions on sexual orientation and gender identity, questions about self-injury, questions about depression, a debriefing page, and a page thanking them for their participation and giving them information on how to enter the draw for a gift certificate.

Data Analysis and Interpretation

The survey was active online for six months, from August 2009, to February 2010, closing shortly after reaching the minimum required fifty heterosexual men. Descriptive data on the sample will be presented at the start of the next chapter. Data was analyzed using a variety of statistical methods, including descriptive data, chi square tests, t-tests, and one-way analyses of variances. When appropriate, distinct subgroups of people identifying as gay, lesbian, bisexual, transgendered, or genderqueer were collapsed into a combined "queer" sample and heterosexual, non-transgendered men and women were collapsed into a combined "straight" sample.

Summary

Overall, the current study involves an internet based survey which investigated the phenomenon of self-injury through the use of the NSSI-Q and CES-D. Specifically, the survey asked respondents about sexual orientation, gender identity, and experiences with self-injury, as well as potentially related phenomenon such as depression and bullying. Participants were

recruited from on-line spaces including websites and list serves. Skip logic was used to ensure only questions relevant to the particular respondent are being asked. Data was analysed with a particular focus on any relevant differences in self-injury rates, severity or function between heterosexual and non-heterosexual individuals.

Chapter 4: Results

The goal of this study was to examine the relationship between sexual orientation and nonsuicidal self-injury from a sample of young adults who responded to an online, self-report survey using the internet. This chapter presents the results of analyzing the data from the online survey. First, the descriptive statistics are discussed. Second, the data analyses are presented for these specific research questions:

1. How do the rates and severity of self-injury in the sample of lesbian, gay, bisexual, and transgendered respondents compare to those of heterosexual, non-transgendered respondents based on responses to an online survey?
2. Is there a connection between parental support of sexual orientation/ gender identity and rates or severity of self-injury?
3. Are the reasons lesbian, gay, bisexual, and transgendered people engage in self-injury different from their heterosexual, non-transgendered counterparts?
4. Does past participation in a gay-straight alliance (GSA) club in high school or similar supportive youth group influence the rates or severity of self-injury among queer youth?

Data Analysis

For the first research question, examining the rates of self-injury in the sample, gay men, lesbians, bisexuals, and transgendered individuals were considered separately, primarily reporting descriptive statistics. This is consistent with previous literature that has also considered lesbians, gay men, and bisexuals separately and reported percentages (e.g., Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003; Whitlock, Eckenrode, & Silverman, 2006). The rates of self-injury in the queer sample were compared to the rates in the straight sample by

conducting a chi-square analysis. The severity of self-injury variable was created by aggregating the five item scores that assessed self-injury. A t-test was conducted to examine differences between straight versus queer people on the severity of self-injury variable.

The second research question examined whether self-injury rates or severity were impacted at all by parents' reaction to finding out their child is LGBTQ. To answer this, I employed a t-test to analyse if parental reaction to coming out, rated on a 10 point scale, impacted rates of self-injury. Also, a one-way ANOVA was computed to determine whether mean scores on the severity of self-injury variable differed between positive parental reaction (defined as 8-10 on the scale) and negative parental reaction (defined as 1-3 on the scale).

The third research question investigated the reasons behind self-injury. The survey contained a list of 28 possible reasons for engaging in self-injury. To analyze these data, I ranked the most frequently endorsed reasons for the collapsed queer sample and for the heterosexual, non-transgendered sample. Where the greatest discrepancies existed, I conducted chi-square goodness of fit tests to determine if the difference was statistically significant.

For the last research question, I utilized the data from the queer participants and examined if the presence of or participation in a supportive youth group such as a GSA had an impact on self-injury rates. Data were analyzed using a chi-square test for independence, since the data here were categorical, though again, an independent samples t-test was used to look at severity of self-injury.

Qualitative content from the study was obtained in the final survey question which asked relevant participants if they believed there was a connection between their experiences with self-injury and their sexual orientation or gender identity. Participants' responses appear in Appendix H and have been included for illustrative purposes. That is, responses have not been fully

analyzed as the purpose of the current study was to obtain quantitative data to examine self-injury. Nonetheless, the comments made by research participants contextualize the findings from the current study and are included for that purpose.

Overall, I examined the data to see whether and how LGBTQ people who self-injure might differ from heterosexual, non-transgendered people who self-injure. In all instances, effect sizes were calculated when statistically significant results were found; when significant results were not obtained, effect size was calculated to ensure minimal effect size corroborated the non-statistically significant results (Wilkinson & APA Task Force on Statistical Inference, 1999). Data were examined to ensure assumptions of normality were met prior to running analyses involving parametric statistics: t-tests and ANOVAs. Normality was assessed in three ways. First, Kolmogorov-Smirnov values were calculated to ensure they were greater than .05 (Tabachnick & Fiddel, 2001). Second, skewness and kurtosis values were examined to ensure that they fell within the range of -1 to 1, and when they did not, the values were divided by the standard error to ensure that the product fell within -1.96 to 1.96. Finally, normal Q-Q plots and boxplots were examined for evidence of non-normality. In one case where the tests indicated normality had been violated, the decision was made to proceed with the parametric statistic because the group sizes were over 30, and the sample was determined to be robust to violations of normality. Finally, homogeneity of variance was also verified through the use of Levene's statistic.

Sample Demographics

A total of 475 people began the survey and of that group, 442 met the criteria of being between the ages of 19-29. The remaining 33 people were automatically directed out of the

survey for not meeting the age requirement. Of the 442 respondents, 385 answered all of the required questions while 57 exited the survey early or skipped key questions that resulted in their data being omitted from the analysis. Sample demographics revealed that 77% (n = 296) identified themselves as being Caucasian, 7% identified themselves as being Chinese, and all other ethnicity categories had rates below 3%: First Nations, South Asian, Filipino, Southeast Asian, Japanese, Korean, Latin American, West Asian, Black, Arab, and "Other." The mean age was 23.4 years old (SD = 3.26 years). The combined queer sample was slightly younger (M = 23.27 years, SD = 3.13 years) than the combined straight sample (M = 23.64 years, SD = 3.45 years) but this difference was not statistically significant [t (383) = -1.077, p =.28]. In total, 69% percent of the respondents reported that they came from a middle income background while 18% and 13% reported that they came from a low and high income background respectively.

The composition of the sample's gender and sexual orientation is given in Table 1.

Table 1

Gender and Orientation of Participants

Gender and Orientation	Total N =385
Male- Homosexual	83 (22%)
Male- Bisexual	5 (1%)
Male- Heterosexual	56 (15%)
Female- Homosexual	80 (21%)
Female- Bisexual	40 (10%)
Female- Heterosexual	99 (26%)
Transgendered (female to male)- all orientations combined	5 (1%)

Transgendered (male to female)- all orientations combined	1 (0.3%)
Genderqueer- all orientations combined	12 (3%)
Male and female- unsure about orientation	4 (1%)

The five bisexual men were included in analyses that compared the collapsed queer sample with the straight sample, but were not included in analyses that kept the groupings separate due to their low response rates. In addition, the transgendered and genderqueer participants were collapsed into one category for the purposes of statistical power. Both transgendered and genderqueer individuals are distinct from the other groups as their classification is based on gender identity rather than sexual orientation, and there is a significant amount of overlap and gray area between the two labels, but this combined grouping may still miss important within group variation. Unfortunately, there were not enough transgendered participants to keep the category separate in the current study.

Self-injury Rates, Frequency, and Severity

The self-injury rate for the total sample ($N = 385$) was 40%. Of this, rates reported in the queer sample ($n = 230$) are 47% and 28% in the combined heterosexual sample ($n = 155$). This difference was statistically significant as calculated using chi-square with a Yates continuity correction; χ^2 (1, n =385) = 12.60, $p < .001$, $\Phi = .19$ (small effect size). Data were calculated based on responses to questions in the NSSI-Q portion of the survey. See Figure 2.

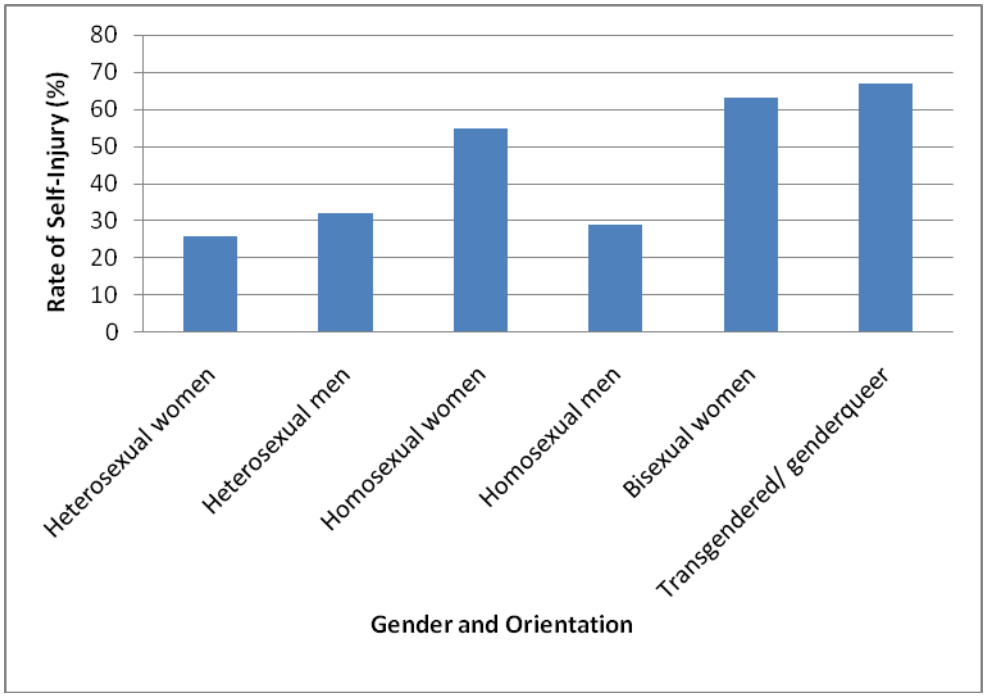

***Figure 2*. Rate of self-injury by group**

The lowest rates of self-injury were found in heterosexual women ($n = 99$) with a rate of 26% while the highest rate was in transgendered and genderqueer people ($n = 18$) at 67%. A chi-square test for independence with all the groups indicated a statistically significant association between gender/sexual orientation and rates of self-injury, χ^2 (5, n =376) = 34.8, $p < .001$, Cramer's $V = .30$ (medium effect size).

