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An existential-phenomenological investigation of self-cutting among adolescent girls

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An Existential-Phenomenological Investigation Of Self-Cutting Among Adolescent Girls

by

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ABSTRACT

The present study examined the experience of self-cutting, what stops adolescent girls from engaging in self-cutting, and what message adolescent girls who are self-cutting would want to send to other girls taking part in this behavior. Using an existential-phenomenological method of interviewing, adolescent girls were asked a serious of questions in order to gain insight into their thoughts, feelings, and beliefs about the experience of self-cutting. Each interview was tape recorded, transcribed, and thematized. The participants in this study were labeled co-researchers due to the significant role that they had in the completion of this study. The co-researchers consisted of six adolescent girls aged 15 to 18 years old. They all attended high schools within a large urban school district in Florida.

Through a reduction of the data obtained during the interviews, five superordinate themes were discovered for the first research question, which examined the experience of self-cutting. The themes depicted the following experience. Before engaging in self-cutting, each co-researcher had “A Lot of Feelings” stemming from “A Big Event” that they needed to “Release.” They chose cutting because “Nothing [else] Ever Worked” and the act of cutting made them “Numb” and feel “No Pain.” Themes developed from the second research question, which examined what stops adolescent girls from self-cutting,

included “Thinking About the People Who Care” or when “Thinking About the Consequences” of cutting. If they could send a message to other girls who are cutting, the co-researchers in this study would say “Don’t Do It.” The co-researchers were able to articulate other coping strategies to serve the same function as cutting but sometimes refused to implement them. Results of this study support the findings of previous research.

Chapter One

Introduction

During the past decade, self-mutilation, including self-cutting, has received much attention. This attention has come from various fields including social work, clinical psychology, school psychology, and counseling fields. Self-cutting also has become a popular fad within the junior and high school aged population as a way to deal with difficulties in their lives (Galley, 2003). Additionally, the media has given this topic a plethora of attention. In 1996, the public had little knowledge about self-cutting behaviors in typical adolescents. Then, Princess Diana volunteered that she had been a cutter in the past and the media began to demystify the behavior (Levenkron, 1998).

Self-cutting has been characterized as an addiction and a gratifying experience (Lieberman, 2004). Levenkron (1998) describes the act of self-cutting as "a frightening barrier that keeps us from seeing a person who is lost, in pain, and in desperate need of help," (p.19). He also states that within his practice as a therapist, he meets many clients who have been turned away by other professionals because of their professed lack of knowledge about this behavior. Within the school and counseling settings, there is a feeling of overwhelming apprehension about how to deal with self-cutting and why this behavior is occurring in such great numbers (Carlson, DeGeer, Deur, & Fenton, 2005; Levenkron, 1998).

School psychologists at many high schools are being asked by teachers, parents, peers, and administrators about how to talk to students engaging in this behavior. Many psychologists are receiving training on the area of self-cutting but are still left without answers. Why are so many girls, and recently boys, engaging in self-cutting when there are alternative ways to deal with stress that do not cause pain and scarring? What is attractive to adolescents about self-inflicting pain? Why do adolescents believe that they are engaging in self-cutting behavior? In order for professionals to be able to help adolescents use healthier coping strategies than self-cutting, it is important to understand the many facets and dynamics of this behavior. These include the predisposing factors for self-cutting and the emotional consequences of it. Adolescents who have engaged in this behavior are likely to best understand their reasons and experiences with it. They are the experts on this topic.

Statement of the Problem

'It wasn't pain I was feeling, it was like an injection of Novocain that the dentist uses…blood ran down the side of my forearm in a neat stream onto a folded paper towel. The stream was dark red and thick, but I wanted to see more so I tilted my arm and the stream broke into three rivulets…and turned my forearm red.' (Levenkron, 1998, p.27). The above passage cites the exact words of a patient in therapy describing her experience with self-cutting.

Self-cutting is a growing problem on many junior and high school campuses (Galley, 2003). The past research on this subject suggests that it is a complex mental health issue that is not taken seriously and is under-researched (Carlson et al., 2005). Ross and Heath estimate that between 0.75% and 14.8% of adolescents may self cut

(2002). The Encyclopedia of Children's Health (2005) cites that girls are almost four times more likely to engage in self-cutting than boys, with girls between the ages of 16 and 25 at highest risk, although many girls begin cutting in middle school (ages 12 or 13). Research supports that individuals most at risk for self-cutting include those who have underlying psychiatric disorders, and up to half of the individuals who are self-cutters were sexually abused as children (Encyclopedia of Children's Health, 2005).

Some researchers believe that self-cutting behavior has been increasing at an astounding rate (Lieberman, 2004). The growing occurrence of self-cutting in the media coupled with the lack of research on this topic may be a couple of the factors leading to the increase in this behavior over the last 10 years. Movies such as "Thirteen" and "Secretary", television shows such as the "Real World", and some popular songs and websites have featured themes revolving around self-cutting. Additionally, popular actors who have admitted to self-cutting may glamorize or confuse adolescents about the utility of self-cutting.

Proposed Reasons for Cutting

"What does it feel like to cut yourself, deliberately, until you feel pain and start to bleed? Why would you do this?" (Levenkron, 1998, p.31). Most of us do not understand how hurting oneself and seeing the blood can make a person feel better. Some people, on the other hand, engage in this act to relieve the tension and pain that has built up inside of them (Levenkron, 1998). Self-cutting is a medicine for some girls, in which pain brings about relief, safety, and security (Levenkron, 1998). A girl who self-cuts may experience a calming effect on her mental pain because of the physical pain she is inflicting upon herself (Levenkron, 1998).

Many researchers support a theory of tension relief as a partial explanation for self-cutting (Favazza & Conterio, 1989; Ross & Heath, 2003). Ross and Heath (2003) have developed anxiety reduction and hostility models of self-cutting based on this theory. Suyemoto (1998) described a similar model known as the affect regulation model and has used it to help explain self-cutting. Another proposed explanation for self-cutting is that it is the solution to defending against feelings of needing someone, and the blood or scars caused by the mutilation are transitional objects used to negotiate the separation/individuation process (Woods, 1988). Nock and Prinstein (2005) believe that self-cutting may be best described by a variety of functions and Yip (2005) shares this view.

Factors Related to Cutting

There are many demographic variables that have shown to be significantly related to self-cutting (Favazza & Conterio, 1988; Suyemoto, 1998). They include gender, age, marital status, employment history, and level of education. Specifically, the majority of adolescents who self-cut are single, female, in middle to late adolescence, and under-employed with a lower vocational achievement than controls with the same level of education. Family characteristics and family history also have shown to be related (Rosen, Walsh, & Rode, 1990) to the engagement in self-cutting behavior. Specifically, the majority of adolescents who self-cut come from divorced families, neglectful families, or families in which there was parental deprivation, are more likely to have lost a parent, have peer conflicts, have another self-cutting family member, or have observed family violence. Additionally, adolescents who have either been abused or have seen abuse, and those with diagnosed mental illnesses are more likely to engage in self-cutting

(Darche, 1990; Dulit, Fryer, Leon, Brodsky, & Frances, 1994). Finally, adolescents with more suicidal ideation and past suicide attempts are more likely to engage in self-cutting (Dulit et al., 1994).

Rationale for the Study

Cutting has been studied using both quantitative and qualitative methods. Studies that have used quantitative methods such as surveys allow researchers to examine many factors related to cutting such as depression, anxiety, hostility, and loneliness (Favazza & Conterio, 1989; Nock & Prinstein, 2004, 2005; Ross & Heath, 2003). These studies further research through finding correlates with self-cutting but do not allow for participants to talk about accompanying emotions, feelings, and cognitions that they experience while engaging in self-cutting.

There have been very few published studies exploring self-cutting using qualitative methods (Favazza, 1998). Additionally, there are a handful of unpublished dissertations that have explored this area of research (Kashgarian, 1999; Moyer, 2004; Rao, 2000). Valle, King, and Halling (1998) believe that only through an interviewee's own words and verbalizations can the full meaning behind his/her actions be known. Other researchers have agreed with this (Lenenkron, 1998; Patton, 2002). More studies are needed to explore adolescents' experiences and reasons for self-cutting. To examine self-cutting at this level, this investigator has selected a method in which a more intense description of the experience will be captured.

Existential-Phenomenological Method

"The best way of understanding why a person would want to harm herself is by listening to the voices of those suffering from the disorder" (Levenkron, 1998, p.33).

Phenomenological approaches allow researchers to hear those voices. Patton (2002) wrote that "phenomenological approaches focus on exploring how human beings make sense of an experience and transform experience into consciousness…" (p. 104). Patton also explained that an existential-phenomenological method would allow a participant to explain how he/she perceives, feels about, remembers, and makes sense of an event. The existential-phenomenological method of interviewing will allow the adolescent girls participating in this study to truly describe their feelings about the phenomenon under investigation without having to choose the way they feel about self-cutting from a forced choice listing. Using this method the researcher hopes to gain a greater comprehension of the reasons adolescent girls are choosing to engage in self-cutting.

Purpose of this Study

As mentioned above, the thoughts and emotions of adolescent girls taking part in self-cutting are poorly understood. The overall purpose of this study was to allow adolescent girls to describe their full experience with self-cutting. To do this, 6 co-researchers were asked several questions regarding self-cutting and their experience with it. They also were asked what stops them from cutting, and what message they would want to send to other girls who are cutting. The answers were tape recorded and analyzed through phenomenological thematic analysis. The thematic analysis of these answers allowed the investigator to gain insight into the experience of self-cutting and the reasons why adolescent girls engage in it at alarming rates.

In summary, this research explored the experience of self-cutting in adolescent girls using the existential-phenomenological interviewing method. Through the use of this method, a more comprehensive account of the experience of self-cutting, within the context of our present culture, was obtained.

Research Questions

1. What is the experience of self-cutting?
    a. Tell me about the first time you self-cut.
    b. What was happening in your life at that time?
    c. What made you decide to start self-cutting?
    d. Please describe the experience of self-cutting in as much detail as possible.
    e. Please describe a recent situation of self-cutting and any thoughts or feelings that you were feeling at the time.
2. Has there ever been a time when you really wanted to cut and you didn't? What stopped you?
3. If you could send a message to other girls who are cutting, what would that message be?

Key Terms

Co-researcher. The title given to each of the girls, aged 15-18 years, participating in this study.

Self-Cutting. Self-cutting was defined in this study as intentional carving or cutting of the skin and subdermal tissue, or scratching, ripping or pulling skin without the intention of committing suicide (Alderman, 1997; Favazza, 1996; Nock & Prinstein, 2005; Suyemoto, 1998).

Chapter Two

An Existential-Phenomenological Investigation of Self-Cutting Among Adolescent Girls

Overview

The purpose of this chapter is to review the existing literature on self-cutting and the possible reasons why adolescent girls are engaging in this behavior at increasingly higher rates. This chapter begins by introducing and defining self-mutilation and self-cutting. The prevalence rates are then discussed. The chapter then addresses the topics of characteristics of adolescents who self-cut and misconceptions about adolescents who self-cut. The chapter concludes with a summary of the research examining existing theories and models of self-cutting among adolescents, methods used to assess the reasons for this behavior in past research, and the specific method that was used for this research project.

Statement of the Problem

Adolescence has been characterized as a time of significant biological, social, and cognitive change (Slavin, 2003). As a result, this period can bring about increased feelings of confusion, anxiety, and depression (Mash & Barkley, 2003). It has been shown that one in five adolescents has a mental, behavioral, or emotional problem and that one in ten has a serious emotional problem (Mash & Barkley, 2003). Notably, in the United States, it has been found that about 4% of adolescents become seriously depressed each year, with girls showing signs of depression at a significantly higher rate than boys

(Mash & Barkley, 2003; National Institute of Mental Health, 2001). At one time, the only individuals that professionals thought were engaging in self-cutting were youth with schizophrenia, severe depression, mental challenges, a history of abuse, a history of chemical dependence, or a history of incarceration (Favazza, 1998). Currently, however, youth without any of these problems are showing the greatest increases in self-cutting behavior (Favazza, 1998). This may be due, in part, to the attention of the mainstream media at the present time to this topic. Famous people such as Johnny Depp, Angelina Jolie, and Princess Diana all have admitted to previous self-cutting behavior. There also are numerous popular songs, books, magazines, and websites about this topic that are made especially for adolescents and young adults. More and more adolescents may be using this method of coping to decrease their sadness and stress levels (Favazza & Conterio, 1989; Selekman & King, 2001). Currently, there is little known about self-cutting in the general population of adolescents (Ross & Heath, 2002).

Definition of Self-Cutting

Three types of self-mutilation were outlined by Favazza (1989). These are major self-mutilation, stereotypic self-mutilation, and superficial or moderate self-mutilation. These three types are distinguished by the amount of tissue damage or injury incurred. Major self-mutilation is the most severe and uncommon form. It usually results in permanent disfigurement such as castration or amputation. Stereotypic self-mutilation is the most common type found in populations with mental handicaps and autism. It involves consistent, routine behavior, such as head banging. The most common type of self-mutilating behavior found in adolescents is superficial or moderate self-mutilation.

Superficial or moderate self-mutilation is a direct, deliberate, repetitive, and socially unacceptable form of self-harm in which a person destroys his/her body tissue without suicidal intent (Nock & Prinstein, 2005; Suyemoto, 1998). It is not a form of indirect self-harm, such as drinking and driving, or a socially acceptable form of self-harm, such as tattooing or ear piercing (Favazza, 1989). Additionally, it is not a major or non-repetitive form of self-harm such as self-castration nor is it related to cognitive impairment, such as stereotypical behavior seen in children identified as mentally handicapped or autistic (Favazza & Rosenthal, 1990). While a person is engaging in self-mutilation, he/she is in a psychologically disturbed state but has no intentions of suicide, no needs for self-stimulation, and no need for a stereotypical behavior (Suyemoto, 1998).

Self-cutting is the label that will be used for the behavior discussed in this chapter and in this study, but there are various names for this behavior throughout the literature (Suyemoto, 1998). One study cited as many as 33 terms for this behavior (Ross & McKay, 1979). A common, universally agreed upon label would be more conducive for research purposes, but that is not readily available at this time (Suyemoto, 1998). Although some researchers believe that self-mutilation is a diagnosable syndrome, the signs and symptoms are not commonly agreed upon or listed accurately (Zila & Kiselica, 2001). Types of self-mutilation include cutting, burning, scratching, skin-picking, and hair pulling (Lindgren, Wilstrand, Gilje, & Olofsson, 2004), but the most common type of self-mutilation is self-cutting (Favazza & Conterio, 1988). Self-cutting is defined as a self-mutilating behavior in which the skin is cut with a sharp object, such as a knife, razor blade, scissors edge, needle, pin, or sharp glass edge until pain is felt or until blood is seen (Simpson, 2001).

The peak age for self-cutters is 16-25 years (Yip, 2005). Cutting is usually done lightly and superficially, without hurting any major arteries (Yip, 2005). Some adolescents may even carve words into their skin to express how they feel about certain things that are happening to them in their current life situation (Yip, 2005). Some adolescents have been known to cut themselves over one hundred times, and the mishandling of self-cutters by parents, peers, student support staff, and school psychologists may trigger further self-cutting (Yip, 2005). There is continuous debate about whether a self-cutting syndrome exists, and it has been proposed to be added to various revisions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) (Levenkron, 1998; Walsh & Rosen, 1988). Even though researchers cannot agree on the syndrome label, there is universal agreement that self-cutting and the larger category of self-mutilation are currently serious problems within the adolescent population (Favazza, 1998; Nock & Prinstein, 2004, 2005; Ross & Heath, 2002; Yip, 2005).

Prevalence

The actual prevalence of self-cutting is challenging to correctly assess (Suyemoto, 1998). Many patients who self-cut do not readily give out this information. Many times their self-cutting behaviors are only discussed when they are explicitly asked about them (Suyemoto, 1998). Some studies that have reported prevalence and incidence may have underestimated this behavior due to the sources of their data, such as police reports, doctors' records, or hospital files. These data only take into account the most severe cases (Suyemoto, 1998). Many adolescents who self-cut are very secretive regarding their behaviors and often times treat their own wounds without anyone else knowing about the self-cutting (Suyemoto, 1998).

Based on the prevalence reported in the DSM third edition, which uses self-cutting as a diagnostic criterion for certain disorders, it is estimated that self-cutting in the general population occurs in about 1,800 per 100,000 persons aged 15-35 (Favazza & Conterio, 1988). Walsh and Rosen (1988), in their review of incidence data, found that self-cutting has drastically increased since the 1960's. They found that the incidence ranged from about 14 to 600 per 100,000 people annually. Prevalence rates found by Favazza, DeRosear, and Conterio (1989), in a study of college students, found that about 12% of this population had or was still self-cutting. Additionally, Favazza (1998) estimated that between 1.5% and 2% of all adolescents are affected. This suggests that adolescents and young adults may be at greatest risk for these behaviors. With regard to the population of adolescents receiving psychiatric care, the rates of this behavior have been found to be much higher than in the general population, ranging from 40% to 60% in some studies (Darche, 1990; DiClemente, Ponton, & Harley, 1991).

Characteristics of Adolescents who Self-Cut

The majority of adolescents who self-cut are single and female (Favazza & Conterio, 1988; Suyemoto, 1998). Most individuals who self-cut have their first episode during middle adolescence (Favazza & Conterio, 1988). Adolescents who self-cut are often under-employed with a lower vocational achievement than controls with the same level of education (Favazza & Conterio, 1988). Adolescents who self-cut are more likely to come from divorced families, neglectful families, or families in which there was parental deprivation (Rosen, Walsh, & Rode, 1990). They are more likely to have lost a parent, have peer conflicts, have above average intelligence, have another self-cutting family member, and have observed family violence (Walsh & Rosen, 1988).

Additionally, adolescents who self-cut often have a history of physical or sexual abuse as children (Rosen et al., 1990). Many times, adolescents who self-cut have been shown to have diagnosable mental disorders such as Major Depressive Disorder or personality disorders such as Borderline Personality Disorder. Although the act of self-cutting is clearly differentiated from suicide, adolescents who self-cut usually have more suicidal ideation and past suicide attempts than adolescents who do not self-cut (Dulit et al., 1994).

Self-cutting is most closely associated with Borderline Personality Disorder (Offer & Barglow, 1960; Walsh & Rosen, 1988). Other diagnoses such as major depression, dissociative identity disorder, obsessive-compulsive disorder, alcoholism and other substance abuse, eating disorders, schizophrenia, anxiety disorders, adjustment disorders, and other personality disorders also have been associated with self-cutting (Darche, 1990; Dulit et al., 1994; Favazza et al., 1989; Offer & Barglow, 1960). Favazza and Rosenthal (1990) have suggested that self-cutting or self-mutilation should be the primary criterion of a distinct diagnosis of deliberate self-harm or repetitive self-mutilation. Favazza (1989) further argued that self-cutting is an impulse disorder similar to eating disorders or Kleptomania. He feels that although many patients are diagnosed with a personality disorder, when their self-cutting ends, so do the rest of the symptoms of their personality disorder. Research for an impulse disorder diagnosis has been in the process for the past decade and a half (Favazza et al., 1989).

Up to this point there is no diagnosis of repetitive self-mutilation syndrome but repetitive self-mutilation meets all the criteria for an impulse control disorder (Favazza, 1998). It may be present in many disorders and is a criterion for five different disorders

in the DSM-IV. The frequency of self-cutting varies among different disorders (i.e., recurrently for Kleptomania and Trichotillomania, persistently and recurrently for Pathological Gambling, more than once for Pyromania, or as several discrete episodes for Intermittent Explosive Disorder). Since Repetitive Self-Mutilation syndrome is not recognized by DSM-IV, it also can be coded as an impulse-control disorder not otherwise specified (312.30).

More is known about the characteristics of adolescents who self-cut within psychiatric settings than about adolescents who self-cut within the general population. Ross and Heath (2002) attempted to address this problem by studying a community sample of high school students and assessing their related mental health problems such as depression and anxiety. The purpose of their study was to provide preliminary epidemiological data on the frequency of self-cutting in a community sample of high school students and to assess if these behaviors were shown more in children who displayed depressive and anxious symptomatology than in those who showed no symptomatology. Participants included 440 students from two schools, one urban and one suburban high school. First, they were given a screening measure to assess self-cutting, the Beck Depression Inventory (BDI; Beck & Steer, 1993b) to assess depressive symptoms, and the Beck Anxiety Inventory (BAI; Beck & Steer, 1993a) to assess anxiety-related symptoms. Then, if they indicated that they hurt themselves on purpose, they participated in a follow-up interview.

