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THE ROLE OF THE SOCIAL ENVIRONMENT IN NON-SUICIDAL SELF-INJURY  
AMONG LGBTQ YOUTH: A MIXED METHODS STUDY

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A Dissertation

Presented to

the Faculty of the Graduate School of Social Work

University of Denver

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

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by

Sarah J. Nickels

August 2013

Advisor: N. Eugene Walls, Ph.D.

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### **Abstract**

Non-suicidal self-injury (NSSI), such as cutting and burning, is a widespread social problem among lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth. Extant research indicates that this population is more than twice as likely to engage in NSSI than heterosexual and cisgender (non-transgender) youth. Despite the scope of this social problem, it remains relatively unexamined in the literature. Research on other risk behaviors among LGBTQ youth indicates that experiencing homophobia and transphobia in key social contexts such as families, schools, and peer relationships contributes to health disparities among this group. Consequently, the aims of this study were to examine: (1) the relationship between LGBTQ youth's social environments and their NSSI behavior, and (2) whether/how specific aspects of the social environment contribute to an understanding of NSSI among LGBTQ youth.

This study was conducted using an exploratory, sequential mixed methods design with two phases. The first phase of the study involved analysis of transcripts from interviews conducted with 44 LGBTQ youth recruited from a community-based organization. In this phase, five qualitative themes were identified: (1) *Violence*; (2) *Misconceptions, Stigma, and Shame*; (3) *Negotiating LGBTQ Identity*; (4) *Invisibility and Isolation*; and (5) *Peer Relationships*. Results from the qualitative phase were used to

identify key variables and specify statistical models in the second, quantitative, phase of the study, using secondary data from a survey of 252 LGBTQ youth. The qualitative phase revealed how LGBTQ youth, themselves, described the role of the social environment in their NSSI behavior, while the quantitative phase was used to determine whether the qualitative findings could be used to predict engagement in NSSI among a larger sample of LGBTQ youth. The quantitative analyses found that certain social-environmental factors such as experiencing physical abuse at home, feeling unsafe at school, and greater openness about sexual orientation significantly predicted the likelihood of engaging in NSSI among LGBTQ youth. Furthermore, depression partially mediated the relationships between family physical abuse and NSSI and feeling unsafe at school and NSSI. The qualitative and quantitative results were compared in the interpretation phase to explore areas of convergence and incongruence. Overall, this study's findings indicate that social-environmental factors are salient to understanding NSSI among LGBTQ youth. The particular social contexts in which LGBTQ youth live significantly influence their engagement in this risk behavior. These findings can inform the development of culturally relevant NSSI interventions that address the social realities of LGBTQ youth's lives.

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## Table of Contents

Chapter One: Introduction .....	1
Conceptual and Operational Definitions.....	2
Study Purpose .....	8
Significance of the Study.....	9
Relevance to the Social Work Profession.....	10
Chapter Summary .....	10
Chapter Two: Review of the Literature .....	12
Minority Stress Theory .....	12
Review of Literature on NSSI.....	21
NSSI among LGBTQ Youth.....	39
Summary of the Theoretical and Empirical Literature .....	50
The Current Study.....	51
Research Questions.....	52
Chapter Summary .....	52
Chapter Three: Methodology.....	54
Research Design.....	54
Qualitative Phase .....	55
Quantitative Phase .....	71
Human Subjects Protections .....	92
Chapter Summary .....	93
Chapter Four: Qualitative Results.....	94
Qualitative Sample Demographics .....	94
Results of the Qualitative Analysis.....	100
Chapter Summary .....	173
Chapter Five: Quantitative Results .....	175
Descriptive Statistics.....	175
Inferential Statistics .....	180
Chapter Summary .....	189
Chapter Six: Discussion.....	190
Summary of Findings.....	191
Limitations of the Study.....	219
Strengths of the Study.....	222
Theoretical Implications .....	223
Practice and Policy Implications.....	224
Implications for Social Work Education.....	230
Future Research .....	230
Conclusion .....	233