Consistent with previous research, results indicated that the most common methods of self-injury were scratching and cutting, with 91 and 74 respectively of the 152 self-injurors endorsing those items. Table 2 presents the frequency data on self-injury for the entire sample as well as for every category of participants.

Table 2
Frequency of Self-Injury

	Straight men *n* = 56	Straight women *n* = 99	Gay men *n* = 83	Lesbian women *n* = 80	Bisexual women *n* = 40	Gender queer *n* = 18	Total *N* = 385
Severely scratched or pinched with fingernails or other objects to point of bleeding or marks remaining on skin.	7	19	12	26	18	8	90
Cut wrists, arms, legs, torso or other areas of the body.	3	14	7	26	13	8	71
Banged or punched objects to point of bruising or bleeding.	9	3	10	23	8	8	61
Bitten self to point that bleeding occurs or marks remain.	4	6	4	15	9	5	43
Carved words or symbols into the skin.	2	6	7	15	6	6	42
Punched/ banged self to the point of bruising or bleeding.	5	3	7	11	5	3	34
Intentionally prevented wounds from healing.	3	1	2	10	4	5	25
Pulled out hair, lashes, etc. with intention of hurting self.	1	4	5	4	6	4	24
Burned hands, arms, legs, torso or other areas of body.	2	2	1	11	2	5	23
Ripped or torn skin.	1	4	2	10	2	3	22
Rubbed glass into skin or stuck sharp objects such as needles or staples into the skin (not including tattooing, body piercing, or needles used for medication use).	1	4	3	9	2	2	21
Performed self asphyxiation (with intent of hurting self).	3	0	4	4	1	1	13
Engaged in fighting or aggressive activities with intention of getting hurt.	2	0	2	5	1	1	11
Tried to break your own bone(s).	1	1	1	4	0	2	9
Created salt and ice burns on the skin.	0	0	1	3	1	0	5
Broke your own bone(s).	0	0	0	2	0	2	4
Ingested caustic substance/ sharp object (e.g. Drano, pins).	2	0	1	0	0	0	3
Mutilated genitals or rectum.	0	0	1	0	1	0	2
Dripped acid onto skin.	0	0	0	0	0	0	0

The mean age for first engaging in self-injury was 14.56 years (*SD* = 3.30 years), with genderqueer/ transgendered people having the youngest mean age of onset at 12.78 years (*SD* = 1.99 years) old versus heterosexual women who started self-injuring on average at 16.15 years old (*SD* = 3.28 years), but this difference was not statistically significant [F (6, 120) = 1.8, p = 0.10, η^2 =.08].

Participants who had self-injured were asked to indicate how many times they had self-injured using a 7 point scale with endpoints ranging from 1 (only once) to 7 (more than 50 times). The majority (98%) of the sample who had self-injured, had done so more than one time and 15% of the total self-injuring sample had injured themselves on more than 50 occasions. The modal response was 4 on the scale, indicating that participants engaged in self-injury between: 6 and 10 times. An independent samples t-test was conducted to determine if there was a statistically significant difference in the mean number of self-injury episodes between the queer (M = 4.58, SD = 1.68) and straight (M = 4.10, SD = 1.75) groups, but the difference was not statistically significant, t (146) = 1.546, p= .12, η^2 =.016. The modal response for the question, "When was the last time you intentionally hurt yourself" was the seventh/ last point on the scale, "More than two years ago," although 15% of the sample had injured themselves within the past three months. Also, when asked how likely they were to self-injure again in the future, the most commonly selected response was, "very unlikely." 14.2% of the sample believed they were very or somewhat likely to self-injure again.

To assess the severity of self-injury, a subscale score was computed by aggregating five questions from the NSSI-Q. The subscale score was uniquely developed for this study and had scores ranging from 2-17. The five questions that comprised the severity subscale were:

1. Have you ever intentionally hurt yourself so badly that you should have been seen by a medical professional (even if you were not)?
2. Have you ever intentionally hurt yourself more severely than you expected?
3. How many times have you intentionally hurt yourself more severely than you expected?
4. Were you under the influence of drugs or alcohol in any instance that you hurt yourself more severely than you expected?
5. How often have you intentionally hurt yourself while you are in your most active phase(s)?

Cronbach's Alpha for the inter-item reliability of the scale was .68. A one-way between groups ANOVA was conducted to compare the mean severity score for participants based on each grouping of sexual orientation/ gender identity. Results of the ANOVA indicated a statistically significant difference among the groups, F (6, 131) = 2.851, p =.012, η^2 =.12. Using Cohen's (1988) guidelines, this would indicate a medium effect size. Tukey's HSD post-hoc test was conducted. This test revealed a statistically significant difference between the mean severity for the genderqueer/ transgendered group (M = 10.82, SD = 3.55) compared to both heterosexual men (M = 6.59, SD = 3.10) and homosexual men (M = 6.82, SD = 2.94). No other statistically significant differences were observed between the groups.

The Role of Internal and External Homophobia with Self-Injury

While not originally set out as a research question, it became clear in the course of running the survey that the connection between homophobia and self-injury was a significant area of findings. In the sample of LGBTQ respondents, the mean age of realizing one's sexual orientation or gender identity was age 13.5 years (SD = 3.98 years), while the mean age of first

telling someone was 16.9 years (*SD* = 2.78 years). When asked about their experiences with harassment due to sexual orientation or gender identity, 10.67% of respondents reported experiencing bullying or harassment "often" or "almost daily," while the largest percentage of people (35.56%) selected the response option "never." Approximately 14% of the LGBT sample reported having been physically attacked due to their sexual orientation or gender identity. Respondents rated their emotional reaction to realizing their sexual orientation or gender identity on a 10-point scale, with 1 being "extremely negative" and 10 being "extremely positive." The overall mean for the sample on this question was 5.4 indicating a fairly neutral though slightly positive response. Participants rated their parents' reaction using the same 10 point scale; the mean of their mother's reaction was 5.38 while the mean of their father's reaction was 4.96.

Analyses were conducted to determine if there was any connection between experiences with homophobia, harassment, or abuse due to sexual orientation or gender identity and experiencing self-injury. The self-injury rates for those who had experienced harassment or bullying "often" or "daily" were 47% while the rates for those who had rarely or never experienced it were almost identical at 46%. A chi-square test for independence (with Yates Continuity Correction) was computed to compare the self-injury rates; however, it was not statistically significant, χ^2 (1, n=225) < 0.001, p = 1.000, Φ = -.008. Similarly, self-injury rates of those who had been physically attacked due to their sexual orientation or gender identity and those who had not was not statistically significant, χ^2 (1, n =225) = 0.012, p = .911, Φ = -.02.

There was a statistically significant difference in the level of severity of self-injury between LGBTQ respondents who reported having been attacked due to sexual orientation or gender identity and those who had not, t (94) = 2.02, p = .046, η^2 = .04 (small effect size). The mean severity of self-injury for those who had been attacked was 10.14 (*SD* = 4.02) while the

mean for those who had not was 8.07 (*SD* = .38). Similarly, the level of harassment or bullying experienced due to sexual orientation or gender identity was significantly correlated with severity of self-injury. A Pearson product-moment correlation found that there was a small positive correlation between the two variables, $r = .28$, $n = 96$, $p = .006$ with higher levels of bullying and harassment associated with higher levels of self-injury severity.

Reactions to Coming Out

Analyses were also run to see if parental reactions to coming out were related to experiences with self-injury. An independent samples t-test was conducted comparing the mothers' mean response as rated on the 10 point scale, where 1 indicated an extremely negative response and 10 indicated an extremely positive response. There was a statistically significant difference in scores for those who had self-injured ($M = 4.69$, $SD = 2.74$) and those who had no history of self-injury ($M = 5.96$, $SD = 2.84$); $t\ (126) = -2.56$, $p = .012$ (two tailed), where the mother's mean response was significantly lower (more negative) in those who had self-injured. The magnitude of the differences in the means (mean difference = -1.27, 95% CI: -2.25 to -0.29) was small to medium ($\eta^2 = .05$). A second independent samples t-test was conducted with the fathers' mean response rated on the same scale. Again, there was a statistically significant difference in scores for those who had self-injured ($M = 4.39$, $SD = 3.02$) versus those who had not ($M = 5.46$, $SD = 3.29$); $t\ (193) = -2.35$, $p = .020$ (two-tailed), where the father's mean response was significantly lower (more negative) for those who had self-injured. The magnitude of the differences in the means (mean difference = -1.07, 95% CI: -1.97 to -0.17) was small ($\eta^2 = .03$).

In addition to examining if parental reaction is connected to rates of self-injury, further analyses were conducted with parental reaction and severity of self-injury. For this analysis, parental reaction was collapsed into three categories: positive, neutral, and negative. The mean severity of self-injury based on mothers' reactions to coming out is as follows: positive reaction (M = 6.56, SD = 1.67), neutral reaction (M = 8.57, SD = 3.25), negative reaction (M = 7.86, SD = 3.77). A one-way ANOVA with planned comparisons between positive and negative reaction found no statistically significant difference between those means, t (51) = -1.004, p =.32, η^2 = .02 (small effect size). Similarly, a one-way ANOVA with planned comparisons comparing fathers' reactions to coming out also found no statistically significant difference in severity of self-injury based on the father having a positive reaction (M = 7.95, SD = 3.61) or negative reaction (M = 9.64, SD = 4.34), t (82) = 1.506, p =.136, η^2 = .03. While parental reaction to coming out was statistically significantly associated to rates of self-injury, it was not statistically significantly associated with severity.

Participants were also asked to rate their own reaction to realizing their LGBTQ sexual orientation or gender identity on the same 10 point scale. An independent samples t-test was conducted to determine if there was a difference in mean reactions for the self-injuring group compared to the non-self-injuring group. There was no statistically significant difference in internal reactions for those who had self-injured (M = 5.22, SD = 2.33) compared to those who had no history of self-injury (M = 5.49, SD = 2.52); t (222) = -0.83, p= .41, η^2.003. As with the parental reactions, a one-way ANOVA with planned comparisons was conducted to determine if having a positive or negative reaction to one's sexual orientation or gender identity had an impact on severity of self-injury. Results of the ANOVA indicated a statistically significant

difference among the means for positive reaction (M = 6.88, SD = 3.10) and negative reaction (M = 8.57, SD = 3.43); t (93) = -2.094, p = 0.04, η^2 =.05 (small to medium effect size).