Based on the interviews with these participants, it was found that 13% (30 students) of those from the urban school and 14.8% (31 students) of those from the suburban school had engaged in self-cutting at some time. Chi square analyses revealed

no significant difference between the two schools in terms of prevalence. In terms of racial differences, Caucasian students had significantly higher rates of self-cutting (20%) than African American, Asian, or Hispanic students (1.2%, 1.7%, .9%, respectively). Additionally, of the whole sample of students interviewed at the urban and suburban schools, girls reported significantly higher rates than boys (16.8% and 9.5%, respectively). Finally, those students who self-cut reported higher symptoms of depression and anxiety than those who did not self-cut. The results of this study suggest that self-cutting is a problem that affects adolescents in high school settings and that it affects more Caucasians than other racial groups and more girls than boys. It also suggests that there are relatively high proportions of students in the general population who self-cut and that self-cutting is related to symptoms of depression or anxiety. One limitation of this study was that a survey was used to screen for self-cutting. This could have positively or negatively skewed the data depending on if the adolescent thought of self-cutting as socially acceptable or unacceptable. Research discussed earlier shows that most students find self-cutting to be socially unacceptable and try to hide it. This may not have allowed all participants to feel comfortable discussing their self-cutting behavior and may have underestimated the frequency. Ross and Heath (2002) suggested that more research is needed to determine the reasons why adolescents are taking part in these activities.

Misconceptions about Adolescents who Self-Cut

There are many misconceptions about self-cutting. The first is that adolescents who self-cut use their behavior to manipulate others (Froeschle & Moyer, 2004). Instead, researchers believe that self-cutting is an attempt to relieve tension or replace rage

(Froeschle & Moyer, 2004). Adolescents who self-cut often go to great lengths not to expose their wounds. A second misconception is that self-cutting is similar to and/or a precursor to suicide (Froeschle & Moyer, 2004). Self-cutting is a ritual performed for other reasons and should not be confused with suicide or intent to destroy the entire body (Levenkron, 1998). A third misconception is that adolescents who self-cut are dangerous and might harm others (Froeschle & Moyer, 2004). Self-cutting is usually secretive and performed in isolation. The violence is not directed toward others. The final misconception is that adolescents who self-cut only want attention (Froeschle & Moyer, 2004). Most adolescents who self-cut do these behaviors in private. Additionally, they are usually embarrassed by their scars and keep them hidden so no one ever knows (Levenkron, 1998). Even though self-cutting may not be performed for the purpose of getting attention, it has been mentioned in the literature that these youth may need more attention if they are taking part in these behaviors (Favazza, 1998).

Theories for the Use of Self-Cutting

There are many hypotheses regarding the motivation for self-cutting (Zila & Kiselica, 2001). Offer and Barglow (1960) proposed that adolescents who self-cut use aggression against themselves to get back at a bad mother. Although not supported, this explanation provided a start for other researchers (Zila & Kiselica, 2001). Two decades later, Ross and McKay (1979) explained that rituals and symbolism from descriptions of self-cutting are filled with religious overtones. Ten years later Favazza and Conterio agreed with this theory, citing that their research showed common references for the need to repent sins by adolescents who self-cut that they studied. Today, many support a theory of tension relief as a partial explanation for self-cutting (Favazza & Conterio,

1989; Ross & Heath, 2003). Favazza and Conterio (1989) and Ross and Heath (2003) noted that self-cutting brings an immediate release of tension that results in a relaxed state.

Ross and Heath (2003) recently developed a model of self-cutting known as the anxiety reduction model. The premise of this model is that individuals experience stress in their lives and, in turn, feelings of tension arise. These feelings of tension build up, and since the individual lacks other coping strategies or problem solving methods to reduce tension, they become anxious. Favazza (1998) found that individuals then resort to self-cutting because it gives them immediate relief. Self-cutting serves an affect regulator function, and the individual can return back to a normal emotional state after it is conducted (Favazza & Conterio, 1989). Based on this model, it is believed that individuals who self-cut may be more likely to manifest higher levels of generalized anxiety and may be more likely to report feelings of anxiety immediately prior to self-cutting.

An extension of the anxiety reduction model is the hostility model (Ross & Heath, 2003). This model rests on the premise that hostility functions in a cathartic way to give emotional relief after a period of stress. It is hypothesized in this model that an individual self-cuts because of an inability to overtly express anger and hostility (Favazza, 1998). The unexpressed feelings of hostility lead to more tension, and the individual self-cuts to bring feelings of relief and direct anger onto an acceptable source, the self (Bennum, 1984). The anger becomes internalized and the self is seen as bad and worthy of punishment. Based on this model, it is expected that individuals who self-cut

would report greater generalized feelings of trait hostility, as well as greater feelings of state hostility right before self-cutting.

Both of these models share the premise that the alleviation of tension is the reason for self-cutting. Ross and Heath (2003) examined whether adolescents who self-cut report greater levels of generalized anxiety and hostility than adolescents who do not self-cut and whether adolescents who self-cut report feelings of anxiety, hostility, or both anxiety and hostility prior to self-cutting. Their sample was comprised of 122 adolescents (78 girls, 44 boys) attending either an urban or suburban high school. The urban high school was made up of ethnically diverse students from lower middle class homes. The suburban high school was made up of mostly Caucasian students from upper middle class homes. The participants ranged in age from 12 to 16 years. Students were categorized as self-cutters or non self-cutters by their responses on an initial screening questionnaire and a semi-structured interview. If they said that they have hurt themselves on purpose, then they were included in this study. Also included in the interview was a series of questions used to examine the feelings and cognitions of the adolescent regarding self-cutting. After the interview, the adolescents were given a series of affective descriptions associated with either hostility or anxiety reduction and were asked to check off the descriptors that best matched the way he or she felt before self-cutting. The Hostility and Direction of Hostility Questionnaire (HDHQ; Caine, Foulds, & Hope, 1967) was used to provide a measure of trait hostility. The Beck Anxiety Inventory (Beck & Steer, 1993a) was used as a measure of trait and state anxiety.

Results indicated support for the hostility model for adolescents who self-cut. Findings from the study indicated that there were higher levels of trait hostility reported

by adolescents who self-cut compared to those who did not self-cut, $F(1,118) = 5.71$, $p<.001$. The results also showed that adolescents who self-cut reported greater levels of both trait and state anxiety compared to their non self-cutting peers, $F(1,118) = 12.26$, $p<.001$. From this study, it seems likely that those who self-cut tend to become more anxious and hostile than their peers when faced with stressful situations (Ross & Heath, 2003). In addition, when provided with a list of reasons as to why they self-cut, over 90% of the sample chose answers that included anxiety and hostility reduction responses. The results of this study show support for the hostility model of self-cutting among non-clinical adolescents and that anxiety and hostility need to be addressed in adolescents who choose to self-cut. One limitation of this study was the list of reasons that the students were given as to why they self-cut. Many of these reasons had a connection to either anxiety or hostility. This may have caused participants to choose an answer that may have been true, but not the answer they may have thought of, regarding why they self-cut. A better way to address this issue might have been to make the reasons for self-cutting behavior an open-ended question and then analyzed the responses for reasons relating to anxiety or hostility.

The anxiety reduction and the hostility models are similar to what Suyemoto (1998) described in her literature review under the name of affect regulation model. She distinguished six different models of self-cutting that fit under one of four larger categories. The categories were environmental, drive, affect regulation, and interpersonal. Under the environmental category, there was the environmental model. Under the drive category, there were the antisuicide and sexual models. Under the affect regulation

category, there were the affect regulation and dissociation models. Finally, under the interpersonal category, there was the boundaries model (Suyemoto, 1998).

The environmental model focuses on behavior and systems theory. It targets the interaction between the self-cutter and her environment (Suyemoto, 1998). The model concentrates on reasons why the behavior may have started and the reasons why it is being maintained. An underlying premise in this model is that the self-cutting serves both the self-cutter and the environmental system. This model posits that self-cutting begins through modeling of abuse within the family system, leading the adolescent who self-cuts to believe that self-cutting is a coping mechanism and to link pain with care. This model also theorizes that self-cutting begins through modeling and learning about the benefits of self-cutting through vicarious reinforcement (Suyemoto, 1998). In the latter idea, self-cutting is reinforced internally through the feelings of relief that the self-cutter feels or through reinforcement through the environment by family, peers, or caregivers. Social learning theory plays a significant role in this model. For the entire environmental system, self-cutting may be a way to preserve homeostasis, expressing or taking away attention from the dysfunctional system (i.e., family, hospital ward, residential home).

The drive category of models is based primarily in psychoanalytic developmental theory (Suyemoto, 1998). These models explain self-cutting in terms of repression of life, death, and sexual drives. The antisuicide model rests on the premise that self-cutting is a compromise between the life and death drives. It is a way to avoid destroying one's body and life and uses the destructive impulses instead through self-cutting (Firestone & Seiden, 1990). This means that the antisuicide model of self-cutting focuses on behavior

as the active coping strategy used to evade suicide and makes a clear distinction between self-cutting and suicide attempts (Suyemoto, 1998).

The sexual model is based on the belief that self-cutting offers sexual gratification or is a punishment for experiencing it. Within this model, self-cutting also can be a way to manipulate sexuality or sexual maturity. This model relies on the fact that there is an absence of self-cutting behavior prior to puberty, that there is a high correlation between sexual abuse and self-cutting, and that there is an increase in the incidence of sexual dysfunction among adolescents who self-cut (Daldin, 1988; Offer & Barglow, 1960). Self-cutting, in this model, is linked positively and negatively to sexuality. It is, for some, a way to obtain sexual gratification, but, for others, it is a way to discipline themselves for experiencing sexual drives (Daldin, 1988).

The affect regulation category of models also has psychodynamic explanations. This category is most related to the anxiety reduction and hostility models researched by Ross and Heath (2003). In this category, the models propose that self-cutting is used to regulate affect. Self-cutting is seen in this category as a way to express emotion and conflict both to the self and others (Suyemoto, 1998). It also enables some individuals to have a sense of control over their emotions. Self-cutting can be used with dissociation, in this category of models, to regulate emotions through distancing. The two models within this category are the affect regulation and the dissociation model. They are both based in ego psychology and concerned with expressing or restraining needs.

In the affect regulation model, self-cutting serves to express and externalize overwhelming emotions that the self-cutter has been keeping inside and also allows the self-cutter to have perceived control over her emotions (Darche, 1990). The affect is

usually related to perceived abandonment before the act of self-cutting is conducted. In this model, self-cutting also can be used to communicate feelings because adolescents who self-cut often have a hard time with verbal or symbolic expression (Rosen et al., 1990). The dissociation model also postulates that self-cutting serves to regulate emotions, but it concentrates on the feelings of dissociation that the self-cutter feels and the way that she uses self-cutting as a defensive strategy for emotional regulation. In this model, self-cutting is a way to end or cope with the effects of dissociation that result from the intensity of emotions (Suyemoto, 1998).

The last category of models that Suyemoto (1998) discussed in her literature review is the interpersonal category. This category includes the boundaries model. The boundaries model of self-cutting focuses on the need to affirm the boundaries of the self (Woods, 1988). This model is based upon object relations and self-psychology developmental theory. Perceived abandonment is seen through this model as creating intense emotions that threaten to take over the self-cutter because she has a lack of boundaries. Due to this lack of boundaries, the self-cutter experiences a loss of another person as a loss of self, which is fixed through self-cutting. Self-cutting serves to create a distinct and separate self, thus creating a boundary (Woods, 1988). This means that self-cutting is a way to separate an adolescent away from another individual. Within this theory, it is believed that adolescents cut themselves literally as a way of cutting the self off from another that they feel can not be done in any other way. The basic premise that this model is based upon is developmental object relations theory, which assumes that adolescents who self-cut were not able to separate from their mothers as children and did not form a secure parental attachment (Walsh & Rosen, 1988).

Woods (1988) hypothesized that perceived abandonment leads to feelings of isolation that result in feeling unreal. Anger at another person becomes shame for the self-cutting adolescent because the dependence on the other person drives them away. The self-cutting adolescent feels the need to regain the other person, so his/her anger becomes rage (Woods, 1988). The rage is directed at the self by the self-cutting adolescent because no other appropriate coping skills are known. Self-cutting behavior is the solution to defending against feelings of needing someone, and the blood or scars caused by the cutting are transitional objects used to negotiate the separation/individuation process (Woods, 1988). Finally, self-cutting may serve to facilitate one's own identity and a firm set of boundaries.

The models discussed so far have been rooted in a combination of behavior and systems theory, psychoanalytic theory, or object relations developmental psychology theory. Additionally, because the reasons many of these models propose for self-cutting behavior are difficult to operationally define and measure, many have not received empirical support (Nock & Prinstein, 2005). Nock and Prinstein (2005) believe that self-cutting behavior may be best described by a variety of functions and not just a single factor such as antisuicide or affect regulation. Yip (2005) shares this view.

Yip (2005) tried to conceptualize a new model based on the six models proposed by Suyemoto (1998). Yip (2005) took a multidimensional perspective to do this. This perspective included sociocultural contexts, peer and parental influences of adolescents' self-cutting, and the antecedents, process, and after effects of adolescents' self-cutting. Regarding the precursors or antecedents to adolescent self-cutting, this model cites six important factors. First, Yip (2005) describes unpleasant experiences and encounters in

childhood and adolescence in the form of abuse, neglect, trauma, and conflicts. Second, Yip (2005) discusses a high level of tension or anxiety from these past events. Third, Yip (2005) explains unpleasant sexual occurrences or impulses that the adolescent may have experienced. Fourth, Yip (2005) cites the lack of coping ability within these adolescents to deal with anger and frustration. Fifth, Yip (2005) hypothesizes that these adolescents may have problems in emotional control or be impulsive or reactive in response to stress. Lastly, Yip (2005) admits that adolescents who self-cut may not have developed a strong self-identity.

Yip (2005) believes that self-cutting may be made worse by inappropriate influences from parents or family. Examples of this include neglect, abuse, and marital discord. On the other hand, supportive familial environments such as good communication, stable family life, and encouragement from parents may decrease self-cutting behavior. Yip (2005) states that inappropriate peer influence works in the same way as inappropriate parental influence. Some examples of this include peer rejection or miscommunication, poor social skills, and problems with dating. However, appropriate peer contact can decrease self-cutting behavior as well. Furthermore, in this multidimensional model of self-cutting, sociocultural contexts also may play a role. Examples include tension and pressure from the school environment, cultural interpretations of body image, and the meaning of beauty and self-cutting.

In Yip's (2005) multidimensional model, there are several stages to self-cutting. First, there are external hardships discussed above. These antecedents may serve to provoke self-cutting. Due to these antecedents, adolescents may gain intolerable levels of anxiety and tension. They may feel empty, lonely, or dissociated and experience the need

to self-cut to stop these feelings. Adolescents may not feel pain in these episodes of mutilation, but the sign of blood may give them back their sense of self-control (Yip, 2005). In this multidimensional model, parental, peer, and other factors may again come into play. The self-cutting process is exacerbated by inappropriate parental and peer influence such as parental or peer rejection.

The after effects of self-cutting are addressed next in this model. There are several components to the aftermath. First, some adolescents may be scared that their behavior will be discovered by others. Peers, parents, and teachers may have a variety of different responses if they find out. When peers, parents, and teachers quickly label an adolescent who cuts as a self-cutter, this may cause the adolescent to mutilate more (Yip, 2005). The adolescent may become a consistent self-cutter to fulfill a self-fulfilling prophecy. She may start conditioning her body to use self-cutting as a method of problem solving. In this multidimensional perspective, parental, peer, and sociocultural influences again come into play. Examples that can increase self-cutting behavior include blaming, outbursts of anger, labeling, and tension and pressure from the demands of education. On the other hand, just as seen earlier in this model, supportive family and friends can counteract the self-cutting and may have a significant impact on its decrease (Yip, 2005). Family members, peers, and teachers can encourage and teach adolescents more adaptive problem solving skills, to participate in meaningful activities, or to engage in creative non-harmful ways to release stress and tension (Yip, 2005).

Similar to Yip's (2005) multidimensional model, Nock and Prinstein (2004, 2005) have recently developed a comprehensive theoretical model to explain the functions of self-cutting. This model posits four primary functions for self-cutting that differ along

two dichotomous dimensions. The two dimensions for the functions of self-cutting are that contingencies are automatic (i.e., within oneself) versus social, and reinforcement is positive (i.e., followed by the presentation of a favorable stimulus) versus negative (followed by the removal of an aversive stimulus) (Nock & Prinstein, 2004). Automatic-negative reinforcement refers to an individual's use of self-cutting to achieve a reduction in tension or other negative affective states. This is similar to the anxiety and hostility models (Ross & Heath, 2003) and the affect regulation model (Suyemoto, 1998). In automatic-positive reinforcement, individuals engage in self-cutting to create a desirable physiological state. This is similar to various other models (Brown, Comtois, & Linehan, 2002; Suyemoto, 1998). Social-negative reinforcement is an individual's use of self-cutting to escape from interpersonal task demands. This model has been supported in women with Borderline Personality Disorder (Brown et al., 2002). Social-positive reinforcement refers to an individual gaining attention from others or gaining access to materials. This was said to be a misconception by Froeschle and Moyer (2004) and has not received much empirical support (Nock & Prinstein, 2004).

Nock and Prinstein (2004) examined the four function model to assess whether there was empirical support for their proposed functions of self-cutting. The main goal of their study was to examine the reasons why adolescents endorsed taking part in self-cutting behavior and to assess if these reasons could be categorized into their four theoretically derived functions of self-cutting (Nock & Prinstein, 2004). Their sample consisted of 108 adolescent participants (76 girls, 32 boys) aged 12 to 17 years. They were recruited from an adolescent psychiatric inpatient unit in New England only if they had consecutive admissions. The sample was 72.2% European American, 11.2% Latin

American, 4.6% African American, and 12.1% mixed ethnicity or other. The socioeconomic status (SES) level of the participants was 3.0% high, 57.6% middle, 24.2% low, and 15.2% poverty. The participants were referred for self-injurious thoughts or behaviors based on their answers on the universal intake evaluation that all adolescents are administered upon arrival to the clinic. The participants included in the study were ones who admitted to a psychiatrist that they had exhibited self-injurious thoughts or behaviors.

The Functional Assessment of Self-Mutilation (FASM; Lloyd, Kelley, & Hope, 1997) was used in this study. This is a self-report measure of the methods, frequency, and functions of self-mutilating behavior. It was initially developed through an extensive review of the literature on self-mutilation within typical and psychiatric populations. Additionally, smaller focus groups containing psychiatric inpatient adolescents were interviewed to enhance the list of methods and functions that were found in the literature.

The participants in the Nock and Prinstein (2004) study specified whether and how often they engaged in 11 different methods of self-mutilation in the past 12 months, but also were given a space to write in other methods not listed. To assess the function of their self-mutilation, each participant indicated how often they engaged in this behavior for each of the 22 reasons, with a space provided for other reasons not listed. The results for all participants in this study were combined in the report because there were no significant age, gender, or ethnic differences found for frequency, methods, or age of onset. Overall, 82.4% of the adolescents examined for this study reportedly engaged in at least one incident of self-cutting in the previous twelve months. The mean number of incidents for those who admitted to at least one incident over the past 12 months was

80.0. The adolescents in this study reported the following methods of self-mutilation: cutting or carving on skin, picking at a wound, hitting self, scraping skin to draw blood, biting self, picking areas of body to the point of drawing blood, inserting objects under skin or nails, tattooing oneself, burning skin, pulling out one's own hair, and eating skin to draw blood. Most adolescents began engaging in self-mutilation during early adolescence, but some did report incidents occurring during childhood. The mean age of onset was 12.8 years.