References.....	234
Appendix A.....	262
Appendix B.....	267
Appendix C.....	268



## List of Tables

Table 1	<i>Overview of Research on NSSI among LGBTQ Youth</i> .....	40
Table 2	<i>Crosswalk Comparing Qualitative Data and Survey Items</i> .....	73
Table 3	<i>Cases Missing Data on Independent and Dependent Variables</i> .....	80
Table 4	<i>Coefficient Matrix of Correlations among Independent Variables</i> .....	86
Table 5	<i>NSSI Methods Reported by Interview Participants</i> .....	99
Table 6	<i>Summary of Findings from Qualitative Analysis with Associated Codes</i> .....	100
Table 7	<i>Demographic Characteristics of Survey and Interview Participants</i> .....	176
Table 8	<i>NSSI Methods Reported by Survey Participants</i> .....	179
Table 9	<i>Logistic Regression Models Predicting NSSI among LGBTQ Youth</i> .....	181
Table 10	<i>Results of KHB Analysis Testing Depression as a Mediator between Social- Environmental Factors and NSSI</i> .....	186

## **Chapter One: Introduction**

In recent years, non-suicidal self-injury (NSSI) has gained attention from mental health professionals, researchers, community groups, and the media, and there is evidence that the behavior is widespread among youth (13-17) and young adults (18-25) (Whitlock, Eckenrode, & Silverman, 2006). It is estimated that between 13-26% of youth and young adults in the United States (U.S.) have engaged in NSSI at some point in their lives (Heath, Toste, Nedecheva, & Charlebois, 2008; Laye-Gindhu & Schonert-Reichl, 2005; Muehlenkamp & Gutierrez, 2004, 2007; Plener, Libal, Keller, Fegert, & Muehlenkamp, 2009; Ross & Heath, 2002; Whitlock et al., 2011).

Though limited research exists, it appears that NSSI is even more common among lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth and young adults. Research involving LGBTQ youth recruited from an LGBTQ youth organization found that between 39 and 47% had engaged in cutting, one form of NSSI, in the previous year (Nickels, Walls, Laser, & Wisneski, 2012; Walls, Hancock, & Wisneski, 2007; Walls, Laser, Nickels, & Wisneski, 2010). A different study involving a nationally representative sample found that LGBTQ high school students were significantly more likely than heterosexual and cisgender<sup>1</sup> students to report self-harm in the previous year (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009). Skegg, Nada,

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<sup>1</sup> A cisgender person is one who experiences congruence between the sex she or he was assigned at birth and her or his gender identity. This word is used in place of “non-transgender” (Nadal, Skolnik, & Wong, 2012) in an effort to “de-centralize [cisgender people] as the dominant group” (Koyama, 2002).

Raya, Dickson, Paul, and Williams (2003) reported a similar trend among young adults. Their findings indicated that the risk of engaging in NSSI was positively associated with an increasing degree of same-sex attraction.

While a few studies have demonstrated higher prevalence rates of NSSI among LGBTQ youth, it remains unclear why this is the case. Research on other psychosocial risks among this group indicates that the social environment in which LGBTQ youth grow up may contribute to this disparity. Studies have found that the psychological, developmental, and social challenges of living in a homophobic and transphobic social environment adversely impact LGBTQ youth's mental health and behavior (Anhalt & Morris, 1998; Peters, 2003; Thompson & Johnston, 2003). These findings raise the question of what role the social environment might play in LGBTQ youth's NSSI behavior and indicate a need for further exploration of this topic. Furthermore, scholars in the field have noted the lack of research on the relationship between social-environmental factors and NSSI among LGBTQ youth (e.g., Deliberto & Nock, 2008; McDermott & Roen, 2012). These researchers have emphasized the need to advance knowledge in this area by exploring social characteristics and processes that may contribute to greater NSSI risk among LGBTQ youth.