The Role of Depression with Self-Injury

Depression at the time of self-injury was investigated through a series of six questions: "Were there long periods of time while you were intentionally hurting yourself that you felt: nervous/ hopeless/ restless or fidgety/ so depressed that nothing could cheer you up/ that everything was an effort/ worthless." Each feeling required a yes or no answer. An analysis of the responses to the questions indicated that hopelessness was the most common feeling, endorsed by 80% of participants; followed by depression, endorsed by 75% of respondents; which was closely followed by feeling worthless, endorsed by 73% of participants. When the queer and straight respondents were compared using a chi-square test with Yates continuity correction, results indicated that the queer sample was statistically significantly more likely to endorse that "everything was an effort," χ^2 (1, n = 125) = 8.65, p = .003, Φ= 0.28 (small to medium effect size).

In addition to this series of questions assessing levels of depression during the time of self-injury, the Centre for Epidemiologic Studies- Depression scale (CES-D) comprised the final section of the survey. This is a brief self-report measure designed to assess levels of symptoms of depression in the general population. Each item has four response options that are scored on a 1-4 scale, whereby higher scores indicate greater levels of depression symptomology. The CES-D has a range of 20-80, and a score of 36 or greater is considered depressed (McDowell & Newell, 1996). The mean score for the total sample (N = 348) was 35.80 (SD = 11.23). Participants who identified as transgendered or genderqueer had the highest mean score (M =

39.13, *SD* = 11.79) while the heterosexual women had the lowest mean score (*M* = 34.44, *SD* = 11.06). A one-way between groups ANOVA was conducted to identify differences in levels of depression among the sexual orientation/ gender identity groupings, but no statistically significant differences were observed, F (7, 340) = 1.917, *p*= .07, η^2 =.04. A subsequent independent samples t-test was conducted to determine if the difference in means between the participants who had a history of self-injury (*M* = 38.66, *SD* = 12.50) and those with no history of self-injury (*M* = 34.09, *SD* = 10.05) was statistically significant. Levine's test for equality of variances indicated a violation, so the results for equal variances not assumed are reported here. The test revealed that the difference was indeed statistically significant; *t* (227.42) = 3.54, *p* < .001, η^2 = .03 (small effect).

Reasons for Engaging in Self-Injury

In the NSSI-Q portion of the survey, participants who had experienced self-injury were presented with a list of possible reasons for having engaged in self-injury and were instructed to check off all the reasons that applied to them. The most commonly endorsed reasons are presented in Table 3.

Table 3
Reasons for Self-Injury

Reasons for self-injury	Queer SI participants *n* =105	Straight SI participants *n* = 44	Total *n* =149
To cope with uncomfortable feelings (e.g. depression or anxiety).	69 (77%)	21 (23%)	90
To relieve the stress or pressure.	58 (77%)	17 (23%)	75
To change my emotional pain into something physical.	49 (77%)	15 (23%)	64
To feel something.	49 (82%)	11 (18%)	60
To deal with anger.	35 (71%)	14 (29%)	49

To deal with frustration.	32 (71%)	13 (29%)	45
In hopes that someone would notice that something is wrong or that so others will pay attention to me.	30 (71%)	12 (29%)	42
Because of my self-hatred.	32 (86%)	5 (14%)	37

Table 2 indicates the most frequently endorsed reasons for self-injury in the total sample. Also, it shows that both the straight and queer subsamples reported engaging in self-injury to cope with difficult feelings (e.g., depression) and to relieve stress or pressure. There were few differences between the straight and queer participants in the reasons they self-injured with two notable exceptions. The reason, "to feel something," was endorsed by 60 participants, 82% of who were queer, even though the queer group only made up 70% of the self-injurors. A chi-square goodness-of-fit test indicated that the increased rate from the expected 70% was statistically significant, χ^2 (1, n =60) = 3.889, p = .049. In addition, the reason, "because of my self-hatred" was endorsed by 37 participants, 32 of who (86%) were LGBTQ. A chi-square goodness-of-fit test compared the rate of 86% to the expected rate of 70% and revealed a statistically significant difference, χ^2 (1, n =37) = 4.789, p = .029.

Support from School and Community

A recent trend in North American high schools is to have student clubs which support LGBT students. These clubs are often called "Gay-Straight Alliance" (GSA) clubs. When asked if their high school had such a club, 18% of the sample stated yes with almost half of that group further stating that they had attended a meeting or otherwise participated in the club. In comparison, 18% of the LGBT sample stated that they had participated in a supportive queer community group such as GAB or Youthquest. A chi-square test for independence was computed to determine if there was a statistically significant difference in the rates of self-injury

between those whose schools had a GSA club versus those who did not. The results indicated there was no statistically significant difference, χ^2 (2, n =225) = .532, p = .766, Cramer's V = 0.049. Similarly, an independent samples t-test was conducted to compare the severity of self-injury in those whose high schools had a GSA club (M = 8.24, SD = 4.45) versus those whose high schools did not (M = 8.48, SD = 3.48). There was no statistically significant difference t (86) = -.245, p =.81 (two-tailed).

There was also no statistically significant difference in the rates of self-injury between those who had participated in a queer youth community group such as GAB versus those who had not as calculated using chi-square with Yates Continuity Correction, χ^2 (1, n =225) = 2.951, p = .086, Φ = .126. In addition, there was no statistically significant difference in the severity of self-injury between those who attended such a group (M = 9.00, SD = 4.28) and those who did not (M = 8.21, SD = 3.41) as calculated with an independent samples t-test; t (94) = .872, p= .39 (two-tailed), η^2= .008.

Help-seeking behaviour was similar between the queer and straight participants who had self-injured, with 53% and 46% respectively confirming that someone knew about their self-injury and had had a conversation with them about it. A chi-squared test with Yates continuity correction revealed no statistically significant difference, χ^2 (1, n = 141) = .284, p = .594, Φ= 0.06. The queer group was most likely to have talked with a friend, followed by a significant other, and then a parent. The straight group was equally likely to have talked with a friend or with a therapist, followed by a parent.

Qualitative Responses

At the end of the survey, participants were invited to respond to an open-ended question asking if they believed there was a connection between their experiences with self-injury and

their sexual orientation. Of the 65 responses, the majority consisted of participants explaining the connection from their perspective. For a printout of all responses, please see Appendix H. A full analysis of the responses is beyond the scope of the current study, but the responses obtained in this study indicate that qualitative research in this area is needed.

Summary

Overall, LGBTQ participants varied from the heterosexual comparison group in several important ways. The queer respondents were more likely to have self-injured overall, they were more likely to have endorsed the item that during the time they were self-injuring, "everything was an effort," and their reasons for self-injuring were more likely to include, "to feel something" and "because of my self-hatred." Other significant differences were queer youth who had self-injured were less likely to have parents who were supportive of their sexual orientation or gender identity, and those who had personally reacted negatively to realizing they were lesbian, gay, bisexual, or transgendered tended to have more severe self-injury. Also, frequent experiences of bullying and harassment were correlated with more severe self-injury. Finally, results indicated that people, both straight and queer, who had a history of self-injury scored higher on a standardized measure of current levels of depression than did those with no history of self-injury.

Chapter 5: Discussion

Researchers have been seeking to better understand the phenomenon of nonsuicidal self-injury, with major strides being made in recent years. Specifically, researchers have succeeded in more clearly defining what does and what does not fit into the definition of nonsuicidal self-injury (Heath, Toste, Nedecheva, & Charlebois, 2008), although there continues to be a lack of consensus, especially between North America and Europe (Nock, 2009). Researchers have also succeeded in accumulating a body of studies which show a converging picture on specifics such as average rates of self-injury in the general population, commonly endorsed reasons for engaging in self-injury and general age of first beginning to self-injury. Researchers are also having some success in finding successful courses of treatment for self-injury, including pharmacological interventions as well as counselling and therapeutic interventions (Miller, Muehlenkamp, & Jacobson, 2009).

The current study adds to this body of knowledge by addressing a gap in the existing literature. A small collection of studies have indicated that rates of self-injury might be higher for lesbian, gay, and bisexual individuals. The current study is the first research to look specifically at this issue and begin to identify a possible connection, if any, between sexual orientation/ gender identity and self-injury. Specifically, the goal of this study was to determine if the rates of self-injury in the LGBTQ sample were different than the rates in the heterosexual, non-transgendered sample. It also investigated if the rates of self-injury varied based on the degree of homophobia experienced, and if the reasons for engaging in self-injury varied between straight and queer respondents. Finally, it examined if school and community support groups, as well as parental support, had any impact on self-injury rates in the LGBTQ sample.

Data was gathered from 385 participants who responded to a self-report survey that was advertised on websites on the internet as well as list serves located in Vancouver, Victoria, Calgary, Toronto, and Montreal, Canada. Participants in this study were between the ages of 19 and 29 years old; the majority of the sample reported their ethnic category as Caucasian (77%) and 69% reported coming from a middle income background.

Results of the present study indicated that overall, the self-injury rates in the total sample were higher than those reported in most of the previous research in the area. Recently, Nock (2009) indicated that the average rate of NSSI in college age samples was 12-13% (Nock, 2009); however, this study found that the rate is nearly triple that, at 40%. One explanation for the increased rates is a recent research finding that rates of NSSI are higher for people experiencing some degree of internet addiction (Lam, Peng, Mai, Jing, 2009). Those researchers, in a joint project between China and Australia, found that teenagers who were addicted to the internet were two times more likely to have self-injured in the previous six months. Since the current study recruited participants strictly using online methods, it is possible that the sample was biased in this way. Another explanation is that it is difficult to compare rates across various studies due to differences in delineating what behaviours to include in a definition of non-suicidal self-injury. With its list of 19 different behaviours plus an "other" category, the NSSI-Q is among the most inclusive of various injury behaviours and thus will tend towards revealing higher rates of self-injury. Importantly, with 60% of the sample of the current study identifying as non-heterosexual, the data from the collective sample here will be unlike the data from any previous study.