To assess the functions of self-mutilation within the sample of participants, various data analytic procedures were used. These procedures evaluated the structural validity of the authors' four function model (Nock & Prinstein, 2004). First, each of the 22 reasons was assigned to one of the four functions according to expert consensus (by Matthew K. Nock and Mitchell J. Prinstein). Next, the authors evaluated the structural validity of the model by proposing the reasons given for self-mutilation to a confirmatory factor analysis and evaluated the reliability of the four subscales through additional analyses. The level of statistical power was found to be .79, which approximated the accepted level necessary (.80) to test the hypothesis that the model was a close fit with the data. Additionally, based on chi square difference tests, the four function model provided the best fit.

The results of the study gave support to a functional model of self-cutting (Nock & Prinstein, 2004). The findings of the study suggested that adolescents engage in self-cutting and self-mutilation for a variety of reasons consistent with learning theory. Reasons related to automatic reinforcement were endorsed most frequently. The automatic reinforcement items were endorsed by 24-53% of the sample depending on

which item was assessed. This suggests that the regulation of emotional or physical experiences is the primary reason for engaging in self-cutting behavior (Nock & Prinstein, 2004). The results also provided support for social reinforcement functions of self-cutting. These functions were endorsed by a significant number of adolescents (6-24%), a finding which is in direct contrast to many of the misconceptions of adolescents who self-cut stated by Froeschle and Moyer (2004). These findings suggest that different learning experiences may be involved in the development of self-cutting and that diverse treatment approaches and interventions need to be considered based on the functions that self-cutting has for each adolescent (Nock & Prinstein, 2004).

There were, however, several limitations of this study. First, the study was conducted with a small sample of psychiatric patients, so the results may not generalize to the non-clinical population of adolescents who self-cut. Second, the method relied only on self-report at one point in time. The participants may have answered in socially desirable ways and their reasons for self-cutting may have changed over time. Finally, there is no support for the construct validity of the model used at this time.

Nock and Prinstein (2005) conducted an additional study to extend this functional model in two ways. They wanted to look at the behavioral antecedents that come before the act of self-cutting in addition to the factors that may serve to punish self-cutting. Some antecedents that were hypothesized were hopelessness and previous suicide attempts for the automatic negative function, symptoms of Major Depressive Disorder and Post Traumatic Stress Disorder for the automatic positive function, and, for both, social functions, social concerns such as loneliness, and socially prescribed

perfectionism. The demonstrations of these relations show construct validity for their four function model, which was previously missing (Nock & Prinstein, 2005).

For the second study, the 89 participants (66 girls, 23 boys) ranged from twelve to seventeen years of age. They were psychiatric patients who reported taking part in self-cutting in the past twelve months. The sample was 76.4% European American, 8.9% Latin American, 4.5% African American, and 10.1% mixed ethnicity or other. The SES levels for the participants were divided as follows: 3% high, 57.6% middle, 24.2% low, and 15.2% poverty. The participants' self-cutting over the past twelve months was measured using the FASM, which was described above (Lloyd et al., 1997). Participants also rated on a scale ranging from 0 (never) to 3 (often) how often they had used self-cutting for each of the 22 provided reasons.

Each participant's number of Major Depressive Disorder and Post Traumatic Stress Disorder symptoms was assessed through the Diagnostic Interview Schedule for Children (DISC: Shaffer et al., 1996). The presence of a suicide attempt in the past four weeks was measured through the adolescent's response to the question, "In the past four weeks, have you tried to kill yourself?" (Nock & Prinstein, 2005). Hopelessness was measured using the Hopelessness Scale for Children (Kazdin, Rodgers, & Colbus, 1986). Loneliness was assessed using the Revised UCLA Loneliness Scale (Russell, Peplau, & Cutrona, 1980). Finally, perfectionism was assessed with the Child and Adolescent Perfectionism Scale (Hewitt & Flett, 1991).

Comprehensive interviews were conducted in order to obtain these data. Several analytic strategies were used to analyze this data. First, the contextual features of self-cutting were evaluated by analyzing the descriptive statistics of the participants'

responses on the FASM. Then, the associations among the contextual features and their relation with each of the four functions of self-cutting behavior were examined through correlational analyses. Finally, after controlling for the variance from the demographic variables, the relationship between each of the four functions of self-cutting and the hypothesized antecedents were analyzed through a multiple regression.

Results of this study showed that for the sample used, adolescent self-cutting is typically performed impulsively, without the use of alcohol or drugs, and in the absence of physical pain (Nock & Prinstein, 2005). The implications of these results are important. These results suggest that self-cutting is done impulsively and influenced by internal and external contingencies, most often without long term thought or planning. This may be specific to those adolescents who have already engaged in this act. Additionally, since it occurs in the absence of physical pain, and is done impulsively, it may be difficult to treat or prevent. A large proportion of participants in this sample also reported that their friends engaged in self-cutting. This result is important because it indicates that adolescents who self-cut may receive positive social reinforcement for their behavior.

Most importantly, consistent with Nock and Prinstein's (2005) hypotheses, the functions of self-cutting were differentially related to certain behavioral antecedents. The automatic negative function was associated with hopelessness and a history of suicide attempts (Beta = .22, p <.05 and Beta = .25, p <.01, respectively). Similarly, there was a relationship found between the automatic positive function and symptoms of Major Depressive Disorder and Post Traumatic Stress Disorder (Beta = .36, p <.01 and Beta = .29, p <.01, respectively). Additionally, both social negative and social positive

reinforcement functions were associated with socially prescribed perfectionism (Beta = .23, p <.001 and Beta = .30, p <.01, respectively). This could mean that adolescents who self-mutilate are trying to get help from others (i.e., social positive function) or get rid of the perceived expectations of others (i.e., social negative function). These results support the functional model of self-cutting, but several limitations are noteworthy. The use of only self-report data may have caused socially desirable answers or inaccurate retrospective recall of events. Second, the sample was a clinical population and the results may not generalize to non-clinical samples of adolescents. Finally, these data were from one point in time and may not accurately represent all occurrences of self-cutting (Nock & Prinstein, 2005).

There have been a variety of models and methods discussed in this section. Many of them overlap. However, each one plays an important role in assessing the reasons and functions of a young adolescent's self-cutting behavior. Many of the studies cited used research that was gathered through standardized methods. All have primarily used quantitative methods. Therefore, new studies need to be conducted using qualitative methods. Additionally, semi-structured or open ended questions should be used to allow the participants to explain their reasons and thoughts about self-cutting in their own words and not the words of researchers. In the next section, the method that will be used in this study is described.

Methods Used to Study Self-Cutting

Both quantitative and qualitative methods can be useful in examining the phenomenon of adolescent self-cutting. However, these two methods differ methodologically in important ways. Quantitative methods have traditionally focused on

standardized assessments of depression, anxiety, hopelessness, loneliness, and self-mutilation (Favazza & Conterio, 1989; Nock & Prinstein, 2004, 2005; Ross & Heath, 2003). These studies have advanced knowledge of self-cutting with regard to frequency, prevalence, intensity, and correlational factors. These studies also have provided insight on the reasons adolescents engage in self-cutting, based on specific choices they have made from standardized lists.

Few studies, however, have allowed adolescent girls who engage in self-cut to talk about their experiences with this behavior (Favazza, 1998). Quantitative research does not allow individuals to talk about the meaning, essence, or structure of the experience of self-cutting. Existential-phenomenology has foundations in both the existential philosophy of Sören Kierkegaard and the phenomenology of Edmund Husserl (Valle & Halling, 1989). Kierkegaard believed that philosophy should address the existence of an individual while illuminating the basic problems with which human beings struggle. Husserl's approach was more focused on academics and tried to understand human consciousness and experience by studying things as they appeared in the world, without bias (Valle & Halling, 1989).

Martin Heidegger was one of the first people to combine existentialism with phenomenology. He wanted to understand the meaning of human existence without letting personal bias get in the way (Valle & Halling, 1989). Psychology has traditionally and predominantly used a natural scientific approach that relied on several assumptions about real world phenomena. First, phenomena needed to be observable and measurable. Second, the existence and characteristics of phenomena needed to be agreed upon by more than one person (Valle & Halling, 1989). Nonetheless, with increasing emphasis on

cognition, experience, and affect, the definition of psychology has now expanded to include both experience and behavior (Ornstein, 1985). Ornstein (1985) believed that there was a need for more approaches that studied the meaning of human phenomena. Through existential-phenomenology, researchers seek to comprehend the basic nature and meaning of certain human experiences through interviews, reflection, or thematic verbalization (Valle & Halling, 1989). When interviewees verbalize their feelings and experiences, it is easier to understand, through bias-free examination, their reasons for doing the things that they do (Valle & Halling, 1989).

Existential-phenomenological interviewing begins to address the depth of a phenomenon and not merely correlational relationships regarding a specific variable. The inquiry is more like a conversation than an interview. The researcher and the interviewee are co-researchers on a journey together to learn about the experience of a specific phenomenon (Moustakas, 1994). After the conversation, the researcher attempts to take all relevant themes out of what was described. During this interview, the researcher's own personal biases must be put aside through the process of bracketing (Valle & Halling, 1989). Bracketing is a self-reflective process that allows the researcher to verbalize her own biases about the phenomena to be described so that they are made as clear as possible to the researcher and others. Then the researcher can listen without preconceptions or bias (Valle & Halling, 1989).

In this study, adolescent girls were asked to describe their experiences with self-cutting. Each girl described her experiences in as much detail as she was able to remember. She was encouraged to give details about the thoughts, sensations, feelings, emotions, and perceptions involved in her experience with self-cutting. The co-

researcher was only able to participate in this study if she had engaged in self-cutting. Each co-researcher had to be familiar enough with her experiences to be able to articulate her insight into the phenomena. She also had to have a minimum level of verbal skills necessary for the researcher to understand her words and ideas. Each girl was an expert as well as an informant about her experience. She did not have a time limit on her description of her experience. She was able to explain her experiences to the fullest extent that she saw fit. She was seen as an equal to the researcher in this process of interviewing. It was hoped that the dialogues with these adolescent girls provided previously unknown insight into the experience of self-cutting.

Summary

Self-cutting is becoming an increasingly frequent way for adolescents to cope with a variety of problems (Favazza, 1998). Despite this, little research has been conducted with individuals exhibiting this behavior except through single case studies or large populations (Lena & Bijoor, 1990; Solomon & Farrand, 1996). Self-cutting usually starts in middle adolescence and can continue indefinitely (Favazza, 1998). Self-cutting has been shown to be related to past sexual abuse, eating disorders, and family or marital discord (Dulit et al., 1994; Favazza, 1998; Rosen et al., 1990). This behavior is related to a variety of diagnoses, symptoms, and past experiences (Suyemoto, 1998). Additionally, many of the participants from past research have had diagnosed personality disorders or psychiatric disorders, which means that results from many studies do not necessarily generalize to the general population (Dulit et al., 1994).

Self-cutting may serve a myriad of functions for an adolescent. Due to this, there are many theories that have tried to explain why it occurs (Nock & Prinstein, 2004;

Suyemoto, 1998). To date, there is no common consensus as to why adolescents engage in self-cutting. Since self-cutting is not totally understood and the reasons for its use are contextually complex, it is hard to distinguish one function from another (Suyemoto, 1998). Nevertheless, efforts to elucidate the functions of self-cutting are necessary to enable clinicians and educators to understand this behavior and figure out why adolescents are taking part in it. A better understanding of self-cutting also is important to facilitate the development of treatments for adolescents who are taking part in this behavior. Unfortunately, there is little information known about adolescent girls within the general population who self-cut (Ross & Heath, 2002).

This study examined a population of adolescent girls and their beliefs about why they engage in self-cutting using an existential-phenomenological interview technique. The girls had the opportunity to describe their experiences with the self-cutting phenomenon. The interviews were used to gather data that could be used to enhance clinicians' and educators' understanding of self-cutting experiences. It was believed that in doing so, the essence of a girls' experience with self-cutting was revealed.

Chapter Three

Method

Design

This was a qualitative study that employed an existential-phenomenological interview to collect detailed descriptive information about the experience of self-cutting in adolescent girls. The existential-phenomenological approach was used to examine the reasons, thoughts, and feelings of each adolescent girl's individual experience leading to and engaging in self-cutting to gain a more complete picture of this occurrence (Valle, King, & Halling, 1989). Existential-phenomenological methodology is based on the premise that in order to fully understand the meaning of human experience, one must examine "phenomena as they are experienced by people" (Becker, 1992, p. 33).

Other qualitative methods, such as the case study method, also document human experiences throughout a person's life (Patton, 2002). The existential-phenomenological method was chosen over other qualitative methods because it addresses the depth of a certain phenomenon, not all of the past experiences that have occurred or the current daily events that shape each co-researcher's life. Additionally, observations or focus groups were not necessary to gather the information sought from the proposed research questions.

Past researchers have suggested that the "interview best fits the qualitative paradigm" (Borg & Gall, 1989, p. 397). Borg and Gall (1989) additionally stated that

researchers must be aware and pay close attention to any presumptions or self-biases that may come about during an interview (Becker, 1992). Any assumptions that a researcher may have when interviewing participants must be kept under the surface and not be used to sway a participant's interview or expression of experiences and feelings. This will ensure the collection of unbiased data. Past literature supports the notion that the interview format is the most appropriate data collection method for qualitative research (Becker, 1992; Moustakas, 1994; Polkinghorne, 1989). The interviews that were conducted for this study were "semi-structured" in that the co-researchers each were asked the same questions and then queried by the investigator as needed to encourage them to expand on their answers.

Co-researchers. The term "co-researcher" was chosen in place of participants because the adolescent girls used for this study were considered the experts of their own experiences. They were the ones who have experienced and lived through self-cutting and therefore, knew more about their experiences than the researcher. Additionally, each girl took on the role of a co-researcher by looking at the themes that the researcher developed and working with the researcher to change the themes as she saw fit to better explain what she meant in her interview.

The researcher sought volunteer co-researchers through the use of purposeful sampling, as described by Patton (2002). Patton reports this type of sampling to involve looking for a certain type of participant. The selection of co-researchers for this study followed the guidelines delineated by Moustakas (1994). Moustakas identified five criteria that were crucial for a co-researcher to be able to fully explain her experience with a phenomenon and participate in a research study. She must have (a) experience

with the phenomenon being investigated, (b) an interest in understanding the reasons she took part in this experience, (c) an ability to speak about her experience in a detailed and meaningful way, (d) an agreement to participate in a tape-recorded interview, and (e) an agreement to the possible publication of the researcher's final data. To be selected, co-researchers and their parents/guardians had to acknowledge, agree, and sign assent/consent to these criteria.

Co-researchers were adolescent girls who volunteered for the study, who previously or currently self-cut, and who were between the ages of 15 and 18 years. Diversity among the co-researchers was sought through the sampling procedure. The goal for selection was to find adolescent girls who had experience with self-cutting, and thus served as "experts" on this topic. It was not a requirement for a co-researcher to have been engaged in therapy related to her self-cutting, but it is documented whether or not she has been, in Table 1. It was essential that each co-researcher not only had experienced the phenomenon but also was able and willing to describe that experience. Thus, a "representative sample" of the adolescent population was not sought (Guba & Lincoln, 1994).

Table 1

Demographic Data

Pseudonym	*Age*	*Ethnicity*	*Been in Therapy*
Jasmine	18	Hispanic	no
Shelly	15	Caucasian and Indian	yes
Brielle	17	Haitian and Indian	yes
Stephanie	16	Caucasian and Hispanic	yes
Jackwolynn	16	Hispanic	yes
Gabrielle	16	Hispanic	no

Each girl's ability to articulate her thoughts and feelings in a clear, detailed manner was imperative to this data collection method. During the first contact with the co-researcher, an initial assessment of verbal ability (Appendix A) was asked to determine if the proposed co-researcher was able to speak clearly and detailed about herself and her experiences. If the co-researcher was not able to answer the questions with detail and clarity, then she was told that she does not qualify for the study, resources were handed out, and the interview ended. Since most early adolescents are able to speak abstractly about themselves with an intricate vocabulary (Slavin, 2003), it was hypothesized that most of the co-researchers volunteering for this study would have no difficulty verbalizing their thoughts and feelings. This hypothesis was supported.

Sample size. The saturation point refers to the number of co-researchers needed for a study until the data that they report become repetitive and exhaustive (Seidman, 1998). Once there had been an exhaustion of potential themes contained in each

description of the experience, the researcher hypothesized that the experience of self-cutting was explained as clearly and fully as possible. Existential-phenomenological researchers have not agreed on a set number of co-researchers needed for a study to be saturated and the numbers of co-researchers vary from study to study (Glesne & Peshkin, 1991; Jones, 1984; Polkinghorne, 1989). While some studies cite as few as five co-researchers, others have cited more than 300. For this study, the researcher interviewed six co-researchers. It is believed, based on past research (Kashgarian, 1999; Moyer, 2005; Rao, 2000) that this number of co-researchers would achieve the "saturation" point of the reasons for self-cutting in adolescents. This belief was supported.

Selection. The director of the Girl's Health Initiative from the Ophelia Project in Florida and two school psychologists from local high schools distributed flyers (see Appendix B) describing this research study to adolescent girls, at their respective sites, who appeared to match the desired criteria. The Ophelia Project of Tampa Bay is a widespread effort on behalf of all girls and young women in an urban county in Florida. This organization tries to connect organizations, schools, and individuals to create a lasting positive change in the community. It is important to note that the two local high schools used had a disproportionately high representation of students of color which may have affected the selection of co-researchers.

After receiving the flyer, the proposed co-researchers had the option, after discussing the criteria and study with their parents/ guardians, to call the researcher and volunteer for her study. The researcher explained in great detail all pertinent information related to the study to all potential co-researchers and their parent(s) or guardian(s). This description included explanations of the voluntary nature of the research study, the use of

audio-taping, confidentiality issues, and the approximate time involved (i.e., two separate meetings). They then had the choice to either consent/assent to the study or choose not to participate.

Researcher. The researcher for this study was a 27-year-old Hispanic female enrolled in a doctoral program in School Psychology at the University of South Florida. During her graduate education she successfully completed coursework, practicum experiences, and an internship that required objectivity, rapport-building ability, and interviewing skills with both children and adults. While collecting data she had her Educational Specialist degree and was a Nationally Certified School Psychologist. It is important to note that she also was known by some of the students enrolled at the schools used to obtain the sample of co-researchers, due to her work in the field of school psychology.

The researcher has never engaged in self-cutting, but was witness to it when her adult friend engaged in the behavior three years ago. The researcher did not understand at the time why anyone would want to engage in this behavior, so, after this experience, she has read many books and scholarly articles, watched films depicting this behavior, and took part in several in-services and professional development opportunities to learn more about this topic.

Today she incorporates an understanding of this behavior into her practice within the school system, her professional skill building of teachers and staff at her schools, and her daily life. Additionally, she frequently discusses self-cutting with her staff and people she meets in her practice as a school psychologist. As a result, she has found that many of her female students and students around the county engage in this behavior. Her

goal is to help learn valuable information from this research project and use it to disseminate information to other adolescent girls who take part in self-cutting in response to a variety of problems.

Instrumentation. Two instruments were used for this study. The instrumentation and questioning used were similar to those methods used by Moyer (2004) and Rao (2000) in their dissertations about self-cutting. The first "instrument" was the following questions posed to the co-researchers (See Appendix C).

1. Tell me about the first time you self-cut.
2. What was happening in your life at that time?
3. What made you decide to start self-cutting?
4. Please describe the experience of self-cutting in as much detail as possible.
5. Please describe a recent situation of self-cutting and any thoughts or feelings that you were feeling at the time.
6. Has there ever been a time when you really wanted to cut and you didn't? What stopped you?
7. If you could send a message to other girls who are cutting, what would that message be?

The first five questions relate to the first research question, which was, what is the experience of self-cutting? Interview questions six and seven related to research questions two and three, respectively. To elicit further description from the co-researchers, the investigator used paraphrasing and summarizing in which information was repeated back to the co-researcher to ensure understanding and to invite the co-researcher to elaborate on her answer. Further queries were used to help the girls shift

their focus from historical accounts of the event that are not considered part of the experience itself. These clarifying probes included statements and questions such as: explain what you mean, tell me more, can you expand on that?, what were you thinking/feeling before, during, and after self-cutting?, what led you to self-cut?, what was that like?, are there other words to describe that?, and can you return to describing…? Additionally, techniques such as self-disclosure and silence were used when needed, and each probe or technique that was used was documented at the time of its use. The second instrument was a demographic data sheet (see Appendix D) which was used to collect basic demographic information about the co-researchers.