### **Conceptual and Operational Definitions**

**Non-suicidal self-injury.** NSSI is defined as “the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned” (International Society for the Study of Self-Injury [ISSI], 2007, para. 2). NSSI is used interchangeably in the literature with terms such as self-injurious behavior, self-mutilation, and auto-aggression and is often conceptualized as fitting under the

umbrella term *deliberate self-harm*, which includes self-injury with suicidal intent (Heath, Ross, Toste, Charlebois, & Nedecheva, 2009). The term NSSI will be used for the purposes of this study in order to explicitly differentiate NSSI from self-harm where death is the intended outcome (Jacobson & Gould, 2007, 2009; Lofthouse & Yager-Schweller, 2009). NSSI is also distinct from socially sanctioned behaviors such as piercing and tattooing (ISSI, 2007; Whitlock, 2010).

The most common NSSI behaviors are cutting, scratching, burning, and self-hitting (Nixon, Cloutier, & Jansson, 2008; Ross & Heath, 2002; Whitlock et al., 2006). Other examples of NSSI include pinching oneself, banging oneself against walls or other objects, and ingesting harmful substances. The preponderance of evidence suggests that the majority of youth who engage in NSSI employ more than one method (Claes, Houben, Vandereycken, Bijttebier, & Muehlenkamp, 2010; Glenn & Klonsky, 2009; Lloyd-Richardson, Perrine, Dierker, & Kelly, 2007; Whitlock et al., 2006).

Researchers vary in terms of whether they classify risky behaviors such as substance abuse, reckless behavior, and eating disorders as NSSI (Jacobson & Gould, 2009; Nixon et al., 2008; Ross & Heath, 2002), which makes it difficult to compare methods and prevalence rates across studies. Nock (2010) argued that these types of risky behaviors are qualitatively different from NSSI because self-harm is a secondary consequence rather than a primary motivation. He suggested that these behaviors should be labeled as “self-damaging,” “self-defeating,” or “unhealthy,” but not as NSSI (p. 342). In the current study, some youth who participated in the qualitative interviews characterized these kinds of risky behaviors as NSSI. Since the aim of the qualitative component of the study was to understand the phenomenon from LGBTQ youth’s own

perspectives, I utilized a broad definition of NSSI that included substance abuse, reckless behavior, and eating disorders when youth described engaging in these behaviors *in order to cause harm or injury to themselves*. Notably, all interview participants who reported one or more of these risky behaviors had also engaged in behaviors more commonly understood to be NSSI, such as self-cutting and self-burning. The NSSI methods reported by participants in each phase of this mixed methods study will be described in further detail in subsequent chapters of this dissertation.

**Lesbian, gay, bisexual, transgender, queer, and questioning youth.** The terms or “labels” used to describe the identities of people who live in the margins of U.S. society are sometimes political and often contested (Young, 2000). As such, the terms that are ascribed to and adopted by people who are marginalized based on their sexual orientation and/or gender identity are continually in flux in relation to personal, cultural, social, historical, and geographic shifts. For the purpose of this study, I have adopted the terms *lesbian, gay, bisexual, transgender, queer, and questioning* to describe six distinct identities. I will utilize the acronym “LGBTQ” when referring to people who are marginalized based on their sexual orientation and/or gender identity as a group. It is critical to emphasize that there is no one label or set of labels that are universally embraced by LGBTQ people and that, for some, the very process of labeling is problematic. I selected these terms because they are widely used among youth and adults in community, education, and research settings to describe sexual orientations and gender identities.