In this study, the rate of self-injury reported by heterosexual men (32%) was much higher than found in previous research, but in examining the items that describe the methods of self-

injury, the results indicated that the most frequently endorsed item for this group is "banged or punched objects to the point of bleeding or bruising." Many studies do not use instruments that include items that capture this type of behaviour; moreover, some studies do not consider this type of behaviour in their conceptualizations and definitions of self-injurious behaviours. If items that describe this behaviour were omitted from this study, the self-injury rate for heterosexual men could potentially be halved, down to 16%. There has been a great deal of inconsistency in NSSI research regarding the comparative rates for men and women, with some studies finding much higher rates in women (Ross & Heath, 2003; Suyemoto, 1998) and others finding nearly equal rates (Klonsky, Oltmanns, & Turkheimer, 2003; Whitlock, 2006). Some researchers have concluded that the differences in rates between men and women diminish or disappear depending on the forms of behaviour included in the survey; men seem to be more likely to burn or hit themselves while women seem to be more likely to cut or scratch themselves (Klonsky & Muehlenkamp, 2007). The current study found very similar rates due in large part to the inclusion of the action of banging or punching objects. Consistent with previous research, this study found that some of the most commonly endorsed methods of self-injury were scratching, cutting, banging/punching, and wound healing interference (Klonsky, 2007).

Sexual Orientation and Gender Identity

In examining the groups separately, the combined 40% rate of NSSI breaks down to 28% in the heterosexual sample and 48% in the queer sample. Furthermore, heterosexual women had the lowest rate of self-injury at 26%, and transgendered and genderqueer individuals had the highest rate at 67%. The difference in rates among all the groups was statistically significant ($p < .001$) with a medium effect size. The transgendered and genderqueer individuals also had the youngest mean age of beginning to self-injure ($M = 12.78$ years), although this difference was

not statistically significant. Interestingly though, the effect size calculation indicated a medium effect size despite the non-significant results, which may indicate a lack of power given the small sub-sample of transgendered/ genderqueer individuals. In addition, the transgendered and genderqueer respondents had the highest average severity of self-injury, and a one-way between groups ANOVA test revealed that this average was significantly higher than the mean for both heterosexual and homosexual men, who had the lowest mean severity ($\eta^2 = .12$; medium effect size).

The Role of Homophobia with Self-Injury

This study examined two different types of homophobia; experiences with external homophobia such as being harassed or attacked, and experiences with internal homophobia, such as having an extremely negative reaction to realizing one's sexual orientation or gender identity. Results indicated that over 33% of the LGBTQ sample reported having experienced bullying or harassment due to sexual orientation or gender identity as a teenager "occasionally," "often" or "almost daily" with only 36% having "never" experienced this. Further, results demonstrated that 14% of the sample reported having been physically attacked due to their sexual orientation or gender identity. Chi-square analyses were computed to determine if having never or infrequently experienced harassment versus having experienced frequent harassment had an impact on rates or severity of self-injury, but the differences were not statistically significant. Similarly, a chi-square analysis indicated no statistically significant differences in rates of self-injury between those who had and had not been physically attacked. However, the severity of self-injury varied based on both experiences of bullying and harassment as well as the experience of having been physically attacked due. Results of this study suggest that being frequently

bullied or physically attacked due to sexual orientation or gender identity is not connected to higher rates of self-injury, but it is connected to more severe levels of self-injury.

As a way of investigating the role of internalized homophobia, LGBTQ participants were asked to rate their own reaction to realizing their sexual orientation or gender identity on a 10 point scale, where 1 was "extremely negative" and 10 was "extremely positive." An independent samples t-test revealed no statistically significant differences in the mean reactions between those who had a history of self-injury ($M = 5.22$, $SD = 2.33$) and those who had none ($M = 5.49$, $SD = 2.52$). However, one-way between groups ANOVA with planned comparisons revealed that the mean severity of self-injury was significantly worse for people whose reactions had been negative ($M = 8.75$, $SD = 3.43$) versus those whose reactions had been positive ($M = 6.88$, $SD = 3.10$). These results indicate that while having a negative reaction to realizing you are LGBTQ may not increase your chance of engaging in self-injury, it may impact how severe the self-injury becomes.

The Role of Depression with Self-Injury

In this study, depression was measured in two ways; first, depression at the time of self-injury was measured with five questions within the NSSI-Q which asked the participant to think back to the time of greatest self-injury. Second, current levels of depression for all participants were measured through the use of the Centre for Epidemiologic Studies-Depression (CES-D). In the first instance, results were analysed to determine if the questions were endorsed differently by the straight and the queer respondents. The LGBTQ people were significantly more likely to endorse the item, "It seemed like everything was an effort." The remaining four items were endorsed at similar rates, by between 56% of the sample for having felt nervous, to 80% of the sample for having felt hopeless. Specifically, 80% of the queer respondents and 65% of the

straight respondents endorsed having felt, "so depressed that nothing could cheer [them] up." Overall, the response rates to these items indicate that depression and self-injury are connected for many respondents.

The current levels of depression in the sample were measured by the CES-D. These results indicated that while there were no differences in the levels of depressive symptoms between the heterosexual, non-transgendered participants and the LGBTQ participants, there was a significant difference in levels of depressive symptoms between participants with a history of self-injury and those who had never self-injured. This further indicates a connection between depression and self-injury, regardless of sexual orientation or gender identity.

Parental Response to Coming Out Experiences

Participants were asked to think back to when they came out to their parents, and rate their parents' response on a ten-point scale ranging from an extremely negative response to an extremely positive response. Results from this question revealed that the average response from both mothers and fathers was worse/ lower for those who had a history of self-injury versus those who had no history of self-injury. While parental response had this impact on rates of self-injury, it did not have a statistically significant influence on severity of self-injury. To fully consider what this result might indicate, it is worthwhile to re-examine chronology. In this sample, the average age of realizing one's sexual orientation or gender identity was around age 13.5. The average age of beginning to self-injure was age 14.5, and the average age of coming out to parents was age 17. Given that a more negative parental response was found in those who self-injured, one possible explanation is that knowing one's LGBTQ orientation and simultaneously knowing that one's family values are not accepting of non-heterosexuality, could

cause high rates of stress which is highly endorsed as one of the reasons for having engaged in self-injury.

One unexpected result is that in the question assessing mean severity of self-injury based on the mother's reaction, the highest severity was in the condition when the mother's reaction was neutral, not negative. Similarly, the highest severity of self-injury based on one's own reaction was also highest when the reaction was neutral rather than negative. It was only the father's reaction that followed the anticipated outcome of highest severity coming from the most negative reaction group. However, in both the case of the mom's reaction and the person's own reaction, there was no statistically significant difference in the means between neutral and negative reactions; in both cases, the only significant difference was in the positive reaction group compared with the other two. More research may be warranted to investigate the impact of neutral versus positive and negative responses to sexual orientation.

Reasons for Engaging in Self-Injury

Results indicated that the three most commonly endorsed reasons for engaging in self-injury were consistent between the straight and queer sample, and also consistent with previous studies (e.g., Klonsky & Muehlenkamp, 2007). Evidence from this study demonstrated that participants were coping with uncomfortable feelings, relieving stress, and the desire to change emotional pain into something physical. In Nock and Prinstein's (2004) four function model, all three of these reasons fall into the category of Autonomic Negative Reinforcement (ANR), although the third is difficult to categorize. In this study, one difference between the rates of endorsement between the queer sample and the straight sample was with the reason, "because of my self-hatred" which was endorsed at higher than expected rates in the queer sample (86% of

endorsements came from the queer participants, though they made up 70% of the sample). Results suggest a link between societal homophobia, internalized homophobia, and self-injury.

In this study, another item that was endorsed at statistically significantly different rates was the reason, "to feel something" which was selected by 83% of the LGBTQ sample. It is less clear why this reason would be more salient to LGBTQ people, but insight into their reasons can be identified in the qualitative responses participants provided which are discussed below. When participants were asked if they saw a connection between their sexual orientation or gender identity and their self-injury, several commented on having felt alienated or isolated from their friends or family. Results suggest that when people experience isolation, they tend to enact behaviour that serves to numb oneself, which could increase the rate of self-injuring as a way of feeling something. Another possibility comes from a participant who said, "So, you're depressed cuz you don't fit in, and you hurt yourself somehow so you can feel alive." In this case, the 'something' that the person would be trying to feel is an antidote for the depression.

Support from School and Community

Few studies have investigated any potential impacts from schools supporting gay-straight alliance clubs, a type of club which has proliferated throughout North America in the past decade. This study investigated whether or not the presence of a GSA club in high school had an impact on rates or severity of self-injury. The majority of the LGBTQ respondents in this study indicated that their school did not have such a club, but 41 participants responded that they had attended a school that had such a GSA or similar type club. No statistically significant differences were observed in either the rates of self-injury or the severity of self-injury between those whose schools had a GSA club and those whose schools did not. Similarly, no statistically significant differences were found in either the rates or severity of self-injury between the

LGBTQ respondents who had participated in a community-based supportive gay youth group such as GAB or Youthquest and those who had not.

Qualitative Responses

At the end of the survey, participants were asked, "If you identify as lesbian, gay, bisexual, transgendered, questioning, or queer, do you feel like there is a connection between this identity and your experiences with self-injury? If so, please describe." A total of 94 participants chose to reply; five responded "yes," eighteen responded "no," and six responded "n/a." The remaining 65 responses provide insight into self-reported connections seen by the participants. Some participants described the link they saw between homophobia and their experiences with self-injury. Some participants identified internalized homophobia as playing a role in their self-injury. For example, one participant indicated, "It was likely related because I was so self hating at that time in my life. I had been pushing away the reality that I was bisexual for a very long time." Other participants identified homophobia in the people around them; in fact, one participant stated, "I only self-injured myself once and it was over frustration and anger over coming out to a friend and their attitude regarding it."

In addition to illustrating the connection between homophobia and self-injury, the paricipants also point to different reasons for self-injuring. Using Nock's four-function model (2004), an example of a social positive reinforcement (SPR) is seen in this response:

> Yes. Even though I did not understand it at the time. I was called fag and sissy a lot, I was not male enough, and in order to try and stop the harassment I created a image of toughness by cutting and burning myself in front of others, wearing leather jackets, listening to heavy music, and drinking and using drugs a lot. Years later I came out as

> queer, and genderqueer, and all the years of harassment began to make sense as I never felt I was male, although I refused to admit it to myself until recently.

An example of an autonomic positive reinforcement is seen in this person's response:

> Many of the people from the community in which I came out in whom are part of the queer community have injured themselves in some way, either with self injury or other means such as drugs and alcohol, or promiscuity. I think that it was used as a coping mechanism, as this area was notoriously conservative and at this point in time there were very few resources available for the community. So, you're depressed cuz you don't fit in, and you hurt yourself somehow so you can feel alive.