Procedure

Bracketing interview. Prior to conducting co-researcher interviews, the researcher herself engaged in a reflection of the initial research questions following an existential-phenomenological process called a bracketing interview. This interview is described in Appendix G. The purpose of this bracketing interview was to identify any preconceived notions she had about the topic and to allow her to identify and acknowledge her own ideas (i.e., emotions, thoughts, and feelings) about self-cutting. Further, this helped protect her from imposing her own personal views on her co-researchers' descriptions (Cihonski, 2005; Polkinghorne, 1989; Valle, King, & Halling, 1989). Her interview was conducted and bracketed by a doctoral graduate student, named Emily Cimino, who has also conducted a qualitative study. This doctoral graduate student also was chosen to assist in the thematic analysis of the co-researcher interviews.

Pilot study. To uncover potential procedural difficulties, a pilot study with three co-researchers was completed. Girls involved with the Ophelia Project and girls at two

local high schools who matched the desired criteria were distributed a flyer describing this research study. Interested adolescent girls called this researcher to schedule a time to meet to hear more about the study and decide if she wanted to be a part of it. These interviews went as planned, and they were included in the actual sample selected for participation. The pilot study helped the investigator refine her skills in conducting an existential-phenomenological interview.

Interviews. Two separate meetings (Oakley, 1981; Seidman, 1998) with no set time limits were completed with each co-researcher during this study at a location selected by the co-researcher and her parent(s) or guardian(s). The co-researcher's home or a quiet, private area was recommended.

During the first meeting the researcher introduced herself to the co-researcher and her parent(s) or guardian(s) and explained what the study entailed. At this time, she also obtained the co-researcher's assent and her parent's/guardian's consent to participate in the study (see Appendix E and F, respectively), and conducted an initial interview to determine if the proposed co-researcher was able to speak clearly and in enough detail to be included in the study. Field notes (Appendix G) were maintained throughout the interview process. First, it was documented whether or not the co-researcher has ever been in therapy related to her self-cutting. Next, the meeting place for the interview was recorded and any other notes the researcher deemed necessary during the process. The actual interview was audiotaped, and the consenting parent/guardian was not present during the questioning.

There was a licensed school psychologist on call in case of negative emotional reactions to the questions, and the researcher documented and followed up after the

meeting on any unusual issues that arose during the interview. Additionally, each girl received a brochure including a listing of helpful resources, skilled therapists in the area of self-cutting, and a list of alternative strategies to use rather than self-cutting. Each co-researcher received this brochure and could use the information within it based upon her preference.

The goal of the first meeting was to capture the co-researcher's emotions, thoughts, feelings, and sensations about her experience of self-cutting. The researcher's role during this interview was to listen to the co-researcher's description of her experience, ask for more detail, seek clarifications when needed, and keep the interview centered around the girl's experience, rather than studying the event itself or providing therapeutic intervention. The researcher attempted to create a relaxed, safe, and nonjudgmental atmosphere during interviews so that her co-researchers were comfortable recalling and sharing as much detail as possible about their experiences (Cihonski, 2005). After this first meeting was finished, a time for the second meeting was set up.

Following the first meeting, the audiotape of the interview was transcribed by the researcher. The researcher and her colleague completed a thematic analysis of this transcription. This thematic analysis followed the guidelines set forth by Jones (1984) and is further described in the Data Analysis section to follow.

During the second meeting the researcher documented the time interval that had passed between the first and second interview, and presented each co-researcher with a thematized protocol of her interview to ensure that her experience was accurately and precisely represented. This meeting was not audiotaped, but notes were taken and the consenting parent/guardian was not present at this meeting. Each girl was encouraged to

offer any changes she thought would make the protocol a more accurate representation of her experience. At this second meeting, the girls were given another opportunity to discuss any additional thoughts they would like to add, as well as to supply new information not recalled or reported in the first interview session. Further, this second meeting allowed each co-researcher to ask any additional questions she had (Cihonski, 2005). The final goal of this meeting was to allow the co-researcher to have an opportunity to add any final thoughts on self-cutting or the interview experience itself. The second meeting concluded the data collection process with the researcher restating the level of confidentiality in the study and thanking the co-researcher for her participation (Cihonski, 2005).

Data Analysis

Analysis of the initial interview transcripts was completed following the guidelines set forth by Charles Jones (1984) entitled "Training Manual for Thematizing Interview Protocols Phenomenologically." This systematic method of analysis allows for the development of themes derived from co-researchers' words expressed during interviews. There are multiple steps required to complete thematization and these steps are detailed in the following section.

Thematic analysis. Each audiotaped interview was transcribed by the researcher. Each transcription was first read in its entirety to gain an understanding of the overall meaning contained therein. Second, tentative thematic units, or "units of significant meaning" were marked off (Jones, 1984). These thematic units contained the actual words used by the co-researcher, and using the co-researcher's exact words was of great concern. Specific units were distinguished if there was a change in verbal direction of

context of the speaker's words. Following Pollio's (1984) recommendation, transitional words such as "but" and "and" were left out of the thematizing process since they generally offered little meaning. In the third step, these tentative thematic units were charted on a separate piece of paper. The themes then were sequenced as they were presented in the interview. Fourth, the themes were clustered, which involved organizing tentative units into groups by identifying similar ideas or phrases in each unit of expression. These groups then were numbered and named as specified by Jones (1984) in the thematic analysis process. During the naming process, stringent efforts were made to preserve the verbatim words spoken by the co-researchers.

Once these interview transcriptions were thematized, the investigator examined all of the protocols together to determine if any superordinate or shared themes among all of the co-researchers emerged. Multiple superordinate themes emerged, and this may suggest that it is possible to characterize the essence of a specific experience across all the co-researchers involved in the study (Jones, 1984)(See Appendix H) .

Chapter Four

Results

One of the most puzzling behaviors that young women commit against themselves is self-injury (Miller, 1994). Miller (2004) names this behavior "Women at war with themselves," (p.3). The young women who have volunteered for this study have examined their experience with this very intimate behavior and have graciously agreed to share it with this researcher. Each young woman agreed to participate in this study for her own personal reasons. To protect their confidentiality co-researchers chose pseudonyms for themselves prior to commencement of the interview process. Each girl will be referred to and identified by her chosen name throughout the remainder of this paper. In the words of Jackwolynn, "I wanted to do this study because this is for me, for me and other girls." Brielle explained in her pre-interview that cutting is hard to understand unless someone is engaging in it. Jasmine admitted "I don't want nobody to follow what I did." For these reasons, each young woman allowed herself to be interviewed and willingly elaborated on her experiences.

This chapter presents the thematized results of six existential-phenomenological interviews completed with adolescent girls ages 15-18 years. Each girl reported that she had self-cut one or more times in her life and discussed her individual experience with self-cutting. Additionally, each girl reported what stops her from cutting, what advice she would give other girls who are cutting, and what she currently does instead of cutting.

The descriptions and experiences of the girls will be reported first, followed by the themes extracted during analysis of the interview transcripts, and finally, what advice they have for other girls who cut and alternatives to self-cutting. All themes were named using the words of the co-researchers. All quotes were carefully selected to represent equally the experiences of all co-researchers.

The following data analysis was performed in an attempt to address three main questions: 1) What is the experience of self-cutting? 2) Has there ever been a time when you really wanted to cut and you didn't, and what stopped you? 3) If you could send a message to other girls who are cutting, what would that message be? Sub investigations for the first question included: 1) Tell me about the first time you self cut. 2) What was happening in your life at that time? 3) What made you decide to start cutting? 4) Please describe the experience of self-cutting in as much detail as possible. 5) Describe a recent situation of self-cutting and any thoughts or feelings you were having at that time.

Through a reduction of data, five core superordinate themes emerged for the first main question, two core themes emerged for the second main question, and one core superordinate theme emerged from the third main question. A list of alternative behaviors to cutting also emerged from the third main question. A reduction of data occurred through the following process. First, each transcription was read and reread in its entirety. Second, units of significant meaning were marked off (Jones, 1984). In the third step, these tentative thematic units were charted on a separate piece of paper. The themes then were sequenced as they were presented in the interview. Fourth, the themes were clustered, which involved organizing tentative units into groups by identifying similar ideas or phrases in each unit of expression. Then, these groups were numbered

and named. This process was completed by the researcher and the researcher's colleague, independently of each other, to allow for a measure of reliability. Finally, the named groups were considered for superordinate themes that existed across all of the co-researchers.

Reliability

This researcher enlisted the help of another graduate student to thematize and tally protocols. Both the researcher and the fellow student independently read and thematized the six protocols, allowing a measure of inter-rater reliability. Each rater categorized the data from each question and placed it into theme categories. Then, the themes were compared to determine whether there was consistency across both raters. This measure of reliability (i.e., percent agreement between raters) was obtained and was found to be 87%. This was calculated by taking the number of theme categories in agreement by both raters divided by the number of theme categories in agreement and disagreement between the two raters. The desired level of agreement for this study was 70%, a level of reliability commonly used in quantitative and qualitative research as a whole (Cihonski, 2005; Thompson, 1996). Additionally, triangulation of the data occurred with data from the second meeting. At this time, each co-researcher was asked if her experience was fairly and accurately represented. Using multiple raters contributed to the trustworthiness of the analysis of the obtained data (i.e., triangulation) and a circumvention of potential researcher biases.

Credibility

In qualitative research, researchers want findings to be trustworthy and defensible (Tashakkori & Teddlie, 1998, 2003). This is also called research credibility. Researcher

bias is a threat to credibility. This was addressed through bracketing. Researcher bias occurs when a researcher only notices the results that are consistent with what he or she wants or expects to find. The researcher must be very careful to avoid this. One strategy is called bracketing, which refers to self-reflection by the researcher on his or her biases and predispositions and assumptions. The point of bracketing is to discover and attempt to minimize the influence of personal biases. Trustworthiness refers to the factual accuracy of the account as reported by the researcher. Each co-researcher reported that she was telling the truth, and her trustworthiness was assumed. Confirmability means that the qualitative researcher accurately portrays the meanings given by the participants to what is being studied. In this study, the researcher asked and involved the co-researchers to address this issue. Theoretical credibility refers to the degree to which a theoretical explanation developed to explain the data actually fits the data. Past research and theories are discussed and compared to this study's data in Chapter Five to address this type of credibility.

General Descriptions of Experience of Self-Cutting

Jasmine. Jasmine is an eighteen-year-old young woman, describing her ethnicity as Hispanic. Jasmine chose her school as a neutral place for the two meeting sessions to be held. Jasmine reported that she lives with her mother, sister, and stepfather. She noted that her relationship with her mother was "…good," with her sister was "…close," and with her stepfather was "…like a brother." She stated that she has many friends and several hobbies. She talked about her interests in sports, writing poetry, and drawing. She admitted to liking school because it was fun. Additionally, Jasmine stated that she liked all subjects at school except math and science. When Jasmine was asked what wish

she would wish for, if she could wish for anything at all, she simply said, “Nothing, life is what it is, and everything happens for a reason.”

Jasmine was very forthcoming with information regarding her self-cutting behavior. Jasmine was the only co-researcher who mentioned that she had thought about including a written document with her interview to make sure that this researcher had a copy of everything that she wanted to say. Prior to the interviews, she admitted to cutting herself on and off for the last five years. She also admitted that sometimes when she was skateboarding, and if she got mad, she “…would fall on purpose,” just to hurt herself. She reported, “You get used to the pain.” She stated that she started cutting because she “…got very upset...” At that time in her life, a female friend of hers started to have feelings for her. Her female friend’s parents found out about these feelings through a note that Jasmine and their daughter had written and blamed Jasmine. Jasmine explained it like this:

> So, it was very frustrating and I was just mad and I don’t know. I didn’t know how to react on anything cause it was like the first time, and her parents told me I couldn’t see her.…I was just angry at them and then they talked to me and made me feel unworthy of anything. I didn’t like that feeling.

Jasmine reported that she started to intentionally cut herself shortly after this event with her friend’s parents and after her initial thoughts that she might be a lesbian. She expressed that she was confused about the whole situation because it was before she was “…like gay or whatever.” After this initial incident of cutting, Jasmine admitted:

> Then every time I was mad, I would just sit there and be like, I wouldn’t scream, I would just cut myself because like I guess like the pain was just, it didn’t

hurt…I guess when you are just so angry, you think about the anger, you don't think about the blood...

Jasmine stated that stress and anger made her decide to start cutting. She recounted that she cut herself because, "I just thought it was something different." Jasmine described the feeling she experienced after cutting as "…it's kinda like a rush that you get in your head….It's like winning a basketball game." She also talked about the act of cutting as an addiction and the feeling she got, "…like a drug." Jasmine would sometimes use cutting as a replacement for talking. She reported that sometimes someone would make her very mad. Instead of talking to him/her about it, she would cut a message into her arm, and then put her arm on a piece of paper and give it to him/her.

She also reported to scrape the blood off as she was cutting and put it into a little jar. She admitted that she thought this was "…nasty…" and "…really disgusting." She would occasionally empty this jar when it got too full. She admitted to using and hiding the jar because she did not want people to find out that she was cutting. She believed that the bloody tissues would be more noticeable than the cuts on her arm. Jasmine reported that her most recent self-cutting occurred about a year ago. She stated that she had cut her girlfriend's initials into her wrist. She admitted that this behavior was conducted to remember who she loved. She showed this researcher initials on her wrist, which were scarred letters. She reported "I know every scar I have on my body and what it is from."

When Jasmine was asked if there had ever been a time when she really wanted to cut and didn't, she replied, "Yes, many times." When she was asked what stopped her, she said:

> The thought of people's faces, expressions, and even though I don't care what people think, and mostly my parents. I wouldn't want to be a bad example for other people, especially like my little sister. She's twelve. She looks up to me…

Jasmine's message to other girls would be "Don't be stupid, do other things. There are other things to do." Jasmine reported that she boxes, wrestles, takes a walk, goes outside, calls a friend, or does something to get moving. She also reported that writing what she feels like doing to herself with a razor, in a poem, helps her the most. Recently, these things have enabled her to get through her initial urge to cut. She reported that staying "…cooped up in the house…" is the worst thing someone can do to get over the urge to cut.

Jasmine's experience with self-cutting seems to have changed over the last five years. At first she described it as a way to relieve her stress and anger. Over the last year or two, she admitted that it was more for recreational purposes. Specifically, Jasmine stated that she was happy the last couple of times she has self-cut, and that she did it to remember things in her life, not to relieve stress or anger. Additionally, Jasmine reported that she no longer displays this behavior. Her poetry writing and her involvement in sports and outdoor activities have helped her to decrease this behavior.

Shelly. Shelly was a fifteen-year-old young woman who described her ethnicity as Caucasian and Indian. Her interview took place in an office at her school per her guardian's request. This is where Shelly and her guardian decided Shelly would be the most comfortable speaking about this topic. Shelly reported that she was living in a group home with a total of seven girls and two adults. Shelly's mother's rights had been terminated a year ago and Shelly had been moved from home to home since that time.

One of the other girls living in this home is Shelly's identical twin sister. All of the girls at this home are foster children. Shelly reported getting along well with the two adults in the home and with her sister. When asked how she got along with the other girls, Shelly responded, "It depends on my mood." Shelly was not as forthcoming with the details of her experiences with self-cutting as Jasmine. She was very succinct with her answers regarding her self-cutting behavior and did not give a lot of description. This was surprising because before the subject of cutting was approached, she spoke very quickly and seemed to enjoy talking as evidenced by her happy facial expressions and engaging body language.

Shelly was a repeated victim of sexual abuse by her biological mother's previous boyfriend. Her mother was aware of the abuse at the time of its occurrence and did nothing to terminate it. Shelly has lived in three different homes over the past year and has attended three different high schools. When asked if she had any friends in her neighborhood, Shelly reported that she was not allowed to go outside of the house. This may be due to the fact that she had recently run away. Shelly talked of her interests in writing poetry and mentioned that she does this sometimes "…instead of cut." When asked about school, Shelly reported that she likes school because "It gets me out of the house, and I hate Fridays because I have to go home all weekend." She reported that mathematics and English were her favorite subjects but admitted that mathematics was her least favorite too "…because it is hard when I don't get it." When Shelly was asked what three wishes she would wish for if she could wish for anything in the world, she replied, "No racism, that everybody could be equal no matter what your sexual

orientation or color, and for me and my sister to be back with my mom and everything to be fine."

Currently, Shelly is in therapy for cutting and a variety of other difficulties. She stated that she started cutting "Because I was mad at my mom." Shelly remembered that she was fourteen, in her living room, and watching television. She said, "I used a razor." She reported that she was upset at her mother for a variety of reasons, but the day she started self-cutting, she had just gotten into a big argument about going outside to play with her friends. Her mom was at work and did not let her go outside. She reported, "I was bored and it gave me something to do." When asked about the experience of self-cutting, Shelly noted:

> It wasn't much of an experience because I didn't feel anything really, I was just like, my mind was blank, and when I was cutting myself I didn't feel it either, and wherever I was cutting was really numb and I didn't feel it, which surprised me because I have this really low pain tolerance, but I didn't feel anything.

Shelly reported that she repeatedly cut herself for about two hours. When asked about her most recent experience with self-cutting Shelly commented:

> I was just sitting in class and I was just thinking that I wanted to be back with my mom, but then I got mad at her at the same time, and I didn't want to go back with her. I was just sitting in class, and I wasn't even listening to the words that the teacher was saying. I took out the eraser from the back of the pencil, and I squeezed the metal together. I used that. So, I was really mad at my mom, but I wanted to go back with her too.

When Shelly was asked if there was ever a time when she wanted to cut and didn't, she replied, "No." On the other hand, she did admit that the consequences in her home and the occasional loss of friends from self-cutting often deter her from that behavior. She reported that she loses all independence at her group home when the staff finds out that she has cut herself. She described that she has to be on constant supervision wherever she goes, "…even in the bathroom and shower." She reported her consequence in her home if she gets caught again to be "…to have to go to a Catholic School or get kicked out of the house." The loss of friends has been particularly hard for Shelly due to the fact that she is very transient in her living situation and has a very hard time making friends. She admitted, "Nobody wants to hang out with someone who does something stupid like that."

When Shelly was asked what message she would send to other girls about cutting she replied while looking down at her arms:

> Don't do it, because you could end up scarring yourself for life. The consequences could be really bad, you could end up killing yourself or lose a lot of blood and it could make you very sick. It's not cool.

Shelly remembered a time when she cut herself so bad that she had to go to the hospital, and her arm was infected. She mentioned that, "Sometimes when I don't cut, I write poetry. The poetry is about death and anger and sometimes I write in my journal." Shelly admitted that she wanted to stop cutting and reported that she had tried a couple of times to stop. She stated, "Sometimes I look at my arms after I cut and think, I've done something really stupid because the scars are bad because I cut myself really deep..." She reported to only think of this after she has finished cutting, not during the act. Shelly

ended the interview repeating statements regarding the detrimental effect that cutting can have on friendships:

> Friends might get scared that you could hurt them too, cause people think that if you can hurt yourself then you can hurt them too. I lost a lot of my friends. No one wants to hang out with you anymore [if you self-cut].

Brielle. Brielle is a seventeen-year-old young woman who described her ethnicity as mixed. Her mother is Haitian and her father is Indian. Brielle lives with her mother, father, and two brothers. She reported that she does not get along with anyone except her oldest brother, who she noted was never home when she needed him. She reported that she has many friends in her neighborhood and at school. She talked of her interests in softball, swimming, football, and basketball. Although Brielle reported having many friends, she stated that she did not like school because of the students. She said, "It is not nice the way kids treat me." She reported her favorite subject to be mathematics and her least favorite to be reading. She stated this was because she "…can't read." When asked what three wishes she would want if she could wish for anything, Brielle responded, "To get accepted into a college for softball, to be pretty, and to help people with what they are going through and make it stop." All of the meeting sessions were completed at Brielle's school because that was the most convenient place for her and her parents.

At the time of the interviews, Brielle had recently reported sexual abuse allegations against her paternal uncle and was recently Baker Acted. The abuse allegedly had been occurring sporadically over the last five years. She was currently engaged in therapy for the abuse and for the self-cutting behavior. Additionally, Brielle was involved

in the prosecution and court proceedings related to the allegations about her uncle. Although Brielle's parents reported to support their daughter during this time, they believed that the stress within their extended family was causing more intense conflict then usual between everyone within their household.

When asked about how she started self-cutting, Brielle reported that she was in sixth grade at the time and was being hurt by a family member. She remembered talking to one of her friends at school about being stressed out, and her friend mentioned, "Cutting sometimes helps with stress." Brielle reported, "I just wanted to do something about it. I went home that night and tried it [cutting her arm with scissors] and it felt actually very relieving." Brielle admitted that she tried cutting because, "I wanted to try something different to see if it would relieve the pain and stress that I was feeling." She reported to have stress about school and was upset that "…nobody picked up what was going at home." She explained that the pain inside of her was the way her uncle made her feel when he abused her.

Brielle admitted that nothing ever worked besides cutting. Brielle used cutting not only as a coping mechanism but also as a way to hurt herself since she believed, "My parents want to see me hurt." She described the most recent episode of cutting like this:

> I was going through an emotional breakdown and when I actually did it, I felt better, cause my parents want to see me hurt, so I figured if I hurt myself without them doing it to me it would be better.

Brielle believed that her parents wanted to see her hurt because they wanted her to be perfect and she did not feel like she was living up to their expectations. She stated that she deserved to hurt herself "…because I screw up all the time and I am not good at

anything, and that makes me not good enough for anything, and I have to do it for all the times I mess up." When asked about the experience of self-cutting Brielle explained:

> It relieves every emotion that you feel inside. Just seeing the scars after, and knowing that you did something to yourself, I like that. I don't feel anything on the outside, I remember everything, but I don't feel anything.

Brielle admitted that she usually uses scissors to cut herself and her cutting usually takes place in her bedroom. Sometimes she asks herself why she did it, but other times she says, "Well, I'm glad I did it, because I deserve it."

When Brielle was asked if there was ever a time when she wanted to cut and didn't, she exclaimed, "Yeah, all the time!" When asked what stops her, she replied, "The fact that…that I can get in trouble for it stops me. I might get Baker Acted again." When asked what message she would send to other girls who are cutting, she responded, "It does relieve a lot of stress, but at the same time, you're better off not harming your own body. There are other ways to relieve how you feel inside." When asked to expand on what other things girls can do instead of cut themselves, Brielle stated that hanging out with friends, staying home and watching a movie, and writing all help to relieve her impulse to cut.

Stephanie. Stephanie is a sixteen-year-old female who described her ethnicity as Hispanic and Caucasian. Similar to the other girls, Stephanie and her parents agreed that meeting at Stephanie's school was the most convenient place to meet. Stephanie lives with her mother, stepfather, brother, and sister. She reported that she was in the process of moving into her biological father's house the next week but admitted that she had not mentioned this to her mother as of yet. Currently, Stephanie's biological father is allowed

visitation with her but it has to be supervised. Stephanie's parents were divorced when she was younger because her dad physically abused her and her older sister. Stephanie does not remember this very well but has been told the details by her mother. Stephanie reported that her dad also was drinking and doing drugs at that time.

Stephanie stated, "I don't get along with my mom or step-dad." She noted that she used to get along well with her stepfather until he and her mother started having problems. Stephanie reported that her mother blamed her marital problems on Stephanie and asked Stephanie to not talk to her stepfather anymore. Additionally, Stephanie stated, "I don't get along with my sister or my younger brother either. I don't get along with anyone at my house." Stephanie perceived her mother and her sister's relationship as "…much closer…" than her mother's relationship with her. Stephanie believed that this is why she and her sister do not get along. Stephanie discussed how she felt like she was always in her sister's shadow. Stephanie mentioned that she had three best friends, but noted that she had limited contact with them. She also stated:

> One's a guy and two are girls. One I don't really talk to as much because she's fourteen. The guy I talk to first because he's been close to where I've been. The other girl has a perfect life and I feel she doesn't understand.

Stephanie spoke of her interests in cheerleading and ROTC. She stated that she loved school, homework, and projects. She reported her favorite subject to be English and her least favorite to be mathematics because, "I suck at it." When asked what three wishes she would ask for if she could wish for anything, she replied, "For world peace, for people to love you for who you are not who they want you to be, and to stop violence,

all violence." Stephanie reported that she had been in therapy for cutting in the past, but had "…graduated from the program."

Stephanie began cutting when she was in eighth grade, claiming to have done it for the first time to try to end her life. "I really just wanted to die at first, but it grew into cutting because it felt good." Stephanie reported that during this time, "I was having problems with my mom and friends at school, and people were just saying mean things like I'm a slut and I'm a bad person and everyone hates me." She mentioned that earlier that year her dad had left and that it was still bothering her during the time she started self-cutting. This is what she remembered thinking:

> Because he's my parent and walks away and I'm told it's my fault and it's all because of everything that is going on…and they decided we should have no contact with him at all whatsoever, so I was like screw it all…

Stephanie recalled that she and her mom "…weren't good." Additionally, she stated she was having problems with her eating habits at that time. She reported not to be eating during this time and also to be bulimic. "I just wanted everything to be fine, and it wasn't so I freaked out, like I'm done with everything." Stephanie remembered her first cutting experience as the "…easiest way out, but it just turned into not just because it was like to die anymore, it was more to get over everything." Stephanie had a very easy time articulating how she felt when cutting herself and her reasons for doing it. She described her experience with cutting in this way:

> Before, it was like, I don't know how to explain it, I was like stressed and pressure, and it's just like you're freaking out, and it's the only thing you can turn to cause, there's nobody to talk to, and you cut and it just relieves everything and

> you just feel so much better that you have control over something, when everything else is whacked out.

She went on to explain how she felt after she finished the act of cutting:

> You feel better for a second and then you get scared and then you're like really scared because you don't know what's going to happen because you might die from the cut. When the blood is pouring out of your arm, it's kinda like scary, but you have control over it, you can stop it.

Her room was the place where Stephanie usually did her cutting, and her tool of choice was a razor. "It was the first thing that popped in my mind…so I went to the garage and looked in the tools in the garage and it was just there." Stephanie claimed that the feeling of cutting to her was "…kind of like a feeling you get off a drug, it just makes you feel better, it releases everything."

Stephanie reported to cut more often whenever she and her mother "…were having a lot of problems." She tried to hide the cuts from her mother when she self-cut because when her mother would see them, the fights would get worse. Stephanie described it like this:

> She doesn't sympathize and she's like, I can't believe you would do that, you're so stupid….and she would get really mad and she would yell at me for it and there were times when she handed me a knife and said do it now and kill yourself, at least you're doing it in front of me, or I'll do it for you.

Stephanie believed that her mother was the reason she continued to cut. She started crying at this point in the interview and explained:

> That's cool, hand me a knife and tell me to kill myself when that's the problem….It's hard when the person that's supposed to love you the most is walking out, and it's the only one you have left. She's supposed to always be there for you and she's not. She's actually promoting it.

Stephanie believed that her mother tried to help her, but always "…helped wrong." She felt that her mother had gone through similar things in her own life but that they had not been as bad. She described how her mother, when she was younger, had laid in the middle of the road in order to get hit by a car. Stephanie reported that her mother brings this story up to try to let Stephanie know that she understands some of the things Stephanie is going through. Stephanie contrasted her mother's experience to hers by responding to her mother, "Yeah, but then you got up before it hit you."

When Stephanie was asked if there was ever a time when she wanted to cut and didn't, she replied, "There have and there have been many times when I have acted upon it, but it's not as bad as it used to be." When Stephanie was asked what stopped her, she responded that therapy had helped her to think of other things to do instead of self-cut. Additionally, not wanting to be Baker Acted or go back to the Crisis Center again and thinking about people who care have helped her not to cut. Stephanie reported that she has realized that there are people who care, "…and if I killed myself whether it's purposefully or on accident because it went a little too deep…I'm leaving a lot of people behind, and that's not fair." When Stephanie was asked what message she would send to other girls who are cutting, she responded, "…not to do it because there are people who care." She added:

If you're afraid that your parents are gonna get mad, tell them anyways, tell someone that is going to listen, there's counselors at your school, there's your friends who care…

Stephanie discussed the alternatives to cutting that she currently uses. She has learned to cry, and this has helped her tremendously. She also has learned that taking a shower or a bath, walking her dog, going for a run, or listening to her music really loud helps. She stated that sometimes, "Parents can get mad [at the music] but you just really need to get it out."

Jackwolynn. Jackwolynn is a sixteen-year-old female who described her ethnicity as Cuban and Puerto Rican. She writes poetry and was very articulate about her experiences with cutting. She admitted to recently running away for three weeks and admitted to using cocaine since she was eleven years old. The meeting sessions took place in the dining room of her home. This is the place where she and her mother agreed would be the most convenient and private place.

Jackwolynn was currently living with her mother, stepfather, and sister. Her biological father had passed away several years ago. She stated that she and her mother got along "…very well…" she and her sister were "…best friends…" and she and her stepfather were "…enemies." She reported that there was much tension in the home due to the strife between her and her stepfather. She cited him as the reason she chose to run away. She explained, "I ran away because I couldn't take it anymore. I can't stand my stepdad." Jackwolynn noted that she has many friends but that most of them had graduated from high school already. She spoke of her interests in hanging out with friends and in writing poetry. When asked about school, she responded that she liked

school in general but she hated the school she attended. Her plan for next year is to attend a career center to finish out her high school credits.

She reported health science to be her favorite subject and mathematics to be her least favorite because she does not do well in it. She discussed her interest in becoming a registered nurse and seemed very excited about this career option as evidenced by the tone of her voice and the expression on her face. When asked what three wishes she would want if she could wish for anything, Jackwolynn replied, "For my father to be reborn in my life, to leave my house on good terms, and for my mother to divorce my stepfather." Jackwolynn reported that she has been engaged in therapy for one year to address her cutting and her drug use. She admitted that she did not like it and did not believe it helped. Jackwolynn either self-cut in her room or in the bathroom, and always used a razor.

Jackwolynn remembered the exact day that she began to cut. "The very first time I was eleven and it was November 2." She remembered this day because it was a couple days after "…something really bad happened…" to her, and she was going to be twelve on November 28. This is how she described her first experience with cutting:

> Throughout my whole life I had gone through a lot and I chose to bottle it up inside. I always analyzed myself as a bottle rocket, and I hold it in until it explodes, and writing didn't help me anymore, talking didn't help me anymore…so I just got the razor blade…

After she initially talked about how cutting felt to her, she elaborated on the "…really bad…" event. Jackwolynn reported that she was raped a couple days before her first cutting experience by a sixteen-year-old boy. She admitted that two days later,

the day she first self-cut, she discovered that he had taken his own life. She stated that after she found out that he was dead, she just grabbed the razor and cut herself. Similar to the other girls, cutting was very memorable for Jackwolynn.

> One slash and it was like euphoria was like there and that one slash was like one story that I hadn't told someone. So when the blood went down, it was like being released down my flesh. The story was released. Each cut is like a story to tell, but the story is kept a secret with a simple smile put on my face.

Jackwolynn remembered every detail of the moment in which she decided to start cutting. She recalled sitting next to her razor blade, doing a couple of lines of cocaine, and then putting it up to her skin. Then she described:

> I just went really deep, one slash, and the pain wasn't there. I did not feel the pain. It was like the cuts didn't hurt, but my pain, my mental pain, that pain was released.

Additionally, she mentioned that she did not feel the actual physical pain until later.

While describing her experience that she had with self-cutting, she went into her room and brought back a journal. It was a book of poems that she had written since she was eleven. She wrote the following poem to describe her personal experience of self-cutting:

> You're my deepest desire
> Every night to pick you up
> And put you to my flesh
> Slash once and slash twice
> I feel as though I'm immortal

An immortal with no concerns and no frights

No tears and no sleepless nights

Jackwolynn described cutting as "…the easy way out" of doing things. She explained what she meant by saying that committing suicide can end one's life very quickly, but cutting is like "…letting the pain come out little by little." She described her cuts as "A cry out for help…marks for life, each with a story to tell." She repeatedly referred to cutting as a replacement for talking or a way to tell her stories. She believed that most people and counselors would say she was a:

> …self-mutilator or something like that, but they never knew that this cut means a story and this one means something else, and this one means a different one. This group meant this big story, and this group meant this big story.

Jackwolynn believed that each girl had her own reason for cutting, and that it served different purposes for everyone. She thought:

> Some girls do it cause they're hurting inside, but others do it because their friends are doing it… and then some people do it because it is their only way out and then some people… just like the way it feels.

Jackwolynn was able to recall a recent experience, approximately one month prior to the interview, during which she cut herself. Jackwolynn and her stepfather had been involved in an altercation. Additionally, she had just found out that her ex-boyfriend, who is currently in jail, had been cheating on her.

> My mind was so low because of the drugs…and I couldn't take it anymore, so I grabbed it…my mom was getting ready for work, my stepfather was getting ready

for work, my sister was getting ready for school, and I should have been getting ready for school, but instead, I was in my room crying…and cutting myself.

She admitted to trying to hide her cuts, but she mentioned that her mother always noticed. She believed, “My mom always notices, she knows every time I cut…not because I tell her, but because she sees it in my eyes.” Jackwolynn reported that sometimes her mom would walk by the bathroom while she was in there cutting, would knock, and would say, “Please stop.”

Her mom discovered that Jackwolynn was cutting herself one morning when Jackwolynn was unable to get out of bed. Jackwolynn recalled that the night before she had run out of space on her arms to cut, so she had used her legs. The cuts covered the tops of her thighs, and Jackwolynn had to be taken to the hospital for stitches because of their intensity. When asked if there was ever a time when she wanted to cut and didn’t Jackwolynn replied, “Um, yeah.” When asked what stopped her, Jackwolynn looked down and stated, “Flashbacks of my mom crying when she found out.” Jackwolynn also reported that one time when she was about to self-cut, she laid in her bed, “…blacked out…” and felt like she was somewhere else. After that, she described seeing her deceased father and him saying, “I’m with you and I’m holding your hand, and if you cut yourself, it’s like I’m cutting you. Do you want me cutting you?” She recalled waking up the next morning with the razor on her bedside table and no fresh cuts on her body. She explained that since then, she has not cut herself at the same frequency. Finally, she reported that thinking about cutting and the people that cutting will hurt can help someone to not want to engage in self-cutting behavior.

Finally Jackwolynn was asked what message she would give to other girls who are cutting, and she replied:

> There's no message you could really send to another girl, cause everyone has their own reasons for doing it, but if I were to say something, it would have to be …there's other ways of getting out, there's only up…cutting is the bottom. You can't go lower because…you're not gonna exist anymore.

She expanded on this by saying, "You may be releasing your pain, but in the long run you are only putting yourself deeper. She proposed several alternatives to self-cutting including picking up the phone and calling a friend and walking with friends.

Gabrielle. Gabrielle is a sixteen-year-old female who described her ethnicity as Puerto Rican/Hispanic. She is in high school and preferred that the meeting sessions be conducted at her school. This also was the most convenient place for her mother. Gabrielle reported that she lived with her mother, stepfather, two sisters, and brother. She described her biological father as "…my mom's sperm donor." She reported that she talked to him occasionally but admitted that he "…was thirty-three, had no driver's license, and was in and out of jail." She was the eldest of the four children living in the house. She reported her relationship with her mother as "…not good," with her stepfather as "…sometimes okay because he acts like a kid," with her sisters as "…okay," and with her brother as "…the best because he doesn't talk." She reported her best friend to be her nineteen-year-old boyfriend and talked of her interests in writing and going to the gym. She admitted that school was not her favorite thing to do but she "…would rather go then stay home." Her favorite subject was reported to be English, while her least favorite subject was stated to be mathematics because it was hard.

When asked what three wishes she would wish for if she could wish for anything, Gabrielle responded, “For my dad to get on his feet, for my mom and me to have a better relationship, and to do good for myself and be more independent.” Gabrielle had never been involved in any type of therapy but was open to the possibility if it in the future. Gabrielle had self-cut three times and “…the little scissors” that were included in manicure sets were her tool of choice. Additionally, she always cut while in her bedroom.

Gabrielle recalled that the first time she cut herself was earlier in the school year, when she was sixteen. She reported being under a lot of stress due to a “…big argument…” with her mother and at the same time, a separate argument with her biological father. Gabrielle reported that her relationship with her mother was her main reason for cutting herself. She reported to be “…very mad and crying a lot” right before the first time she engaged in self-cutting behavior. She remembered that her mother was mad at her for not waking up for school on time. She recited her mother’s words “You’re so irresponsible…I don’t know why you can’t do anything right…what’s wrong with you?”

Gabrielle remembered throwing a shoe against her closet and saying, “I hate her, I hate her” about her mother. She described the experience like this:

> I was crying a lot…and was like why me, I’m not a bad kid, I don’t want to be here, but then I thought about my family and how we are religious, and at the same time I was thinking, I’m not stupid. I’m not gonna try to kill myself…cause I’m scared of what could happen after I kill myself…I grabbed the scissors and I kept making scratches.

Then she described what started happening to her arms by saying that at first it was white and then each mark became darker and turned into red. Gabrielle recalled that it hurt the first time, but after she continued to cut it went "…numb." She remembered her thoughts during this time. "I just kept thinking about my mom." She also remembered thinking it was "…no big deal because it was not bleeding that much, but then it was bleeding and then it was really swollen."

Gabrielle repeated throughout her interview that since her mother thought she was "…so bad already," why doesn't she do something worse? She perceived that her mother thought that she deserved the cutting and, in turn, Gabrielle started believing that too. At that time, Gabrielle felt that cutting was the only thing that helped her get over being mad at her mother. Gabrielle recalled the most recent time that she self-cut and remembered that it was about one month ago. She stated that it was because she was upset at her mother for not letting her go to her boyfriend's graduation from the Army.

When Gabrielle was asked if there was ever a time when she wanted to cut and didn't, she replied, "Yeah." When she was asked what stopped her, she admitted, "My boyfriend stopped me." Gabrielle mentioned that her boyfriend was very upset when she told him that she had cut herself. He became very worried and made her promise not to do it again. Gabrielle reported that the thought of her boyfriend caring and the fact that she does not like breaking promises stopped her. When Gabrielle was asked what message she would have for other girls who are cutting, she responded, "Cutting only makes things worse." She also warned that if a girl self-cuts and is Baker Acted, it could be on her record and could affect her future. Gabrielle realized, "Even though I thought it would make my life better, it wouldn't." In conclusion, Gabrielle shared what she

currently does instead of cutting, now that she has stopped that behavior. She mentioned that she goes to the gym. In Gabrielle's eyes, going to the gym "…made me kill two birds with one stone. I went to relieve stress, but I ended up getting in better shape too."

Common Themes Across the Co-Researchers

The co-researchers ranged in age from 15-18. Five of the six had an age of onset in early adolescence (i.e., 11-14). Of the six co-researchers, four had previously been involved of some type of therapy. Additionally, five out of the six came from divorced families in which they were living with one or no biological parent, and five out of the six perceived that they were experiencing significant family/home dysfunction. Finally, four out of the six had either been sexually or physically abused. The following section contains five themes derived from the interviews with the co-researchers. After these young women shared the very personal and intimate details about their self-cutting experiences, these recurrent themes emerged. Although each co-researcher in this study had a myriad of differences in personality and life experiences, each described the experiences of self-cutting using similar terminology. Each young woman used cutting to help "relieve" something on her own and "feel better."

Research question one was developed to examine the full experience of self-cutting in adolescent girls. The following superordinate themes were obtained from the five sub-investigations of the first research question.