However, the most common reason among the replies relates to using self-injury as a way to cope with difficult feelings tied to sexual orientation or gender identity; an autonomic negative reinforcement (ANR). Examples of this include: "yes, learning that I was queer contributed to my depression, which resulted in me looking for ways to cope, including self-harming" and "yes, at that time when I was young the shame about being different, and wishing I could be 'normal', fit in better with peers, and just...not have same sex feelings, and gender confusion all at once." These replies are consistent with other research on NSSI which has found that the most common reason for engaging in self-injury is to deal with overwhelming or difficult emotions (e.g., Klonsky & Muehlenkamp, 2007).

Implications for Counselling Practice

This study uncovered some important findings that are relevant for counsellors, particularly those working with LGBTQ young people or young people who self-injure. Given the relatively high rates of self-injury in queer young people, especially in those questioning their gender identity, it is important for counsellors and other service providers working with these

youth to be aware of what self-injury is and to be checking in with their clients to find out if they struggle with self-injurious behaviour. It is especially important for counsellors working with GSA clubs or queer community youth groups to do psychoeducational sessions with young people to educate them about self-injury, and encourage those who are experiencing it to seek help.

The finding that reasons for engaging in self-injury differ slightly for queer youth is important for counsellors and researchers. Many of the qualitative responses indicated engagement in self-injury because of feelings of shame, which aligns with the reasons endorsed by many LGBTQ respondents around self-hatred; therefore, counsellors who work with queer young people need to be cognizant of this risk and they may need to address this in their work with their clients to reduce it by building self-esteem and developing adaptive coping strategies. This is connected to the finding that rates of depression are high in those who self-injure, regardless of sexual orientation or gender identity, so counselling work to lessen feelings of depression may also have an impact on self-injury. Previous research has demonstrated that queer youth are particularly at risk for depression due to feelings of isolation, lack of connectedness, and stress from homophobia (Saewyc et al, 2007). This is important as there may be a connection between queer youth's increased rates of depression found in previous studies and the increased rate of self-injury found here.

A significant finding in this study was that queer self-injurors were less likely than heterosexual, non-transgendered self-injurors to have spoken with a therapist about their self-injury. This finding has important implications for counsellors; considering that LGBTQ youth may be more likely to turn to a friend or family member, counsellors can be working on community education projects to better equip those people to help.

Most importantly, this study revealed some key findings regarding the impact of homophobia. Negative parental reactions and negative internal reactions coincided with higher rates or greater severity of self-injury. Many of the qualitative responses spoke to young people turning to self-injury as a way to fight off feelings of same-sex attraction or as punishment for those feelings. Counsellors need to take information like this and other studies on the negative effects of homophobia and work within their communities to improve societal views on homosexuality, bisexuality, and gender variations.

Strengths of the Study

Few studies on nonsuicidal self-injury have examined sexual orientation and none have investigated the connection as their primary purpose. Compared to other self-injury research, this study captured one of the largest samples of LGBTQ respondents: a total of 230. This large sample is also noteworthy for having been recruited and conducted over the internet; many of the other studies on self-injury have limited their sample to first-year undergraduate students. Given that the current survey was advertised on a variety of websites and list serves, the sample here may be more diverse than a typical university sample. In addition, this survey recruited only participants within Canada, and so is an important addition to the wealth of self-injury research currently existing in the United States.

Another strength of this study was its inclusion of transgendered and genderqueer participants. Although it is difficult to rely too heavily on the results due to a small sample size, it was important to compare the results of this group to those of the LGB sample and those of the heterosexual sample. The results of this study indicated that transgendered and genderqueer

people may be at an increased risk for self-injury, highlighting an important need for further research on this population.

When self-injury research has included a question on sexual orientation, the researchers have rarely gone beyond simply calculating the self-injury rates for non-heterosexual participants. This study is vital for having investigated the connection more thoroughly, questioning not only the risk factors such as experiences with homophobia, but also protective factors such as community support groups. This study was also the first to compare the reasons for why straight versus queer participants engaged in self-injury.

Severity of self-injury is a difficult item to quantify, and few researchers have attempted to create a scale on which to measure severity. This study built upon past research which has investigated issues related to severity such as the need to seek medical attention for an injury and combined several such questions into a scale of severity. While this was a preliminary attempt, it provided important data on how severity differed across groups and situations; differences that may not have been noticed in single questions and which were remarkably different than the results on straightforward rates of having engaged in self-injury.

Limitations of the Study

Despite the interesting findings revealed through this study, caution should be used in generalizing these findings as there are limitations of this research. In some cases, results were not statistically significant, even when there were sizeable differences in the means between the groups. It is likely that this occurred due to insufficient power, that is, a relatively small sample size. One example of this is in the question asking participants about having ever participated in a GSA club in high school. The rate of self-injury and mean severity of self-injury for those who

had participated in a GSA club was higher than those whose schools had such a club but did not attend. The differences were not statistically significant, but there were only 41 respondents who had attended schools with this type of club. Had there been more, the differences may have become statistically significant, and if it is indeed the case that those teenagers participating in these clubs have higher than average rates and severity of self-injury, then that becomes important information for teacher sponsors to be aware of.

Another limitation of this study came from the challenges faced in conducting quantitative research within the queer community. Two participants wrote to the researcher to express frustration over having to select a sexual orientation and gender category, especially when the option of "queer" was not available. Previous studies in the area of self-injury have published results on rates of NSSI within the labels gay, lesbian, and bisexual. In order to compare the results of this study with the previous research, it was necessary to keep the same labels. The result of this, however, was a drop-out rate of participants at the questions regarding sexual orientation and gender identity. While it is impossible to determine exactly why these people dropped out of the survey, it is possible that the survey design made participation by 'queer' young people who are unable or unwilling to define themselves by a more restrictive label less likely.

An additional limitation of this study is in the inadequacy of the questions investigating experiences with homophobia, including harassment, bullying, and being physically attacked. It was interesting that these events did not consistently find statistically significant relationship with rates or severity of self-injury, yet in the qualitative response section, many people wrote in about how being bullied due to their sexual orientation led, as they saw it, to their experiences with self-injury. It is possible that the questions asked in the survey would have captured a

stronger connection if they had focused on the frequency of such events and the personal impact the homophobia had. In the current format, infrequent harassment received a lower score than frequent harassment, but a single bullying incident could have an equal or greater impact on a young person's sense of self than frequent bullying had on someone else's sense of self.

Suggestions for Further Research

In the growing body of literature on nonsuicidal self-injury, there are many questions that remain to be answered in our goal to better understand this phenomenon, especially as it appears in certain minority populations such as LGBTQ young people. There is currently a significant collection of studies examining self-injury in general populations and researchers can feel confident in their understanding of the basic nature and functions of NSSI. Research studies investigating self-injury in specific subgroups of the population, such as the current study, are relatively new to the field. Further research into self-injury in minority populations may help inform the literature on self-injury in general populations, especially with regard to what life circumstances and stressors put someone specifically at risk for self-injuring. For example, it seemed from this study that feeling shame or having unsupportive parents played a role in self-injuring. These circumstances are not unique to LGBTQ young people, so the findings here could be used to further research into triggers of self-injury in other populations as well.

Future research into self-injury in the queer community is warranted. It would be valuable to determine whether the results reported here, specifically the high rates of self-injury, are replicated in a non-internet based sample. Further research is also indicated for self-injury in transgendered or genderqueer people. Due to low response rates, those two groups were put into one category, but there may be important differences between people who identify within the

gender binary as transgendered or transsexual and those who do not and identify as genderqueer. People identifying strictly as queer may have been missed entirely in the current study, so more research into the coping strategies of these populations would help to inform the results of the current study. Finally, the written comments participants made about the connection they believed existed between their sexual orientation or gender identity, the homophobia they experienced, and their experiences with self-injury indicate that a qualitative study in this area is warranted.

Afterword

In the early days of nonsuicidal self-injury research, the term most commonly used was self-mutilation. This term was gradually replaced with the more sensitive term of self-injury. At times, researchers have also used the term self-harm. What all three of these terms have in common is the word "self." The definition coined by the INSS opens with the words, "the deliberate, self-inflicted destruction of body tissue..." The notion that this form of injury is done by the self to the self is inextricable from not only our understanding of the behaviour, but from the very label we have assigned to the phenomenon.

The purpose of this study was to closely examine nonsuicidal self-injury in LGBTQ youth. The findings indicate that the rates were significantly higher in the LGBTQ respondents. However, the survey results went on to demonstrate how experiences with bullying, harassment, physical attacks, parental rejection, and low self-esteem are connected with experiencing self-injury. It would be unethical to draw a conclusion that being gay, lesbian, bisexual, or transgendered causes increased rates of self-injury. Instead, the only conclusion that should be taken from the results is that injury done to LGBTQ young people from a homophobic, biphobic, and transphobic society sometimes takes the form of cutting, burning, scratching, etc. The origin of the injury does not lie with the 'self' as the name would imply, but rather with the society which enacts violence upon these youth on a sometimes daily basis. The violence can take overt forms such as homophobic bullying in high schools, or covert forms such as a lack of representation of their lives in many TV shows, movies, and magazines directed at youth. The result of living in this type of society causes some LGBTQ youth to internalize this violence and enact it upon their bodies. Under this new conceptualization, self-injury is a misnomer, and instead, the phenomenon is better characterized as societal injury enacted upon the self.

With this new framework, it is important to recognize that the first step towards helping prevent self-injury in queer youth is to work towards increasing acceptance of LGBTQ people in society. Researchers and practitioners alike need to work not only with queer youth on building self-esteem, learning about positive queer role models, and self-acceptance, but need to work also with parents, teachers, and the larger society to increase positive acceptance of LGBTQ people and the valuable contributions they make to society. An end to societal violence against queer people is likely to go a long way towards reaching an end to nonsuicidal "self" injury in LGBTQ youth.

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Appendix A: Ethics Board Approval

The University of British Columbia
Office of Research Services
Behavioural Research Ethics Board
Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL - FULL BOARD

PRINCIPAL INVESTIGATOR:	INSTITUTION / DEPARTMENT:	UBC BREB NUMBER:
Lynn Miller	UBC/Education/Educational & Counselling Psychology, and Special Education	H09-00414

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:

Institution	Site
UBC	Vancouver (excludes UBC Hospital)

Other locations where the research will be conducted:

Subjects will be recruited from PRIDE UBC, Out On Campus (SFU), GAB youth group (Gay and Lesbian Centre of Vancouver), as well as from the readership of Xtra West newspaper (Vancouver) and the Georgia Straight newspaper. The survey will also be advertised on the following websites: superdyke.com, xtra.ca, vancouver.craigslist.org, facebook.ca, and straight.com. Finally, posters advertising the survey will be displayed in Little Sister's Bookstore, at the Gay and Lesbian Centre of Vancouver, at Turk's Coffe Shop on Commercial Drive (Vancouver), and various community centres and coffee shop notice boards around Vancouver.