Table 2

Superordinate Themes for Question 1

Themes
A Lot of Feelings
A Big Event
A Release
Nothing Ever Worked
Numb, No Pain

A Lot of Feelings

The superordinate theme, "A Lot of Feelings" was reported by every co-researcher as occurring during the period before self-cutting. The self-cutting experience involved a range of deep emotional reactions for every young woman interviewed. The predominant emotional feelings reported were upset, mad, angry, stressed, and crying a lot. Co-researcher Jasmine said, "I was very upset...I was just mad…I was just angry at them…then every time I was mad, I would just sit there…and I wouldn't scream, I would just cut myself." Jasmine also explained it like this, "I guess you are just so angry, you think about the anger, you don't think about the blood." Shelly reflected when recalling a time that she started to self-cut in class, "I was really mad at my mom, but I wanted to go back with her too." Recounting a time prior to self-cutting, Brielle put it this way, "They started making fun of me…and they stressed me out!"

Stephanie, remembering how she felt immediately before self-cutting, said, "I was…stressed out with everything…and it's like you're freaking out." Jackwolynn said,

"I was upset with myself…I couldn't take it anymore...I was in my room just crying, and crying, and crying, and cutting myself" Gabrielle recalled the first time she self- cut remembered feeling like this, "I just kept crying…I was just pissed at my mom…I was so upset." Every young woman interviewed reported a wide range of negative emotional feelings prior to self-cutting.

A Big Event

Next, every co-researcher in the study engaged in self-cutting after remembering a significant "Big Event" that had happened previously in her life. The young women described remembering this difficult or problematic situation in their lives prior to and/or during their self-cutting. For some co-researchers this event was either physical or sexual abuse that had been committed against them. For others it was a big argument that they had gotten into with their mother or stepfather. These thoughts of their life events would be remembered over and over during the times they used their razors and scissors to cut. Shelly recalled, "I was just sitting in class, and I was thinking…I wasn't even listening to the words that the teacher was saying." Brielle described the event that she remembered many times before she self-cut, "I was being hurt by a family member." Brielle not only remembered the significant recurring event of sexual abuse, but she also remembered fights with her family while she engaged in self-cutting behavior.

Stephanie's and Gabrielle's main events that they remembered before and during cutting revolved around their families too. Stephanie described that when she first started cutting, "I was having problems with my mom…we fought everyday…me and my mom weren't good." Gabrielle described her thoughts before and during cutting and they were similar to Stephanie's:

> Me and my mom got into a big argument…I was fighting with my mom a lot…I was pissed at my mom and was saying, I hate her, I hate her….I said it [the cutting] was because of you [mom]… I thought you should know…I wanted her to see that she is the only person that could get to me like that.

The best articulations were obtained in talking with Jackwolynn about her cutting. Jackwolynn remembered the exact date that she first started cutting and the event that occurred two days before. "Something really bad happened to me, and I was going to be twelve, and it was November 2nd....I was raped by a boyfriend." She described each cut like a story or an event that happened to her. Additionally, she remembered which scar meant which event. "This cut means a story, and this one means something else." Jasmine also recalled this, "I know every scar I have on my body and what it is from." Jackwolynn explained her thought process of self-cutting when she stated, "You don't just…cut…everyday for the next fifteen years, it's…you go through something and you can't take it anymore…and you just start cutting."

The co-researchers seemed to perseverate on these big events before and during their cutting episodes. They allowed "A Lot of Feelings" and emotions about "A Big Event" to multiply concurrently and make them start believing that they deserved to cut themselves and that it would make them feel better. At night, before school, or during the day when something in their life was not going right, the feelings of anger, sadness, and/or hurt were overwhelming to them. "I couldn't take it anymore," Jackwolynn recalled. By cutting themselves, these young women felt that they were able to overcome the past event in their lives and the emotions that they were feeling because of those

events. The sensation of cutting seemed to relieve the feelings that these big events in their lives had caused them to hold inside.

A Release

Unfortunately, the familial expectations, the stress, and the pain that each of the co-researchers was dealing with in their lives had become overpowering. The co-researchers believed that self-cutting was a way to "Release" these things, when there was no other escape in sight. The co-researchers in this study were dealing with questions of sexual orientation, past sexual and physical abuse, parental separation and fighting, family dysfunction, and a number of other stressors in their lives, such as school, friendships, and dating. Two of the girls in this study labeled cutting as "…an easy way out." All of the co-researchers used words such as, "…release…" and "…relieving…" to describe the experience of self-cutting. Jasmine remembered, "It's like a drug….it's kinda like a rush that you get in your head and you are like YES!" Brielle, similar to the other co-researchers, liked the feeling of self-cutting. She described, "It felt relieving…it felt good…it relieves every emotion that you feel inside….it does relieve a lot of stress."

Stephanie used similar terminology to Brielle by stating, "It just like relieves everything and you feel so much better." Stephanie's words were similar to Jasmine's when she recounted, "It's like a feeling you get off a drug. It releases everything." Jackwolynn used a metaphor to describe the release she feels from cutting. "When the blood went… down my flesh, the story was released." Jackwolynn saw herself as a bottle rocket and cutting helped her to let it out and not explode. She admitted that:

> It was like the euphoria was like there... it would be bottled up for months…and maybe even years, and then I can't take it anymore and it can't be in my head no more and I'd cut.

Gabrielle remembered recalling that the first time she had cut had helped, so she did it a second time to see if it would make her feel better again. Another form of release that Jackwolynn depicted with her words was that cutting was a replacement for talking. Jackwolynn, like many of the other co-researchers, saw self-cutting as a type of catharsis. She mentioned that so many times there was no one to talk to, and no one to understand her. "…and there's nothing, no one to care." She utilized cutting to let her release her story silently. As long as she had her blade, she did not need an actual human being to be there for her. Stephanie also alluded to this when she illustrated how hard it was for her mother and friends to understand what she was going through. Many of the co-researchers in this study used cutting as "A Release" for "A Lot of Feelings" about "A Big Event" in their lives, instead of talking it out or writing about it in a journal.

Nothing Ever Worked

All of the co-researchers in this study appeared as if they failed to choose healthy alternatives to cutting; however, many of them tried other methods before cutting and "Nothing Ever Worked" for them. Jasmine used her cutting to refrain from screaming. She had tried other methods, but none of them seemed to work for her. She "…just thought it was something different…" that might work better. Similar to Jasmine, Shelly had tried other things, but she had never tried cutting. "I had never seen anyone do it before, but I just thought I wanted to try it." Brielle articulated it the best when she recounted, "I tried, and nothing ever worked….I decided that the only thing that could

help me at this point was to cut myself." Similarly, Stephanie described cutting as "…the only thing you can turn to, because there's nobody to talk to." Jackwolynn went into more detail than any of the other co-researchers in explaining the things that she had tried before cutting, which in her mind, all had failed her. "Writing didn't help anymore, talking didn't help anymore…so I just got the razor blade." This superordinate theme again was linked to the other ones because due to "A Lot of Feelings" from "A Big Event" the co-researchers cut themselves to find "A Release" because "Nothing [else] Ever Worked."

Numb, No Pain

The final superordinate theme that each co-researcher mentioned during her interview was how the act of cutting made her arm "Numb" and she felt "No Pain." Jasmine admitted that she did "…kinda like the feeling…" of cutting. She recalled, "It didn't hurt…it doesn't hurt." Shelly remembered being surprised that it didn't hurt, due to her low tolerance for pain. "I didn't feel anything really…and when I was cutting myself I didn't feel that either and wherever I was cutting was really numb and I didn't feel it." Brielle and Stephanie described that there was no pain when they engaged in cutting but that it actually felt good to them. They recalled that the pain inside of them led them to cut, but the act of cutting did not hurt them. Jackwolynn also reported that cutting felt good, not painful. "The pain wasn't there, I did not feel pain. It was like the cuts didn't hurt." Gabrielle had a slightly different experience because her first cut stung her, but after that she recounted, "It went numb, I couldn't feel it anymore…I couldn't feel anything." In summary, each co-researcher had "A Lot of Feelings" stemming from

"A Big Event" that they needed to "Release." They chose cutting because "Nothing [else] Ever Worked" and the act of cutting made them "Numb" and feel "No Pain."

The second research question was developed to examine what stops adolescent girls from cutting themselves when they have already cut themselves on a prior occasion. Two major themes were discovered based on the results of this question.

Table 3

Themes for Question 2

Themes
Thinking About People Who Care
Thinking About the Consequences

Thinking About People Who Care

Four of the six co-researchers in this study reported that "Thinking About People Who Care" was one of the reasons that they chose not to cut one or more times when they really felt like cutting. Shelly and Brielle were the two young women who did not report this theme. On the other hand, the other co-researchers felt very strongly about this theme. Jasmine described it like this, "The thought of people's faces, expressions…and mostly my parents…and I wouldn't want to be a bad example for…my little sister." Stephanie, even though she felt like she did not get along with anyone in her home, had a strong sense that people cared very much about her. "Thinking about people who care stops me from cutting.…I have realized that there are people who care." Jackwolynn clearly remembered flashbacks of her mother crying sometimes before she cuts and this allows her to stop herself from cutting. She also has dreamed of her deceased father

speaking to her and asking her not to cut, which additionally helps her to stop herself from cutting. Gabrielle pictured her boyfriend asking her not to cut and recounted that she promised him that she would never cut again. This allows her to control some of her urges to cut herself. “My boyfriend stopped me.”

Thinking About the Consequences

Four of the six co-researchers cited “Thinking About the Consequences” helped them to stop themselves from cutting. Two sub-themes emerged in this category including the thought of getting Baker Acted and the loss of something, such as privileges, independence, or friends. Three co-researchers admitted that the thought of being Baker Acted has stopped them from self-cutting many times. Stephanie reported, “I got Baker Acted and part of the reason why I don’t cut anymore is because I don’t want to go back.” Stephanie and Brielle had been Baker Acted before and decided that they never want to have that experience again. Gabrielle had watched her friend go through the Baker Acting process and decided that she never wanted to go through it herself. Shelly recounted that when she thought about everything she could lose (i.e., getting kicked out of her home, her independence, and her friends), it deterred her from cutting even when she really wanted to cut. “Sometimes I look at my arms and think, I’ve done something stupid…the consequences are really bad…I lost a lot of my friends.”

The third research question was developed to examine what message adolescent girls who engage in self-cutting behavior would want to send to other girls who are cutting. One superordinate theme emerged from the answers to this question. Additionally, several alternatives to cutting that the co-researchers currently use also came out of the analysis of this question.

Table 4

Superordinate Theme for Question 3

Themes
Don't Do It

Don't Do It

Every co-researcher in this study answered, "Don't Do It" or used similar terminology to answer the last research question. Many of the girls replied, "It's stupid" and "There are other things to do." Every co-researcher recounted the many other things that they do instead of self-cut. There answers consisted of, "Do something moving," "Go outside," "Go for a walk," "Call a friend," "Write poetry," "Walk your dog," "Box," "Exercise or run," "Cry," "Take a shower or a bath," and "Listen to your music really loud."

Chapter Five

Discussion

The purpose of this study was to examine adolescent girls' lived experiences with self-cutting behavior. Additionally, this study aimed to explore what inhibits an adolescent girl from cutting, and what adolescent girls who have engaged in self-cutting would want to tell other girls who currently self-cut. A summary of the results of this study, how these results relate to past research, and their implications for school psychology are described in this chapter. Additionally, the delimitations and limitations of this study, recommendations for future research, and conclusions are included.

Self-cutting was defined in this study as the intentional carving or cutting of the skin and subdermal tissue, or scratching, ripping, or pulling skin without the intention of committing suicide (Alderman, 1997; Favazza, 1996; Nock & Prinstein, 2005; Suyemoto, 1998). This study set out to elucidate the self-cutting behavior of six adolescent girls, analyzing how they first started cutting, and why they chose self-cutting as their personal coping strategy. A methodological approach that would allow for maximum insight into the emotions, cognitions, and feelings that make up the self-cutting experience was of extreme importance. Therefore, the existential-phenomenological approach was chosen. The use of this approach facilitated an atmosphere of safety, comfort, and impartiality in which each co-researcher openly explored the research questions (Cihonski, 2002). The average response time used to answer the seven, open-ended research questions was 35

minutes. This researcher believes that the information gathered in the interviews was truthful, unguarded, and enlightening of the intensely lived experience of self-cutting. Using this interviewing method, all co-researchers were asked questions about their experiences with self cutting, what stops them from self-cutting, and what they would want to tell other girls who are engaging in self-cutting behavior. Following the interviews, the tapes were transcribed, and themes were developed based on the actual words of the co-researchers.

The six spirited co-researchers who volunteered to take part in this research study and share the private details of this personal experience all started engaging in self-cutting behavior during early to middle adolescence. Their ages of onset ranged from 11 through 16 years of age. Past research has supported this age of onset (Conterio & Lader, 1998; Favazza, 1998; Favazza & Conterio, 1988; Nock & Prinstein, 2004). According to Slavin (2003), adolescence is a time of biological, social, and cognitive change that can bring about increased feelings of confusion, anxiety, and depression (Mash & Barkley, 2003). Many of the co-researchers in this study were not only exposed to the normal teenage stressors but also to a significant event (i.e., rape, sexual or physical abuse, fight with parent or friend, etc.) that had negatively affected them in some way.

Demographic Impressions

Through the analysis of the interviews, it appears that neither co-researcher's age nor racial/ethnic background had a distinguishable impact on the self-cutting experience. Adolescent girls in this study (i.e., 15-18 years) who were from diverse racial and ethnic backgrounds (see Table 1) easily recalled at least one self-cutting experience and described it with marked consistency. Even though they ranged in age and ethnicity, the

themes extracted from each co-researcher's interview were extremely similar in thought and terminology to the other co-researchers' themes. In addition, regardless of the significant life events that were taking place in each co-researcher's life at the time when she first started to engage in self-cutting behavior, the meaning structure of each experience was similar for all co-researchers. This suggests that a variety of life events may lead to an adolescent girl engaging in the lived experience of self-cutting, and this may be important in understanding what triggers this behavior.

As previously reported, all of the co-researchers were either living with families affected by divorce or remarriage or were experiencing perceived family dysfunction. Additionally, four out of the six had some form of abuse committed against them. This supports the finding from Rosen et al. (1990) that claimed that adolescents who self-cut are more likely to come from divorced families, neglectful families, or families in which there was parental deprivation. Rosen et al. (1990) also found that adolescents who self-cut often have a history of physical or sexual abuse as children. The data from this study support that finding as well.

Extracted Themes

Research question one investigated what the experience of self-cutting in adolescent girls entailed. Five superordinate themes were discovered from this research question. These included, A Lot of Feelings, A Big Event, A Release, Nothing Ever Worked, and Numb, No Pain.

A Lot of Feelings. "A Lot of Feelings", the first major theme identified in the interview transcripts, reflected an intensity of emotion immediately before engaging in self-cutting. Each co-researcher reported powerful emotional feelings which led her,

ultimately, to self-cut. Some examples of these emotions included anger, stress, frustration, hurt, and sadness. Jasmine reported that she was very angry and upset before she self-cut. Shelly reported that she was mad at her mom. Brielle, Stephanie, Jackwolynn, and Gabrielle recalled being highly stressed and upset with their mothers and/or other family members. This theme has been found in other research studies, both qualitative and quantitative (Bennum, 1984; Darche, 1990; Froeschle & Moyer, 2004; Moyer, 2005; Nock & Prinstein, 2005; Ross and Heath, 2002, 2003). For example, Darche (1990) reported that self-cutting served to express and externalize overwhelming emotions that the adolescent engaging in self-cutting behavior had been keeping inside and also allowed the adolescent who self-cut to have perceived control over her emotions. Yip (2005) also discussed a high level of tension or anxiety as a precursor to self-cutting.

Self-cutting behavior was seen by Suyemoto (1998) as a way to express "A Lot of Feelings" and conflict both to the self and others. Moyer (2004) agreed with this. The participants who volunteered for the Moyer (2004) study reported that self-cutting was useful in dealing with their feelings of hurt, pain, anger, stress, and frustration. Additionally, those participants stated that self-cutting started with a build-up of emotions, and the cuts on their skin replaced those emotions. Similarly, Nock and Prinstein (2005), Ross and Heath (2002, 2003), and Yip (2005) found that the adolescent girls in their studies had a range of intense emotions before they decided to engage in self-cutting behavior. Galley (2003) reiterated this theme by stating that often when students self-cut, they are acting out emotional distress.

Self-cutting can provide an escape from feelings of anger, sadness, or frustration (Miller, 1994). This can be important for intervention planning. Specifically,

interventions that focus on allowing adolescent girls to express their feelings and emotions in healthy ways could be developed in order to serve the same function as self-cutting. Jasmine, Shelly, Brielle, and Jackwolynn all had engaged in writing poetry or writing in a journal. They recalled that this has helped them in the past and that they sometimes used these methods instead of cutting. Further research is needed to ascertain why girls sometimes self-cut while at other times can use more adaptive means for coping with stress.

A Big Event. A second superordinate theme that was found across all co-researchers was that self-cutting occurred after "A Big Event" that each girl remembered before and/or during each time she self-cut. The event that each girl focused on had a very strong significance to her. For Gabrielle, it was an altercation or intense argument with one of her parents or guardians. For Shelly, Brielle, Stephanie, and Jackwolynn it was a recurrence of violence against them, and for Jasmine it was dealing with feelings about the deterioration and stigma of her first homosexual relationship.

Zila and Kiselica (2001) and Moyer (2004) talked about self-cutting as a way to escape an unbearable emotional situation, such as a fight with a parent, a break up, or stress about school. Moyer's participants recounted that cutting was their way to deal with their difficult situation or significant life events. Other research studies also have found this theme when their participants have answered standardized instruments about their self-cutting behaviors (Rosen et al., 1990; Yip, 2005). Yip (2005) described unpleasant experiences and encounters in childhood and adolescence in the form of abuse, neglect, trauma, and conflicts as antecedents or precursors to engaging in self-cutting.

Selekman and King (2001) agreed that participants may use self-cutting as a coping strategy to deal with difficult life situations. Darche (1990), Dulit et al. (1994), and Rosen et al. (1990) all found that adolescent victims of abuse are more likely to engage in self-cutting. A significant event, such as abuse, may have led these adolescents to be more likely to commit this act against themselves. Additionally, some adolescents may even carve words into their skin to express how they feel about the big events that are happening to them in their current life situation (Yip, 2005). Jasmine noted that she engaged in this type of cutting after fighting with a friend. She also recalled cutting initials into her arm to remember relationships and who she had loved, which is a significant and big event in an adolescent's life.

A Release. Conterio and Lader (1998) and Galley (2003) showed support for the third superordinate theme that cutting can bring about a feeling of calmness and soothing. Additionally, the co-researchers in this study and the participants from both qualitative and quantitative studies conducted in the past substantiated this finding (Favazza & Conterio, 1989; Froeschle & Moyer, 2004; Nock & Prinstein, 2004; Ross & Heath, 2003; Suyemoto, 1998; Yip, 2005). Jasmine described cutting as a rush. Brielle and Stephanie recounted that it relieved every emotion they were feeling. Jackwolynn reported cutting to be a feeling of euphoria that released her untold stories.

Moyer (2004) and Kashgarian (1999) reported that the students in their studies used cutting to release tension and strong emotions. Their participants recalled that their feelings were going into their cuts and were allowed to be released through each cut. Jackwolynn verified this finding in her words discussed earlier. Ross and Heath (2003) found that the overall reasons for self-cutting were to release feelings of hostility, anger,

and anxiety. These researchers described self-cutting similar to the way that the co-researchers in this study did, as a way to release unwanted feelings and emotions. Suyemoto (1998) reported that self-cutting behavior is reinforced internally through the feelings of relief that the person who self-cuts feels. Levenkron (1998) believes some people engage in self-cutting to relieve the tension and pain that has built up inside of them. Self-cutting is a medicine for some girls, in which pain brings about relief, safety, and security (Levenkron, 1998). A girl who self mutilates may experience a calming effect on her mental pain because of the physical pain she is inflicting upon herself (Levenkron, 1998).

The knowledge that self-cutting behavior often provides a sense of relief (Lenenkron, 1998; Miller, 1994) can be beneficial for intervention planning. Adolescents who are self-cutting need to feel this sense of relief in order to get out the emotions and feelings that they are having about big events in their lives. Interventions that serve this function, to release, can be developed. Gabrielle stated that running serves this purpose for her. It allowed her to feel better and release the tension and stress that she was holding inside.

Another form of release that the co-researchers believed could come from cutting was a replacement for talking. Self-cutting can be used to communicate feelings because adolescents who self-cut often have a hard time with verbal or symbolic expression (Rosen et al., 1990). Jackwolynn, Stephanie, and Jasmine recounted how they had no one to talk to and no one who would understand them. They all used cutting to release their stories and memories without the need for people. This may be an important piece of intervention planning with an adolescent who self-cuts. If a therapist can establish a

trusting, understanding, and loyal relationship with an adolescent who self-cuts, this may enable her to be able to talk about her significant life events and emotions and not use cutting to release them. Miller (1994) named this type of intervention "replacing the symptom [self-cutting] with the therapeutic relationship" (p.250).

Nothing Ever Worked. A fourth superordinate theme that was extracted through the interviews with the co-researchers in this study was that after trying other things, self-cutting seemed to be the only thing that worked at the time. Brielle used the words "Nothing Ever Worked." Simpson (2001) reported a similar finding. Simpson noted that many adolescent girls felt that self-cutting was the only plausible way to handle or dissociate significant events in one's life that were causing her pain. Likewise, Kashgarian (1999) and Rao (1999) reported similar findings from their participants, including that self-cutting was the best way that their participants felt they could control their physical self and have mastery over their lives. Yip (2005) wrote of similar findings that showed that self-cutting may be the only way that some adolescents are able to ease their emotions and feelings. When other coping strategies failed, many adolescents believed that self-cutting would help them (Zila & Kiselica, 2001).

In contrast to this finding, even though the co-researchers in this study used cutting to deal with stressful life events and felt that nothing else worked, they also were able to recite healthier alternatives to self-cutting, which they reported to occasionally use instead. The co-researchers shared these options with this researcher, and they were listed in Chapter Four. The alternatives that the co-researchers reported to be beneficial could be helpful when deciding how to design interventions for adolescents who engage in self-cutting behavior. Specifically, even though an adolescent client believed that

nothing else worked for her, a therapist could show her the data from this study. This would allow her to understand that other girls her own age, in a similar situation to her, have used other coping strategies instead of cutting, and they have worked.

Numb, No Pain. As portrayed in the name of this final superordinate theme, each co-researcher reported to either feel "Numb" or "No Pain" while engaging in self-cutting behavior. Similar to the co-researchers in this study, Conterio and Lader (1998) found that adolescents who engage in self-cutting often feel numb until after the cutting takes place. Many of the girls in this study recalled that while in the process of self-cutting, their arms were numb and they felt no pain. Other researchers also have supported this finding (Nock & Prinstein, 2005; Yip, 2005). Yip (2005) cited that adolescents may not feel pain in episodes of self-cutting but the sign of blood may give them back their sense of self-control. Jasmine, Shelly, and Jackwolynn admitted that they did not feel any pain while self-cutting. Brielle remembered not being able to feel anything at all while engaging in self-cutting behavior. Gabrielle recalled that her arm was numb while self-cutting.

Moyer (2004) and Kashgarian (1999) made this same discovery while interviewing their participants. They reported that many adolescent and adult females feel a numbness of the skin where they cut, and this allows them to take their mind off of everything. Miller (1994) reported that self-cutting can serve as a form of dissociation or analgesia which means numbing physically or emotionally. Many females who self-cut describe being physically numb, either before or during their engagement in self-cutting behavior (Miller, 1994). More research needs to be conducted to find out what other interventions could obtain these same functions, dissociation and numbness. On the other

hand, through the use of various therapeutic techniques, one goal of therapy could be to enable an adolescent girl to be able to talk about how she is feeling instead of dissociating or numbing herself from dealing with it.

Research question two addressed if there was ever a time in the co-researcher's life when she wanted to self-cut but did not and what stopped her. Two themes were extracted from the data for this question. These included, Thinking About People Who Care and Thinking About the Consequences.

Thinking About People Who Care. Four of the six co-researchers recounted that "Thinking About People Who Care" helped to deter them from self-cutting at a time when they wanted to engage in this behavior. Jasmine thought about her parents and little sister. Stephanie remembered her best friends. Jackwolynn thought about her mother and biological father, and Gabrielle remembered her boyfriend. Few studies have examined this question, but this finding has been supported in the research conducted (Miller, 1994; Yip, 2005).

Yip (2005) found that supportive familial environments such as good communication, stable family life, and encouragement from parents or guardians may decrease self-cutting behavior. Although many of the co-researchers in this study did not have all of the ingredients in their life that Yip mentioned, they did have one or two people in their lives who cared about them and did not want to see them hurting. Miller (1994) reiterated this finding by stating that before a woman or adolescent can stop cutting, she needs to establish a caring, supportive relationship with someone. This will enable her to work through her memories that are causing her pain and anger, which fuels her self-cutting behavior. This finding is important because it means that for most of the

co-researchers in this study and for a variety of participants in other studies, having someone in life that really cared or that could listen to them when they needed to talk served as a resilience factor to decrease cutting.

Shelly and Brielle did not validate this theme. Some proposed reasons follow. Shelly did not have many people in her life who showed that they do care for her, except for her sister. She has been moved around from foster home to group home since her mother lost custody of her. This could explain why she did not think of this theme. Similarly, Brielle has been sexually abused by a family member, feels that much of her extended family has been against her since she made the allegations, and does not feel that her parents love her like they love her little brother.

Thinking About the Consequences. More then half of the co-researchers reported that "Thinking About the Consequences" helped decrease their self-cutting behavior. The two sub-themes that emerged were thinking about getting Baker Acted and thinking about what they will lose, such as friends, privacy, and independence. Levenkron (1998) noted that placing someone in a crisis center or related facility decreases cutting by nearly one hundred percent immediately. He further stated that once a patient leaves these facilities, she may cut again. On the other hand, the co-researchers in this study recalled that the experience of being Baker Acted was so traumatic for them, that thinking about going through it again helped them to drastically decrease their self-cutting behavior.

Shelly recounted that when she thought about everything she could lose (i.e., getting kicked out of her home, her privacy, her independence, and her friends), it deterred her from cutting even when she really wanted to cut. Lenvenkron (1998) found evidence to support that when therapists frequently check their clients' arms, stomachs,

and legs to see if there are new self-inflicted wounds, this loss of privacy usually decreased future self-cutting behavior. He recounted when he examined the damage conducted, at regular intervals, it created the anticipation of nonprivacy or the expectation of the discovery of the cuts while the act of self-cutting was being committed by his clients. Additionally, Nixon, Cloutier, and Aggarwal (2002) found that many of their participants reported to have lost friends and developed unwanted social difficulties due to their cutting behavior. This, in turn, had an impact on their desire to cut and the frequency of their cutting behavior.

Research question three examined what message the co-researchers would want to give other girls that are engaging in self-cutting behavior. One superordinate theme emerged from this data, “Don’t Do It.”

Don’t Do It. Nixon et al. (2002) found that many adolescent girls who were engaging in self-cutting behavior recognized that it was harmful, wanted to stop, and admitted that the urges to self-cut were upsetting to them. This finding from past research reiterated what the co-researchers in this study proclaimed with conviction. When asked what message they would want to send to other girls who are cutting, the co-researchers all answered with a resounding, “Don’t Do It.” “Do other things.” They also admitted that they felt self-cutting was a “stupid” behavior that they wished they could stop altogether. In a review of an Internet survey of adolescents who self-cut, 42% admitted that they wanted to stop self-cutting sometimes, while about 37% admitted that they wanted to stop self-cutting often or always (Murray, Warm, & Fox, 2005). Few studies specifically have asked their participants what message they would want to send to other girls who are cutting, so this was a very important part of this study.

Additionally, the co-researchers in this study each gave examples of what they meant by "Do other things." These were listed earlier in Chapter Four. This list of alternative behaviors to self-cutting can be very helpful in intervention planning with students who engage in this behavior. Some of these behaviors, specifically running and boxing, have been shown to serve similar functions to self-cutting. These functions include the release of endorphins or the release of tension (Levenkron, 1998). Additionally, these alternative behaviors need more evidence and empirical data to support their efficacy at decreasing self-cutting behavior.

Structure and Meaning

The structure of the self-cutting experience seemed to encompass a variety of themes. Before engaging in self-cutting, each co-researcher had "A Lot of Feelings" stemming from "A Big Event" that they needed to "Release." They chose cutting because "Nothing [else] Ever Worked" and the act of cutting made them "Numb" and feel "No Pain." The co-researchers decided not to engage in self-cutting behavior when "Thinking About the People Who Care" or when "Thinking About the Consequences" of cutting. If they could send a message to other girls who are cutting, the co-researchers in this study would say "Don't Do It." The co-researchers knew other coping strategies to serve the same function as cutting but sometimes refused to implement them.

A review of the themes extracted from interview transcripts appear to align well with the existing literature on the experiences of adolescent girls who engage in self-cutting. Similarly, the data collected from the co-researchers lend support to past theories that have been developed from quantitative studies in order to explain the reasons for self-cutting (Favazza, 1998; Favazza & Conterio, 1989; Ross & Heath, 2003; Suyemoto,

1998; Yip, 2005). Both Favazza and Conterio (1989) and Ross and Heath (2003) have supported the finding that self-cutting brings about a release of tension and alleviates stress. Suyemoto (1998) also has cited this finding. The co-researchers in the current study showed support for this theory. Suyemoto's (1998) antisuicide theory was also supported through the words of several of the co-researchers in the current study. This theory cited that self-cutting was used as a compromise to taking one's life. Several of the co-researchers stated that they first thought about suicide before cutting, but realized they did not actually want to kill themselves, just release their pain. Jackwolynn and Stephanie even described self-cutting as the "easy way out" when comparing it to suicide. Additionally, Yip (2005) combined the work of Suyemoto (1998) and others into a multidimensional theory. Specifically, the experience of a big event, a high level of tension from this event, unpleasant sexual occurrences, and a lack of coping ability were all parts of Yip's (2005) theory that were supported by the data from the current study.

More importantly perhaps, the results illuminate the meaning structure of the lived experience of self-cutting. This model of the lived experience offers compelling insight into the powerful emotions and sensations of girls engaging in a self-cutting event. It can be hypothesized that this meaning structure of the self-cutting experience in adolescent girls reveals the essence, or core experience, of self-cutting. This speculation is supported by the fact that variables of age, ethnicity, and life events failed to demonstrate any disparity in aspects of the experience. A comparison of the themes from the interview conducted with the six co-researchers showed great overlap. Since extensive effort was made during data collection and analysis to ensure that the biases of the researcher were not imposed on those of the co-researchers, this outcome can be

viewed as evidence that the experience of self-cutting is commonly shared among those who engage in this behavior. It could be argued that this sharing of themes among all interviews was due to investigator bias. However, the interrater reliability of 87% between two independent thematizers would suggest that the extracted themes reflect the words and experiences of the co-researchers and not those imposed by the lead investigator. Further, the interviews were tape-recorded and transcribed, allowing the investigator and her doctoral colleague to review the interviewer's comments and questions to determine whether she was leading the interviewee or otherwise inappropriately re-phrasing co-researchers' words. Neither of these occurred, further suggesting that adequate thematizing was used during the interview and analysis processes.

Implications for School Psychology

Self-cutting has been shown to be a growing problem on many school campuses (Galley, 2003). The past research on this subject suggests that it is a complex mental health issue that has been under-researched (Carlson, DeGeer, Deur, & Fenton, 2005). This study enhances the research in this area. It is clear that self-cutting is a widespread problem that affects girls with a variety of ethnic backgrounds and life experiences; therefore, it is crucial that school psychologists and other mental health professionals know how to correctly intervene with these adolescents. Adolescents learn about self-cutting behavior from friends, family, media images, Internet, and some inadvertently start using this behavior as a coping strategy. Within the field of school psychology, researchers are assessing the impact of self-cutting and what approaches can be used to decrease its prevalence. To date, few published studies have investigated the lived

experience of self-cutting in a non-clinical sample of adolescent girls. The results of this study are linked to past research in which the same variables were examined (Kashgarian, 1999; Moyer, 2004; Rao, 1999).

Many of the co-researchers in this study believed that they engaged in self-cutting behavior because they either had no one to talk to or did not feel that anyone would understand what they wanted to say. The emotions that each girl was struggling with were suppressed, and no alternative healthy behaviors were conducted to release these intense emotions. In turn, cutting for them was a replacement for talking and a release of their extreme internal feelings. The implications of these findings suggest that school psychologists need to consider the specific function of self-cutting when working with adolescent girls who self-cut. The relationship that is developed through therapy may be the intervention needed to replace the function that was sustained by the cutting behavior. One co-researcher expressed to this examiner that after describing her feelings and reasons for cutting during this study's initial interview that she realized she did not want to cut anymore. Additionally, if adolescent girls are taught specific healthy coping skills to use instead of cutting that works for them and their personal situation, their self-cutting behavior may start to decrease or become extinct.

A further implication for the field of school psychology is the use of the results of the present study in training programs. Past research supports the findings of this study and the proposed reasons and functions of self-cutting that the co-researchers described (Levenkron, 1998; Ross & Heath, 2003; Yip, 2005). There also has been evidence in past research that many of the alternative behaviors that the co-researchers listed have been shown to be beneficial in serving the same function as self-cutting (Levenkron, 1998).

Training programs might want to assign articles, develop assignments, and design research to explore these reasons and functions further to ensure that future school psychologists have the ability to design behavioral interventions taking these findings into account.

Limitations

By design this study was limited to studying the meaning of the self-cutting experience in adolescent girls between the ages of 15 and 18. To minimize limitations when completing a qualitative research study using an existential-phenomenological approach, researchers have reported that great care must be taken (e.g., Becker, 1992; Moustakas, 1996; Polkinghorne, 1989). First, this researcher needed to establish an awareness of her own thoughts and perceptions about the experience under investigation to reduce the imposition of her subjectivity and bias during data collection and analysis. Although great care was taken during the course of this study to implement an objective data collection and analysis process, it is possible that researcher subjectivity and bias may have impacted these processes in some way.

Interview studies are subject to certain limitations (Oakley, 1981; Samdahl, 1991; Scott & Godbey, 1990). For example, Mittelstaedt (1996) reporting on the strengths and limitations of the interview method, found that some interviewees recalled that they wished they could change what they said, or that they said the wrong things. No girls in this study corrected or changed her interview transcript during the final meeting session. On the other hand, it is possible that although each girl reviewed her interview protocol and had the chance to change what she had said, clarify her thoughts, and give feedback, she may not have wanted to assert herself and correct her transcript for a variety of

reasons. For example, girls may have feared being judged as indecisive, may have perceived that it would make the study more difficult, might have worried about upsetting the researcher, or may not have wanted to share her truest feelings.

Additionally, Mittelstaedt's (1996) interviews were tape-recorded, as in the present study. As in Mittelstaedt's (1996) study, girls in this study may have felt uncomfortable with the physical presence of a tape recorder. Additionally, the girls may have had some difficulties with memory or recall due to the stress of situation or the adverse and emotional nature of the events they were recalling and relating.

Generalization of results to a larger population is one common goal of traditional research studies; however, the ability to generalize results is not a focus of existential-phenomenological research. Rather the goal is to provide enough detail so a reader can connect and understand the experience (Seidman, 1994). In this study of self-cutting, the shared themes extracted and their derived meaning structure may help to create an understanding of the meaning of the self-cutting experience. Further, the results of this study complement the findings of past research, which may give evidence to a universal experience of self-cutting for all girls who engage in this behavior. More research on different ages and different ethnic samples of girls are needed to confirm this.

Directions for Future Research

This study, unlike other studies, both qualitative and quantitative, focused on cognitions, emotions, and sensations surrounding the self-cutting experience. Further, while research on self-cutting in adolescent girls has traditionally focused on the comparison of scores on standardized measures (Ross & Heath, 2003; Yip, 2005), this

study provides a rich and detailed description of the meaning, essence, and structure of the lived self-cutting experience, thereby filling a void in the literature.

There are a few things that should be kept in mind when future studies, similar to this one, are conducted. First, the pilot study was a very important part of this study. During the first interview the researcher was not as comfortable with the questions and the interview process as in the last interview and did not give many prompts or ask as many follow-up questions as in the latter interviews. The final interviews went smoother and were more detailed because of the additional prompts used.

Additionally, if future studies use the same instruments as this one, the order in which the questions are asked should be changed. In this study question number two, has there ever been a time when you wanted to cut and didn't, and what stopped you, was given before question three. Question three asked what message the co-researcher would want to send to other girls who are cutting. Due to the negative wording of question two, the co-researchers may have been led to believe that the socially desirable answer would be to talk negatively about cutting to other girls, which they ultimately did. Due to the ordering of the questions, the responses to question three may have been skewed in a negative direction. This hypothesis can only be tested in future research studies using this same method and questions.

Additionally, other methods may be more appropriate to get a fuller picture of the experience of self-cutting. For example, if a case study method was used, it would allow a researcher to be more immersed into the life of the co-researchers. Observations or interviews with parents and teachers could be conducted, and more detailed interviewing would also be an option. This may allow for more exploration in the hardships and life

situations that the co-researchers have faced. In addition, this would allow a co-researcher to tell her full life story and get out all of the things that she believed to be important. Using the existential-phenomenological method of interviewing, the co-researchers were discouraged from going off topic, and they were not allowed to expand on the events from their lives.

Not only can this study be enhanced, but there are many areas in which the research on self-cutting also can be improved. Continued research is needed to provide alternative methods of coping for adolescents who self-cut. Although the co-researchers in this study were able to name several interventions that served the same function as cutting does for them, other girls may gain a different function from cutting. Additionally, many of the co-researchers talked of a desire to stop self-cutting, but only a few of them admitted that they have actually been able to stop. More then half of the co-researchers still cut occasionally when they do not know any other way to deal with their emotions or when other things are not working for them. In order for school psychologists and counselors to be useful when working with students who self-cut, they must be aware of effective, evidence-based strategies and interventions. The goal of this study was not to investigate treatment options, and although some interventions were mentioned through the co-researchers words, this area still is in need of research to be fully developed.

Additionally, more research is needed on the first experience with self-cutting so that prevention and early intervention can be utilized. If more research was conducted on what specific events lead to self-cutting, interventions to replace the function of self-cutting could be initiated immediately instead of waiting for the symptoms of cutting to

be made apparent. More research also is needed with larger samples of adolescents and a mixture of gender, ages, and ethnicity to learn how the experience differs across all of these variables. This will help to make the intervention development less biased and more culturally appropriate.

Further, interventions using information from the actual experiences of other girls close in age to the client may be much more effective in the prevention and treatment of phenomena such as self-cutting (Kashgarian, 1999; Rao, 1999). Data from this study can be presented to girls in a therapeutic environment, such as in one-on-one or family counseling, allowing girls to examine openly their self-cutting experiences and make choices and changes in their lives. Further, these data offer a guide to the thoughts and behaviors that may be targeted for therapeutic intervention. Since many girls undergo a change in attributional style during adolescence and may lose the ability to tolerate frustration without becoming overwhelmed (Pipher, 1994), girls would likely benefit from attribution training. Additionally, instruction should include positive self-talk and problem-solving skills to help girls cope with the past and future experiences in their lives.

Conclusions

This study was conducted to examine the experience of self-cutting, what deters adolescent girls from continuing this behavior, and what message adolescent girls who are self-cutting would want to send to other girls who are cutting. The findings indicate that five superordinate themes came from the first research question, what is the experience of self-cutting. These included, “A Lot of Feelings,” “A Big Event,” “A Release,” “Nothing Ever Worked,” and “Numb, No Pain.” The second research question,

has there ever been a time when you really wanted to self-cut and you didn't and what stopped you yielded the themes, "Thinking About People Who Care" and "Thinking About the Consequences" as the reasons the co-researchers chose not to cut. The third research question, if you could send a message to other girls who are cutting, what would it be yielded one superordinate theme. The co-researchers in this study all would say "Don't Do It." The co-researchers also developed a list of alternative behaviors to self-cutting. Since self-cutting can be a dangerous behavior and since it is such a widespread problem facing schools, these results are important for the field of school psychology and the future of mental health. The themes revealed through this study need to be taken into account when designing individual interventions and when conceptualizing family intervention and treatment.