CO-INVESTIGATOR(S):
Signe Finnbogason

SPONSORING AGENCIES:
N/A

PROJECT TITLE:
Nonsuicidal Self-Injury in Queer Youth

REB MEETING DATE:	CERTIFICATE EXPIRY DATE:
May 14, 2009	**May 14, 2010**

DOCUMENTS INCLUDED IN THIS APPROVAL: **DATE APPROVED: June 9, 2009**

Document Name	Version	Date
Protocol:		
Thesis proposal	N/A	April 1, 2009
Consent Forms:		
Informed Consent	B	May 30, 2009
Advertisements:		
Banner ad	B	May 30, 2009
Poster Ad	B	May 30, 2009
Questionnaire, Questionnaire Cover Letter, Tests:		
Questionnaire	N/A	April 1, 2009
Other Documents:		
Deception form	N/A	May 23, 2003

The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:

Dr. M. Judith Lynam, Chair
Dr. Ken Craig, Chair
Dr. Jim Rupert, Associate Chair
Dr. Laurie Ford, Associate Chair
Dr. Anita Ho, Associate Chair

Appendix B: Informed Consent

Thank you for choosing to learn more about this survey. My name is Signe Finnbogason and this survey is being administered in partial completion of my Master's thesis in Counselling Psychology at the University of British Columbia, under the supervision of Dr. Lynn Miller. This survey has received ethical approval from the University of British Columbia's Research Ethics Board for research involving human participants.

To thank you for your participation in the survey, if interested, you will be invited to enter a lottery draw for a $100 gift certificate. When you reach the end of the survey, you will be provided with an email address where you can enter the lottery draw. A winner will be chosen at random after all data have been collected. The gift certificate will be emailed to the winner. Your entry in the lottery draw cannot be linked in any way with your survey and the names and email addresses will be destroyed once a winner is chosen.

Purpose:
The purpose of this survey is to explore the relationship between sexual orientation, gender identity, depression, stress, and coping mechanisms. As a Canadian resident between the ages of 19-29 years old, you are invited to participate in this research study.

Study Procedures:
As a participant in this study, you will be asked to answer questions on an online survey. The survey can be completed from any computer with secure access to the internet. The survey should take between 10-20 minutes to complete. Once you begin the survey, explicit instructions will guide you through completion of the survey.

You may only complete this survey once. However, you can go back to earlier parts of the survey by clicking the "Back" button at the bottom of the page. You may also save your progress and return to the survey at a later time to complete it by clicking the "Exit this survey" link in the top right-hand corner. Please note that in order to do this, you must have cookies enabled on your computer.

Potential Risks and Benefits:
There are no anticipated physical, social, or legal risks associated with participating in this study. As with any study involving personal questions, there is the potential for questions to trigger some emotional discomfort. You are encouraged to participate only to your level of comfort. A list of resources for counselling or support will be provided at the end of the survey.

Your participation in this study will ideally contribute to a greater understanding of how stress and coping may relate to sexual orientation and gender identity. At the end of the survey, you will be given information on how to request a copy of the results once the study has been completed.

Confidentiality:
Your identity will remain anonymous; the questionnaires will not have any identifying data. The survey company is a U.S. company and as such is subject to U.S. laws, in particular the Patriot

Act which allows authorities access to the records of internet service providers. This survey does not ask for any information that may be used to identify you. The survey company servers record incoming IP addresses of the computer that you use to access the survey but no connection is made between your data and your computer's IP address.

Contact for information about the study: If you have any questions or desire further information with respect to this study, please feel free to contact:

Dr. Lynn Miller
Department of Education & Counselling Psychology and Special Education
University of British Columbia
604-822-8539
lynn.miller@ubc.ca

Contact for concerns about the rights of research subjects:
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or RSIL@ors.ubc.ca.

Consent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy.

Thank you for your interest in this survey!

1. If you agree to the above conditions and wish to participate in this survey, then please check the box marked "Yes, I understand the conditions and wish to participate in this survey." Selecting this box signifies that you have read and understood the above information, and have consented to participate in the survey.

- Yes, I understand the conditions and wish to participate in this survey.
- No, I do not wish to participate in this survey.

Appendix C: Debrief

Thank you for completing the survey. Your responses will help researchers better understand depression, self-injury and ultimately how to help people who struggle with these issues. Answering questions relating to depression and self-injury can be a difficult experience. If you are feeling upset, please contact one of the resources below for assistance or more information.

Self-injury support:

www.selfinjuryhelp.com

www.selfinjurysupport.com

Depression support:

www.depressioncanada.com

or call a local crisis line (phone numbers can be found online or in a phone book)

Vancouver crisis line: 604-872-3311

BC crisis line: 1-800-784-2433

or see your doctor

Again, your participation in the survey was extremely valuable and I thank you very much.

TO ENTER THE DRAW FOR $100: please send an email to ubcselfinjurystudy@gmail.com with the subject "contest" and your preferred contact information (e.g. phone number or email).

This contact information will be used only for the purpose of contacting the winner. This contact information can NOT be linked to your survey responses and will be destroyed after the winner is selected. Odds of winning are roughly 1 in 200.

Appendix D: Advertisements for the Survey

Web advertisements read:

"Are you age 19-29? Queer? I need your help! Click on the link below to take a survey on stress and coping for a chance to win a $100 gift certificate to a store of your choice!"

Or

"Are you age 19-29? If so, I need your help! Click on the link below to take a short survey for a chance to win a $100 gift certificate to a store of your choice!"

Appendix E: Survey Demographics and Sexual Orientation

1. How old are you? (Please note, you must be over 18 and under 30 to participate in this survey) (Responses under 19 or over 29 will be redirected to an exit page, thanking them but explaining that they do not qualify for the current survey)

2. What kind of place did you primarily grow up in?
Urban/ city
Suburb of a city
Rural/ country/ small town
I moved- grew up in both

3. Do you primarily live in Canada?
Yes
No (Responses of No will lead the participant to an exit page, thanking them but explaining that they do not qualify for the current survey)

4. Did you attend at least one year of high school in Canada?
Yes
No

5. What income level best describes your family during the time you were a teenager?
Low income
Middle income
High income

6. What is your dominant ethnic background?
White/ Caucasian
First Nations
Chinese
South Asian
Filipino
Southeast Asian
Japanese
Korean
Latin American
West Asian
Black
Arab
Other:

7. What is your gender identity?
Male
Female
Transgendered – Male to Female
Female to Male

Genderqueer

8. What category best describes your sexual orientation?
Mostly gay/lesbian/ homosexual
Mostly bisexual
Mostly straight/ heterosexual
I'm not sure what my orientation is
I don't understand this question

*Respondents who answer either male or female to question 7 AND heterosexual/straight to question 8 will be advanced to the NSSI-Q.

Note: If you are transgendered, please reply to the following questions by considering your gender identity, rather than your sexual orientation.

9. To the best of your memory, how old were you the first time you told someone else that you were gay/ lesbian/ bisexual/ transgendered?

10. To the best of your memory, how old were you when you first realized you were lesbian/ gay/ bisexual/ transgendered?

11. On a scale of 1 to 10, with 1 being extremely negative and 10 being extremely positive, what was <u>your</u> initial reaction to realizing you were lesbian/ gay/ bisexual/ transgendered?

12. If you came out to your mother, what was her reaction, using the same scale as above, with 1 being extremely negative and 10 being extremely positive?

Note: if you were raised by caregivers other than a mother and father, please consider those caregivers when answering this and the following question.

13. If you came out to your father, what was his reaction, using the same scale as above, with 1 being extremely negative and 10 being extremely positive?

114. To what degree did you experience harassment, bullying, or discrimination as a teenager due to your gender identity or sexual orientation?
Never
Very rarely
Occasionally
Often
Almost daily

15. Have you ever been physically attacked due to your sexual orientation or gender identity
Yes
No

16. Did your high school have a gay-straight alliance club (or similar type of club supportive of gay students)?

Yes
No
I don't know
*If answer yes- go to question 17, if no- go to question 18

17. Did you ever attend a meeting or otherwise participate in this club?

18. As a teenager, did you participate in any supportive community queer youth group (e.g. GAB, Youthquest, Surrey's LGBT group, etc)?

Appendix F: Non-Suicidal Self-Injury Questionnaire (NSSI-Q)

(Note: responses in blue will lead to questions in blue which follow. Lack of endorsement of the blue responses will cause the survey to skip the blue question.)

1. Have you ever done any of the following ***with the purpose of intentionally hurting yourself?*** *(Please check all that apply)*

Severely scratched or pinched with fingernails or other objects to the point that bleeding occurs or marks remain on the skin
Cut wrists, arms, legs, torso or other areas of the body
Dripped acid onto skin
Created salt and ice burns on the skin
Carved words or symbols into the skin
Ingested a caustic substance(s) or sharp object(s) (Drano, other cleaning substances, pins, etc.)
Bitten yourself to the point that bleeding occurs or marks remain on the skin
Tried to break your own bone(s)
Broke your own bone(s)
Ripped or torn skin
Performed self asphyxiation (with the intention of hurting yourself)
I have never intentionally hurt myself in these ways

2. Have you ever done any of the following ***with the purpose of intentionally hurting yourself?*** *(Please check all that apply)*

Burned wrists, hands, arms, legs, torso or other areas of the body |
Rubbed glass into skin or stuck sharp objects such as needles, pins, and staples into or underneath the skin (not including tattooing, body piercing, or needles used for medication use)
Banged or punched *objects* to the point of bruising or bleeding
Punched or banged *oneself* to the point of bruising or bleeding
Intentionally prevented wounds from healing
Mutilated genitals or rectum
Engaged in fighting or other aggressive activities with the intention of getting hurt
Pulled out hair, eyelashes, or eyebrows (with the intention of hurting yourself)
I have never intentionally hurt myself in these ways

3. Are there any other ways that you have physically hurt or mutilated your body ***with the purpose of intentionally hurting yourself?***

Yes; please specify
No

***If a participant answers that they have never hurt themselves in questions #1-3, they will be advanced to the CES-D.**

4. The statements which best describe why I intentionally hurt myself include: (Please check all that apply)

To help me cry
As self-punishment or to atone for sins
As a way to practice suicide
As an attempt to commit suicide
Because my friends hurt themselves
Because my friends expect me to
To be part of a group
To feel something
To get a rush or surge of energy
To cope with uncomfortable feelings (e.g. depression or anxiety)
In hopes that someone would notice that something is wrong or that so others will pay attention to me
To get control over myself or my life
To relieve stress or pressure
To feel closer to God
So I do not hurt myself in other ways
So I do not hurt someone else
To shock or hurt someone
To distract me from other problems or tasks
To change my emotional pain into something physical
Because it feels good
To avoid committing suicide
Because I get the urge and cannot stop it
To deal with frustration
Because I like the way it looks
To create an excuse to avoid something else
To deal with anger
Because of my self-hatred
Other; please describe

5. In the above question, you indicated that you intentionally hurt yourself with the intention of practicing or committing suicide. Was practicing or attempting suicide the ***primary*** reason you intentionally hurt yourself?