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Appendices

Appendix A
Initial Assessment of Verbal Ability

1. Who do you live with?

2. How do you get along with each of them?

3. Do you have friends in your neighborhood?

4. What are your hobbies?

5. How do you feel about school and why?

6. What is your favorite and least favorite subject and why?

7. If you had three wishes, and they could be for anything in the world, what would you wish for?

Appendix B
Flyer to Distribute

Have you ever cut on yourself?
If so, I'd like to hear your voice.

WHO: Adolescent girls ages 13-18.

WHAT: An interview with a doctoral student at the University of South Florida to share your actual words and thoughts about self-cutting.

WHEN: Whatever time is best for you.

WHY: For a study exploring why girls cut themselves.

NOTE: Anything that you share will be held in the strictest confidence; however, you will need parental consent to participate. You will choose a fake name for the interviews.
To participate, please contact Amanda Prive at 813-335-3012 or e-mail at aprive@mail.usf.edu

Appendix C
Protocol of Questioning

Each co-researcher will be presented with the following questions both verbally and in written forms. Co-researchers will be given adequate time to answer all questions presented. They will get the questions during the initial interview and will have them to think about until the second interview date. The researcher will add open-ended questions or gentle prompts to clarify and facilitate the interview.

Interview Questions:

1. Tell me about the first time you self-cut.

2. What were some things that were going on in your life at that time?

3. How did you decide to start self-cutting?

4. Please describe the experience of self-cutting and what it means to you in as much detail as possible.

5. Please describe a recent situation of self-cutting and any thoughts or feelings that you were feeling at the time.

6. Has there ever been a time when you really wanted to cut and you didn't? What stopped you?

7. If you could send a message to other girls who are cutting, what would that message be?

Appendix D
Demographic Information

Age_____

Gender_____

Ethnicity_____

Co-researcher name to be used_____
(Name to be used will be a fake name chosen by the co-researcher in order to protect her confidentiality)

Appendix E

UNIVERSITY OF SOUTH FLORIDA

Assent to Participate in Research

University of South Florida

Information for Individuals under the Age of 18 Who Are Being Asked To Take Part in Research Studies

A STUDY OF ADOLESCENT GIRLS' EXPERIENCES WITH SELF-CUTTING

WHY AM I BEING ASKED TO TAKE PART IN THIS RESEARCH?

You are being asked to take part in a research study about self-cutting. You are being asked to take part in this research study because you have cut yourself in the past and have experience with this behavior. If you take part in this study, you will be one of about 5-8 people in this study.

WHO IS DOING THE STUDY?

The person in charge of this study is Amanda Privé, Ed.S., NCSP (PI) of the University of South Florida. Dr. Linda Raffaele Mendez is guiding her in this research.

WHAT IS THE PURPOSE OF THIS STUDY?

By doing this study, we hope to learn the reasons why adolescent girls engage in self-cutting and how they felt before, during, and after they cut themselves.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

The study will be take place at a private location of your choice, such as your home or your room. You will be asked to meet with Ms. Privé two times during the study. Each of those visits will take about 30-60 minutes. The total amount of time you will be asked to volunteer for this study is 60-120 minutes over the next week. There will be 5-8 participants in this study.

WHAT WILL I BE ASKED TO DO?

You will be asked to answer a series of questions during the first session, and you will have all of the time that you need to think about and answer these questions. During the second meeting, Ms. Privé will show you a list of the things that you told her during the first meeting. You will have to tell Ms. Privé if she heard you correctly and help her change anything that she misquoted you on. After this meeting you will be finished with this study.

WHAT THINGS MIGHT HAPPEN THAT ARE NOT PLEASANT?

To the best of our knowledge, the things you will be doing will not harm you or cause you any additional unpleasant experience.

Although we have made every effort to try and make sure this doesn't happen, you may find some questions we ask you may bring up bad memories or upset you. If so, we will tell you and your parents about some people who may be able to help you with these feelings.

In addition to the things that we have already talked about, listed above, you may experience something bad that we do not know about at this time.

WILL SOMETHING GOOD HAPPEN IF I TAKE PART IN THIS STUDY?

We cannot promise you that anything good will happen if you decide to take part in this study; however, you will be able to share your feelings, and have a part in helping girls in the future who have lived through similar situations to you.

DO I HAVE TO TAKE PART IN THE STUDY?

You should talk with your parents or anyone else that you trust about taking part in this study. If you do not want to take part in the study, that is your decision. You should take part in this study because you really want to volunteer. If you do not think you want to take part in this study, you should talk this over with your parents and decide together.

IF I DON'T WANT TO TAKE PART IN THE STUDY, WHAT WILL HAPPEN?

If you do not want to be in the study, nothing else will happen.

WILL I RECEIVE ANY REWARDS FOR TAKING PART IN THE STUDY?

You will receive a $10 gift card for taking part in this study. If you should have to quit before the study is through, you will receive the full gift card when you decide to quit.

WHO WILL SEE THE INFORMATION I GIVE?

Your information will be added to the information from other people taking part in the study so no one will know who you are.

CAN I CHANGE MY MIND AND QUIT?

If you decide to take part in the study, you still have the right to change your mind later. No one will think badly of you if you decide to quit. Also, the people who are running this study may need for you to stop. If this happens, they will tell you why.

WHAT IF I HAVE QUESTIONS?

You can ask questions about this study at any time. You can talk with your parents or other adults that you trust about this study. You can talk with the person who is asking you to volunteer. If you think of other questions later, you can ask them.

Assent to Participate

I understand what the person running this study is asking me to do. I have thought about this and agree to take part in this study.

_____ _____

Name of person agreeing to take part in the study Date

_____ _____

Signature of parent Date
of child taking part in the study

_____ _____

Name of person providing information to subject Date

Appendix F

UNIVERSITY OF SOUTH FLORIDA

Parental Permission to Participate in Research

Social and Behavioral Research

Information for parents to consider who are being asked to allow their child to take part in a research study

IRB # 105357

The following information is being presented to help you/your child decide whether or not your child wants to be a part of a research study. Please read carefully. Anything you do not understand, ask the doctor.
We are asking you to allow your child to take part in a research study that is called:

A STUDY OF ADOLESCENT GIRLS' EXPERIENCES WITH SELF-CUTTING

The person who is in charge of this research study is Amanda Privé, Ed.S., NCSP**.** This person is called the Principal Investigator. Interviews will be conducted at a private location of your choice (i.e., participant's room or home, USF classroom, etc.).

Should your child take part in this study?

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

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

Before you decide:

- Read this form.
- Have a friend or family member read it.
- Talk about this study with the person in charge of the study or the person explaining the study. You can have someone with you when you talk about the study.
- Talk it over with someone you trust.

- Find out what the study is about.
- You may have questions this form does not answer. You do not have to guess at things you don't understand. If you have questions, ask the person in charge of the study or study staff as you go along. Ask them to explain things in a way you can understand.
- Take your time to think about it.

It is up to you. If you choose to let your child be in the study, then you should sign the form. If you **do not** want your child to take part in this study, you should **not** sign the form. .

Why is this research being done?

The purpose of this research study is to gain insight into the experience of self-cutting from a female adolescent's perspective. One of the goals of this study is to interview your daughter about her feelings before, during, and after self-cutting. Your daughter will have two short meetings with Ms. Privé. These meetings will occur in two sessions of approximately 30 minutes each at a location of your choice. The total time required to participate is approximately 1-2 hours. The first meeting will be audiotaped, transcribed, and destroyed at the study's completion. During the first meeting, Ms. Privé will learn about your daughter through a series of questions. Your daughter will then see the list of interview questions. She will have time to think about each question before answering. Before the end of the first meeting, your daughter will receive a brochure containing a list of resources for counseling and interventions regarding cutting behavior. After the first meeting, the participant's answers will be transcribed and then placed into categories of themes. Finally, a second meeting will be made to discuss the results of the first meeting and to close out the study and distribute a gift certificate.

Why is your child being asked to take part?

We are asking your child to take part in this research study because she has cut herself in the past. We want to find out more about why this behavior occurs, what do adolescent girls believe they can do instead, and what they would tell other girls about cutting if they had the chance.

What will happen during this study?

Your child will be asked to spend about a week in this study. What your daughter will have to do is answer a series of questions about her cutting behavior, and then go over their answers with Ms. Amanda Privé to determine if she has been truly understood and quoted correctly.
A study visit is one your child will have with Ms. Privé. Your child will need to come for 2 study visits in all. Most study visits will take about 30-60 minutes. Some study

visits may be shorter or longer depending on the think time your daughter needs before answering the questions.

1. At the first visit, your child will be given a brochure of resources and asked:

- Who do you live with?
- How do you get along with each of them?
- Do you have friends in your neighborhood?
- What are your hobbies?
- How do you feel about school and why?
- What is your favorite and least favorite subject and why?
- If you had three wishes, and they could be for anything in the world, what would you wish for?
- Tell me about the first time you self-cut.
- What was happening in your life at that time?
- What made you decide to start self-cutting?
- Please describe the experience of self-cutting in as much detail as possible.
- Please describe a recent situation of self-cutting and any thoughts or feelings that you were feeling at the time.
- Has there ever been a time when you really wanted to cut and you didn't? What stopped you?
- If you could send a message to other girl's who are cutting, what would that message be?
- The answers to these questions will be audiotaped, transcribed, and then destroyed at the end of the study. No identifying information will be recorded on these tapes. These tapes will be kept confidential and secure throughout the study until they are destroyed. One other researcher will listen to these tapes to transcribe them, but she will never know any of your daughter's identifying information.

2. At the second visit your child will be asked to look at their answers that Ms. Privé has transcribed and tell her if this is what they meant to say. Your child will then get to ask any final questions and receive a $10 gift card for the movies for participating.

How many other people will take part?

About 5-8 people will take part in this study at USF.

What other choices do you have if you decide not to let your child to take part?

If you decide not to let your child take part in this study, that is okay. Instead of being in this research study your child can choose not to participate.

Will your child be paid for taking part in this study?

We will pay your child with a $10 movie gift card for the time she volunteers while being in this study.

What will it cost you to let your child take part in this study?

It will not cost you anything to let your child take part in the study.

What are the potential benefits to your child if you let her take part in this study?

Your daughter may benefit from sharing her experience with Ms. Privé, a Nationally Certified School Psychologist; however, Ms. Privé's role in this investigation is not therapeutic.

What are the risks if your child takes part in this study?

Your daughter may experience mild emotional distress during her interviews. She has the right to discontinue the interviews at any time without penalty and will be provided with follow-up information.

If your child has any of these problems, call Ms. Privé right away at 813-335-3012.

What will we do to keep your child's study records private?

There are federal laws that say we must keep your child's study records private. We will keep the records of this study private by keeping them locked in a safe with a combination lock in Ms. Privé's home. The only information that will have your daughter's name will be the consent and assent forms.

We will keep the records of this study confidential by keeping the safe locked at all times. However, certain people may need to see your child's study records. By law, anyone who looks at your child's records must keep them completely confidential. The only people who will be allowed to see these records are:

- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your child's records. These include the University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Individuals who work for USF that provide other kinds of oversight to research studies may also need to look at your child's records.
- Other individuals who may look at your child's records include: the Florida Department of Health, people from the Food and Drug Administration (FDA), people from the Department of Health and Human Services (DHHS) and from the Office for Human Research Protections (OHRP). This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your child's rights and safety.

We may publish what we learn from this study. If we do, we will not let anyone know your child's name. We will not publish anything else that would let people know who your child is.

What happens if you decide not to let your child take part in this study?

You should only let your child take part in this study if both of you want to. You or child should not feel that there is any pressure to take part in the study to please the study doctor or the research staff.

If you decide not to let your child take part:

- Your child will not be in trouble or lose any rights he/she would normally have.
- You child will still get the same services he/she would normally have.

You can decide after signing this informed consent document that you no longer want your child to take part in this study. If you decide you want your child to stop taking part in the study, tell the study staff as soon as you can.

- We will tell you how to stop safely. We will tell you if there are any dangers if your child stops suddenly.

Even if you want your child to stay in the study, there may be reasons we will need to take her out of it. Your child may be taken out of this study if:

- We find out it is not safe for your child to stay in the study. For example, your child's health may get worse.
- Your child is not coming for the study visits when scheduled.

You can get the answers to your questions, concerns, or complaints.

If you have any questions, concerns or complaints about this study, call Amanda Privé, Ed.S., NCSP at 813-335-3012 or Linda Raffaele Mendez at 813-974-1255.

If you have questions about your child's rights, general questions, complaints, or issues as a person taking part in this study, call the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-9343.

Signature of Parent(s) of His/Her Consent for Child to Participate in this Research Study

It is up to you to decide whether you want your child to take part in this study. If you want your child to take part, please read the statements below and sign the form if the statements are true.

I freely give my consent to let my child take part in this study. I understand that by signing this form I am agreeing to let my child take part in research. I have received a copy of this form to take with me.

_____ _____

Signature of Parent of Child Taking Part in Study Date

_____

Printed Name of Parent of Child Taking Part in Study

_____ _____

Signature of Parent of Child Taking Part in Study Date

_____

Printed Name of Parent of Child Taking Part in Study

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person signs this form, to the best of my knowledge, he or she understands:

- What the study is about.
- What procedures/interventions/investigational drugs or devices will be used.
- What the potential benefits might be.
- What the known risks might be.

I also certify that he or she does not have any problems that could make it hard to understand what it means to take part in this research. This person speaks the language that was used to explain this research. This person reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her.

This person does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give informed consent.

This person is not taking drugs that may cloud their judgment or make it hard to understand what is being explained and can, therefore, give informed consent.

_____ _____

Signature of Person Obtaining Informed Consent Date

_____

Printed Name of Person Obtaining Informed Consent

Appendix G
Field Notes

Bracketing Interview:

Date: 5/2/07

Thoughts:

Q: How are you feeling?

A: I am excited about this interview because I want to know what my pre-conceived notions are about cutting. I have never written them down before. I also really wonder what the girls are going to say. I think they might say that they wanted to relieve stress or tension and that's why they cut, but I don't really know. What am I going to do if they cannot remember how they felt or what it felt like to cut?

Q: What pre-conceived notions do you have?

A: My pre-conceived notions do not really matter. I will listen with an open mind and let the girls talk to me without judging them. I have to do this in counseling all the time. The difference is in counseling, I do counsel them and in this I can't. That will be the hardest part. The main thing that I have to focus on is not asking them any leading questions. I really just want to hear what they think about their experiences, not what researchers, who have never cut, have said in the past. I have always wondered why someone would cut. Sometimes when I am reading about it and watching movies about it, it disturbs me. Other times it sounds intriguing and I wonder what it would actually feel like on my skin. These times scare me. I think that girls just get addicted to the feeling and the process. It is scary. Some movies and books glamorize it and make it sound exciting, and this would make girls want to try it. I can definitely see why young girls, who are very easily swayed, would try this behavior especially if their friends are talking about how it helps them relieve stress.

The purpose of this bracketing interview was to identify any preconceived notions she has about the topic and to allow her to identify and acknowledge her own ideas (i.e., emotions, thoughts, and feelings) about self-cutting. Further, this helped protect her from imposing her own personal views on her co-researchers' descriptions.

Jasmine:

First Meeting Co-researcher #1: 5-10-07

Location of Meeting: at the co-researcher's school

Been in therapy: no

Notes: Wow, Jasmine really prepared her answers. She read over the questions ahead of time and knew exactly what she wanted her answer to be. She even told me that she was going to bring be a written document with more stuff on it after she thought about if she realized she forgot anything. I hope all the girls are as easy to interview as Jasmine.

Second Meeting Co-researcher #1: 5-14-07

Notes: Jasmine agreed with everything I transcribed and thanked me for interviewing her. I told her that it is me who should be thanking her. She made this process so much easier. She was awesome.

Shelly:

First Meeting Co-researcher #2: 5-11-07

Location of Meeting: at the co-researcher's school

Been in therapy: yes

Notes: Wow, this interview was a lot harder than the first one. Getting her to explain and expand was like pulling teeth. I hope I got enough information. I can tell that these interviews are going to be hard to listen too. I almost had a tear in my eye in this one and she barely said anything. The events in her life make this one hard to hear.

Second Meeting Co-researcher #2: 5-14-07

Notes: Shelly agreed with everything that I transcribed and helped me to understand her experience a little better at this meeting. I really hope therapy starts to help her over the summer. If not, she may be out of a place to live soon.

Brielle:

First Meeting Co-researcher #3: 5-11-07

Location of Meeting: at the co-researcher's school

Been in therapy: yes

Notes: Wow, this girl has had a lot happen to her, and it has really affected her self-concept in a variety of different domains and her self-esteem. Brielle really believes that her parents do not like her as much as her brother. That is very sad.

Second Meeting Co-researcher #3: 5-18-07

Notes: Brielle really agreed with everything that I showed her at the meeting today. I asked her if she wanted to add anything, and she said that I pretty much had it all there already. That was good to know.

Stephanie:

First Meeting Co-researcher #4: 5-15-07

Location of Meeting: at the co-researcher's school

Been in therapy: yes

Notes: Wow…Stephanie really believes that she has no one there to listen, but yet thinking about the people who care about her stops her from cutting. I wonder if these girls really use these strategies to not cut as much as they talk about them. I hope so.

Second Meeting Co-researcher #4: 5-17-07

Notes: Stephanie agreed with everything that I transcribed and she also felt like she said everything that she wanted to.

Jackwolynn:

First Meeting Co-researcher #5: 5-17-07

Location of Meeting: at the co-researcher's house

Been in therapy: yes

Notes: This interview was scarier than the others because I went to a house that I was not familiar with; however, it may be my best interview. Jackwolynn was the best at describing and articulating her thoughts and feelings about self cutting up to this point. I know I gained a lot of information from her. It was great!

Second Meeting Co-researcher #5: 5-21-07

Notes: Jackwolynn agreed with the transcriptions and did not have anything to add.

Gabrielle:

First Meeting Co-researcher #6: 5-23-07

Location of Meeting: at the co-researcher's school

Been in therapy: no

Notes: Gabrielle really expressed how much she enjoyed talking to me. Sometimes I do not think that I am making a difference with everything that I do, but she really made me feel important today. She said that talking to me about this really helped her understand why she was cutting. She believes that she now has other behaviors in her repertoire that she can do instead. That is great to hear.

Second Meeting Co-researcher #6: 5-24-07

Notes: Gabrielle agreed with everything that was transcribed and did not want to add anything to it. Today was the last day of school and she was very excited and sad at the same time. She really does not like going home and fighting so much with her mother. I really hope she stays exercising over the summer and continues to not cut anymore.

Appendix H

Thematic Analysis

A. Read and Reread the Transcription in its Entirety

B. Mark Off Tentative Thematic Units

   a. Identify “units of significant meaning” avoiding transition words <Bracket>

C. Chart Tentative Thematic Units

   a. Write units on a different piece of paper grouping them by “what fits together”

D. Clustering the Units

   a. Connect – chart the units by linking similar units together
   b. Check – check the chart against marked transcriptions for any missing units
   c. Group – group the themes that seem to “hold together”
   d. Number – number the themes on the chart and in the transcript as well
   e. Name – name the themes according to “sorting factors” – preserve the co-researchers’ words

E. Tally

F. Summary

   a. Summarize the speaker’s experience

G. Determine Reliability

   a. Compute the percentage of total agreement between two thematizers (Polkinghorne noted that a measure of reliability is determined when the researcher “checks back” with the co-researchers to make sure their expressions were captured fairly and accurately).

H. Consider Superordinate Structures

   a. A certain set of themes that occur across interviews

About the Author

The author of this dissertation is Amanda A. Privé. She was born and raised in Tampa, FL. She attended elementary, middle, and high school in Brandon, FL. After graduating high school in the top one percent of her class, she attended the University of South Florida and obtained a Bachelor's Degree with honors in psychology. After the completion of her undergraduate degree, she attended the University of South Florida and obtained her Master's and Educational Specialist's degrees in 2003 and 2006, respectively. With the completion of this dissertation, she will obtain her Ph.D. in school psychology on August 11, 2007. Amanda is a Nationally Certified School Psychologist and works for the Hillsborough County Public School District. She will obtain her Board Certified Associate Behavior Analyst certification in August of 2007 and will obtain her school psychology licensure in January of 2009.