Yes
No
I am not sure

The following questions ask about your experience with intentionally hurting yourself. We know that this can be a difficult issue to think and talk about. Please note that there are web links on the bottom of every page and at the end of the survey with contact information you can use if you feel like you want to talk with someone. The information you provide about this topic will

be used to help others who intentionally hurt themselves. It will take about 15 more minutes to complete this survey. Please remember you can exit the survey at any time. Thank you in advance for your time and honesty.

7. When was the last time you intentionally hurt yourself in one of the ways listed in the previous question?

Less than 1 week ago
Between 1 week and 1 month ago
Between 1 and 3 months ago
Between 3 and 6 months ago
Between 6 months and 1 year ago
Between 1 and 2 years ago
More than 2 years ago

8. How likely are you to intentionally hurt yourself again?

Very likely
Somewhat likely
Not sure
Somewhat unlikely
Very unlikely

9. Approximately on how many total occasions have you intentionally hurt yourself?

Only once
2-3 times
4-5 times
6-10 times
11-20 times
21-50 times
More than 50 times

10. If you had to estimate the total number of occasions you have intentionally hurt yourself, what would you estimate?

(open ended)

11. On what areas of your body have you intentionally hurt yourself?
(Please check all that apply)

Wrists
Hands
Arms
Fingers
Calves or ankles

Thighs
Stomach or chest
Back
Buttocks
Head
Feet
Face
Lips or tongue
Shoulders or neck
Breasts
Genitals or rectum
Other; please specify

12. Which of the following descriptions best describes your motivations for first intentionally hurting yourself? (Please check all that apply)

A friend suggested that I try it
I read about it on the Internet and decided to try it
I saw it in a movie / on television or read about it in a book and decided to try it
It seemed to work for other people I know
It seemed to work for celebrities I have heard of
I accidentally discovered it - I had never heard of it or seen it before
It was part of a dare
I did it because I had friends who did it and I wanted to fit in
I wanted to be part of a group
I wanted to shock or hurt someone
I was upset and decided to try it
I wanted someone to notice me and / or my injuries
It felt good
I was angry at someone else
I was angry with myself
I was drunk or high
Other; please specify
I cannot remember

13. Have you ever intentionally hurt yourself more severely than you expected?

Yes
No

14. Have you ever intentionally hurt yourself so badly that you should have been seen by a medical professional (even if you were not)?

Yes
No

15. How many times have you intentionally hurt yourself more severely than you expected?

1
2-3
4-5

More than 5

16. Were you under the influence of drugs or alcohol in any instance that you hurt yourself more severely than you expected?

Yes
No

17. Please briefly describe one specific thing you have done to intentionally hurt yourself.

18. Have you ever sought medical treatment (not therapy) for any of the physical injuries you intentionally caused?

Yes
No

19. How old were you the first time you intentionally hurt yourself?

20. How often have you intentionally hurt yourself while you are in your most active phase(s)?

Every day
2-3 times a week
Once a week
1-3 times a month
Once every few months
About once a year
Once every two years or more years

21. During the period(s) in which you most actively hurt yourself, what was the longest interval of time during which you ***did not*** hurt yourself?

Less than a week
Less than a month
1-3 months
4-6 months
7-12 months
More than a year

22. Which of the following are true for you? (Please check all that apply)

I always intentionally hurt myself in private
I have friends who intentionally hurt themselves
I do not feel much physical pain when I intentionally hurt myself
I sometimes intentionally hurt myself in the presence of others
I sometimes let other people intentionally hurt me physically
I have intentionally physically hurt another person
I have a regular routine I follow when I intentionally hurt myself
I have a particular place / room I prefer to be in when I intentionally hurt myself
I tend to go through periods in which I intentionally hurt myself, then periods in which I do not, and this pattern repeats
Other; please specify
None of the above

23. Which place / room?

24. How true are each of the following statements for you?

	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Does not apply
I have had to intentionally hurt myself more deeply and / or in more places on my body over time to get the same effect						
I want to stop intentionally hurting myself altogether, but have trouble stopping						
I will not need help from someone to stop intentionally hurting myself altogether - I can do it on my own						
I sometimes intentionally hurt myself while under the influence of drugs and/or alcohol						
Nothing else works as well as intentionally hurting myself to calm me down or give me relief						
I have had to fight the						

urge to start intentionally hurting myself again						
When I have the urge to intentionally hurt myself it is easy to control it						
The fact that I intentionally hurt myself is a problem in my life						

33. The fact that I intentionally hurt myself interferes with: (Please check all that apply)

Relationships which are important to me
My ability to complete school or work obligations
My ability to take care of myself (eat right, exercise, etc.)
My ability to engage in hobbies or things that I like to do
My self-worth / self-esteem
The clothing I wear
Other; please specify
It does not interfere with my life in any way

34. Does the following statement describe your experience? Someone knows that I intentionally hurt myself and ***has*** had a conversation with me about it.

True
False

35. Who knows about it and has talked with you about it? (Please check all that apply)

Parent or custodial guardian
Sibling
Friend
Significant other (boyfriend, girlfriend, or spouse / partner)
Other relative
Teacher
Coach
Adult friend
Therapist
Physician
Religious or spiritual leader (e.g., priest, pastor, rabbi)
Health care provider
Other; please specify

36. (For each selected) Did you initiate the conversation or did they?

I initiated the conversation
They initiated the conversation

37. (For each selected) Have the conversation(s) you've had with this person been helpful?

Yes
No
I do not know

38. Does the following statement describe your experience? One or more people ***know or suspect*** that I intentionally hurt myself but has ***not*** had a conversation with me about it.

True
False
Possibly, but I do not know

39. Who knows / suspects about it and has not talked with you about it? (Please check all that apply)

Parent or custodial guardian
Sibling
Friend
Significant other (boyfriend, girlfriend, or spouse / partner)
Other relative
Teacher
Coach
Adult friend
Therapist
Physician
Religious or spiritual leader (e.g., priest, pastor, rabbi)
Health care provider
Other; please specify

40. (For each selected) Do you wish this person would talk with you about it?

Yes
No
I do not know

41. Does the following statement describe your experience? No one knows that I intentionally hurt myself.

True
False

42. Have you ever gone to therapy because you intentionally hurt yourself?

Yes
No
Intentionally hurting myself was part of the reason I went but not all of it

43. Did someone else insist you go to therapy or did you decide to go on your own?

Someone else insisted that I go
I went on my own
Other; please specify

44. Have you had a conversation about intentionally hurting yourself with one or more therapists?

Yes
No

45. How did your therapist(s) respond to the information that you intentionally hurt yourself? (Please check all that apply)

They were comfortable with the information
They seemed **un**comfortable with the information
They asked me to sign a "no harm" contract
They only talked about it if I raised it or it came up as part of another discussion
They asked me about it even if I did not raise it or it did not come up as part of another discussion
It seemed like stopping me from intentionally hurting myself was a goal of therapy
They said I would have to leave college, at least for a while, if I did not stop intentionally hurting myself
They said it was okay for me to hurt myself if I needed a way to cope with really bad feelings and there was nothing else I could do
They said it was a coping mechanism and suggested other methods to cope
I have talked to more than one therapist about this and they have each handled it differently
Other; please specify

46. How old were you the **first time** you talked to a therapist about **intentionally hurting yourself?**

47. If you have received **therapy for any reason**, did you intentionally hurt yourself ***after*** your treatment ended?

Yes, I did intentionally hurt myself after treatment
No, I completely stopped intentionally hurting myself after receiving treatment
I have seen multiple therapists about intentionally hurting myself and some helped me and some did not

48. In your opinion, how helpful was **therapy** in helping you to stop intentionally hurting yourself?

Very helpful
Helpful
Somewhat helpful
Not at all helpful

49. What in your experience with therapy (even if your experience with intentionally hurting yourself was ***not*** the focus of your therapy) has been ***most*** helpful in helping you to understand or control intentionally hurting yourself?

50. What in your experience with therapy (even if your experience with intentionally hurting yourself was ***not*** the focus of your therapy) has been ***least*** helpful in helping you to understand or control intentionally hurting yourself?

51. Do you think you will intentionally hurt yourself again?

Yes
No

52. Looking back, how has your experience with intentionally hurting yourself impacted your life, both positively and negatively? (Please check all that apply)

It was a working emotional coping strategy
I still cannot talk about it and sometimes even thinking about it is difficult
It prevented me from attempting suicide
The lasting marks / scars are constant reminders of a bad / rough time in my life
I am now able to help others who intentionally hurt themselves
In thinking / discussing my experience around intentionally hurting myself, I have learned a lot about myself and because of it have mentally / emotionally grown
My scars are my battle wounds - I made it through
It pushed me further away from people; this is still a problem
Discussion of my experience around intentionally hurting myself has helped me grow closer to the people I care about
The remaining marks / scars are a source of embarrassment for me
It really did not impact my life much at all
Other; please specify

53. Please feel free to expand on your response to the previous question here.

54. If you have stopped altogether (you are confident that you will not intentionally hurt yourself again) please describe why you stopped ***and*** what specifically helped you to stop.

55. What do you think is important for people who want to understand and help those who intentionally hurt themselves to know?

56. Were there long periods of time **while** you were intentionally hurting yourself that you felt:

	Yes	No	I do not know
Nervous			
Hopeless			
Restless or fidgety			
So depressed that nothing could cheer you up			
That everything was an effort			
Worthless			

63. How old were you the *last time* you intentionally hurt yourself?

Appendix G: Centre for Epidemiological Studies- Depression (CES-D)

The 20 items below refer to how you have felt and behaved during the last week.

1. I was bothered by things that don't usually bother me.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

2. I did not feel like eating; my appetite was poor.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

3. I felt that I could not shake off the blues even with the help of my family or friends.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

4. I felt that I was just as good as other people.

Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

5. I had trouble keeping my mind on what I was doing.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

6. I felt depressed.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

7. I felt everything I did was an effort.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

8. I felt hopeful about the future.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

9. I thought my life had been a failure.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

10. I felt fearful.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

11. My sleep was restless.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

12. I was happy.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

13. I talked less than usual.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

14. I felt lonely.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

15. People were unfriendly.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)

Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

16. I enjoyed life.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

17. I had crying spells.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

18. I felt sad.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

19. I felt that people disliked me.
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

20. I could not get "going".
Rarely or none of the time (<1 day)
Some or a little of the time (1-2 days)
Occasionally or a moderate amount of the time (3-4 days)
Most or all of the time (5-7 days)

Applied Psychological Measurement, 1, 385-401.

Appendix H: Participants' Written Responses

It was likely related because I was so self hating at that time in my life. I had been pushing away the reality that I was bisexual for a very long time.

yes and no.. in high school when i was closeted yes, it was giving me a lot of anxiety.

yes, at that time when I was young the shame about being different, and wishing I could be "normal", fit in better with peers, and just...not have same sex feelings, and gender confusion all at once.

I attempted suicide the day that my friend at youth group discovered I was a lesbian. At that point, I knew that it would eventually leak out to the rest of the church community. I was a big part of it, a leader at a youth group, and I really liked the kids there. I think that is the only time there was a connection. Since the attempt, I haven't cut myself for long periods of time. I am aware of when I am becoming depressed and take pro-active steps in preventing it from hitting full-on. I am also very out in the community and am currently questioning my gender identity.

Not really, other factors in my life were the main reasons .. discovering my latent preferences during added on slightly.

I don't feel that there was a connection between my bisexual identity and my experiences with self-injury. I hurt myself mostly to cope with the anger and depression caused by childhood sexual abuse and the subsequent loss of my family and friends.

There is a bit of a negative kink in my personality; I think that in the end, no matter what I ended up identifying as, I would have resorted to self-injury. Certainly, the turbulence in my relationships have directly affected how much I self-mutilated (or should I say, self-medicated?)- on the other hand, I'm not so sure now... It's true that because those I loved were female (and mostly straight, at that), I felt even more hopelessly restricted, what with society's views on homosexuality and all, thereby adding fuel to the fire. Still, I'm not sure it would have made a difference what gender I preferred.

I do not feel that there is a direct connection between my identity and experiences of self-harm. I feel that my experiences were in part related to feeling isolated, and having no access to resources or supportive community for an aspect of my identity.

yes, as previously stated it was a fool-hardy attempt at classical conditioning myself away from being gay, however, i should also note that this time was a period of great depression in general, but leaving high school i sought medical help and was placed on antidepressents (which have helped tremendously)

One of the reasons I started cutting myself was to try and "train" myself to be straight - It was how I punished myself for thinking about girls in a sexual way.

I believe there is a connection in that I see my sexuality as being linked to the negative sexual experiences I had as a child, and those experiences contribute to my moments of self-harm. My sexuality then mediates a connection between the two others.

I still haven't figured that out. I started doing this not long before I came out, and it might have been a subconscious response to it. I haven't any conclusive evidence either way, however.

yes. Even though I did not understand it at the time. I was called fag and sissy a lot, I was not male enough, and in order to try and stop the harrassment I created a image of toughness by cutting and burning myself in front of others, wearing leather jackets, listening to heavy music, and drinking and using drugs a lot. Years later I came out as queer, and genderqueer, and all the years of harassment began to make sense as I never felt I was male, although I refused to admit it to myself until recently.

Many of the people from the community in which I came out in whom are part of the queer community have injured themselves in some way, either with self injury or other means such as drugs and alcohol, or promiscuity. I think that it was used as a coping mechanism, as this area was notoriously conservative and at this point in time there were very few resources available for the community. So, you're depressed cuz you don't fit in, and you hurt yourself somehow so you can feel alive.

yes, since before coming out I felt alone and segregated from others. Often leading to depression

Yes. The first time I injured myself was because I was depressed. My best guy friend and I were in love with the same girl. He got the girl, and I didn't know how to cope. I felt like I was stupid even thinking that she might like me the same way I liked her. After that I continued to injure myself but for different reasons. It was mostly whenever I felt like I deserved a punishment for the way I acted, or for something I said or thought. It was usually my secret, because I didn't want people to know. I only started talking about it recently.

At 14 I was dating a boy while trying to work out my sexual identity. He wasn't sure how to handle it and the stress on our relationship caused me a lot of anxiety.

I am not sure. I was emotionally stressed in my relationship with my boyfriend and that is why I did it. Some of the stress in our relationship was from my bisexuality and curiosity that he didn't approve of.

Yes. I grew up in a small town where homophobia was extremely difficult to live amongst. Constant gay jokes and gay bashing really prevented me from feeling comfortable enough to explore my sexuality without consequence. I jumped from boyfriend to boyfriend even though I had very little interest, just so I could appear normal. It was horrible on my self esteem and I did things just to fit into the heterosexual-norm that everyone expected of me. When I felt "strong" and decided to be single, people grew suspicious of me. I felt too afraid to engage in a same sex relationship in fear of bullying. It was so frustrating that I would blame myself and take it out on myself, including self-injury.

Possibly. There were many factors involved. I think I only really admitted being bisexual, even to myself, after my experience with hurting myself. At the time I think it was just too much to feel and think about

completely. I was in denial for many, many years and i have just recently come out and been able to properly address my past habits.

Yes, I had great difficulty reconciling my family's religious beliefs with my own personal experience. Self-injury was a coping mechanism

Yes for a few reasons: lack of support; negative attitudes in society towards queer and gender queer people.

My primary reason for SI was self-hatred from obesity. Later in life I did it because I could not find a same-sex love. Still later I did it because of my frustrations with my gender.

maybe a small bit, because being gay and transgendered makes life just that little bit more complicated, aside from having to explain that to parents. Generally, though, it's not the gender/sexual orientation that affects my experiences with self-injury, it's other stressors on my life (such as school etc).

Yes. My self-injury got worse once I was rejected by my parents. Also, my same sex partner was a cutter herself, which drew me back into it.

Yes, i was hurting myself directly because of my homosexuality

Yes. As a young person growing up in a religious family and with a religious education, my identity as gay was a cause for self-injury. I thought that I was just not a good enough Christian and if I hurt myself, I might somehow cause the sexual urges to disappear.

I knew I was gay. I went to an all-guys school. It was very hard to fit in. I hated school so much, even though I was in the closet and wasn't bullied that much. This had an impact in my grades, which were very important to my mom. I was too scared to confront her about my low marks, which made me very scared to even talk about my sexual orientation.

On the first occation, but not the second.

I beat myself in an attempt to somehow stop my attractions to other guys. I could not accept my sexuality when I was younger because of what I had been taught in my conservative Christian religion. So in a way I would say that there is as much a connection between my self-injury and my sexual identity as there is a connection between my self-injury and my religion.

The first times I did it were due to stress from my mother going through a difficult time along with coming to accept myself for being gay, bullying at school from someone (later to come out as lesbian) who suspected I was gay and general stress over school work.

i never hated myself for being gay, my issues related to societies view and treatment of me and the fact that i was raped repetedly by a male neibour as well as other non gay issues in my life

Not really. Maybe slightly when i was coming out. But for the most part it had to deal with anger and fustrations I didnt know how to deal with.

Being gay has always alienated me from parts of my family and seemed to act as an extra stresser in tense situations. At a young age, there was an immense amount of fear and anxiety of being "discovered" and actively tried to suppress anything that would force me to come out.

I don't think this had much bearing on it, but I think it had a small part to play

Just felt as if hurting myself would make God love me again and he'd make me straight, so everyone would love me again.

There has been a small connection as my relationship with my family was negatively influenced. Also my relationship was also unhealthy for me which resulted in the self injury as well.

Maybe. Mostly just everything about my identity and life.

I only self-injured myself once and it was over frustration and anger over coming out to a friend and their attitude regarding it.

Yes, I believe that not really knowing who I am has affected my self-loathing and confusion throughout my life

My sexuality has been a source of great anxiety for me. I hit puberty at the age of eleven and I dealt with the ensuing feelings through self-harm. Although I was raised in a family largely accepting of LGBTQ persons, I knew this would change when I came out, and this knowledge came with very complicated feelings. From a young age, my lack of sexual interest in boys prompted homophobic experiences from my peers that made social interactions uncomfortable, inspired shame, and made me try to suppress my sexuality. I developed a strong aversion to physical touch and became unable to talk about my feelings. This disconnection from my body and feeling silenced or voiceless was one of the major factors in my self-harming activities.

I self injured as a way of feeling something - I became depressed later and that was definitely to do with my sexual identity.

Yes. I used self destructive coping mechanisms to deal with the self hate and sadness I felt at that time.

It's hard to explain. There is a connection between my queer identity and my self-injury, but it certainly wasn't the main connection by any stretch.

yes, i had no self worth and felt very alone in the world. i partially injured myself for attention and partially just too feel something other than the oppressing dread of life. i worried that i could not cope with the things in my life at that young age, and feared that as i grew up things would get tougher and i would fail at life. at that point i tried suicide, but, did not really want to die and got help. i am now a very happy and out lesbian.

yes. guilt

Self hatred when discovering my identity was a contributing factor to self injury.

somewhat -- me just not being able to cope with why i didn't fit in with others

Yes, learning that I was queer contributed to my depression, which resulted in me looking for ways to cope, including self-harming.

Maybe. I pick my fingers when I'm very anxious...and often I'm anxious around family because they're homophobic. So probably indirectly yes, but it's more just a habit I do when I'm anxious.

I identify as lesbian and I believe there is a connection between my identity and my self-injury mostly because the coming out process for me was not easy - I lived in a small town where most people (including my parents and my peers) have very traditional views on sexuality. I was ashamed when I was young because I was taught that being gay was wrong and stemming from that I had issues with self-acceptance. My parents reacted negatively to my coming out as well and made me feel as if I was a failure to the family. I think my denial of my self-identity was a root cause of my depression as a teenager before I came out. Self-injury was a way for me to cope with the negative emotions I was having at that time in my life.

I knew I was different from my friends; however, I was unable to understand what it is, causing a certain amount of self-doubt. much like living a lie.