Next, I will outline definitions for each of the terms in order to create a common understanding among readers. The term *lesbian* is used to describe a woman whose

primary sexual, emotional, and physical attraction is to other women (Sonnie, 2000). Similarly, the term *gay* refers to a man who is primarily sexually, emotionally, and physically attracted to other men (Sonnie, 2000). The word *bisexual* refers to a person who experiences attraction to people of any sex or gender (Sonnie, 2000). *Transgender* refers to a person whose gender identity differs from the sex they were assigned at birth (Sonnie, 2000). The term *queer* has historically been used as a hateful slur against LGBTQ people; thus, there is considerable generational, cultural, and geographical variation among those who adopt or reject this label. In recent decades, some have reclaimed the term *queer* as both a personal and political identity that embraces the complexity and fluidity of gender and sexuality and rejects binary social norms (Sonnie, 2000). *Queer* is also used as an umbrella term to refer to LGBTQ people that can be used in place of cumbersome acronyms (i.e., “I am part of the queer community;” Sonnie, 2000). Finally, the word *questioning* is used to describe someone who is unsure about one’s sexual orientation and/or gender identity and may be in the process of exploring these aspects of their identity (United States Department of Health and Human Services, 2013).

An important consideration related to these terms and definitions is the distinction between sexual attraction, behavior, and identity. Youth may experience same-sex attraction and engage in sexual behavior with someone of the same sex, but may not label themselves as lesbian, gay, or bisexual (Savin-Williams, 1994, 2001; Thompson & Johnston, 2003). This can be attributed to multiple factors, including: (a) the possibility that youth have not yet labeled their sexual attraction or behavior, (b) the desire to avoid the social stigma associated with identifying with a marginalized sexual identity, (c) the

dynamic and fluid nature of sexual orientation, and (d) the rejection of labels due to their political and social ramifications (Savin-Williams, 2001). Similarly, a youth may identify as LGBTQ, but may not have engaged in sexual behavior with someone of the same sex.

Given these complexities, researchers vary widely in how they define and measure these dimensions of sexuality (Savin-Williams, 1994, 2001). My decision to use the terms lesbian, gay, bisexual, queer, and questioning to describe sexual orientation in this study was informed by the way in which the construct was measured in the qualitative and quantitative data. In both datasets, youth were asked to describe or select the term(s) they used to self-identify their sexual orientation. Therefore, the data captured the dimension of LGBTQ *identity* more so than attraction or behavior.

**Social environment.** The profession of social work emphasizes the importance of understanding human behavior within the social environment (Council on Social Work Education [CSWE], 2008; Miley, O'Melia, & DuBois, 1998; National Association of Social Workers [NASW], 2008). Drawing from ecosystems theory (Germain & Gitterman, 1995, 1996), a person's *social environment* can be conceptualized to include social systems (i.e., families, neighborhoods, schools, organizations, etc.) and contextual influences (i.e., stereotypes, power dynamics, values, etc.; Miley et al., 1998). Social work research and practice focus on the dynamic interactions between individuals and their social environments in order to enhance well-being and promote social change (Miley et al., 1998; NASW, 2008).

**Homophobia, transphobia, and heterosexism.** LGBTQ people in the U.S. face widespread prejudice and discrimination based on their sexual orientation and/or gender

identity. These forms of prejudice and discrimination against LGBTQ people are rooted in several interlocking systems of oppression: homophobia, transphobia, and heterosexism. *Homophobia*, in the most basic sense, is defined as the fear of gay, lesbian, and bisexual people or those who are perceived to have a sexual identity other than heterosexual (Herek, 2004; Morrow, 2006). In practice, homophobia is a system of attitudes and actions rooted in the belief that heterosexuality is “normative and desirable,” while being LGBTQ is abnormal and deviant (The National Center for Victims of Crime and the National Coalition of Anti-Violence Programs, 2010, p. 4). Similarly, *transphobia* refers to “attitudes, beliefs, and behaviors that devalue, stigmatize, or render invisible...transgender people and gender-variant modes of expression” (Elze, 2006, p. 52). Finally, Herek (1990) defined *heterosexism* as “an ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship or community” (p. 316).

Homophobia, transphobia, and heterosexism are embedded into all levels of society and manifest in overt and covert ways. At the individual level, LGBTQ people are perceived to violate social norms and are stereotyped as deviant, immoral, mentally ill, and criminal (Herek, 1991; Herek, Chopp, & Strohl, 2007). At the institutional level, LGBTQ people are denied basic civil rights and are subjected to exclusionary policies (Herek, 1991, 2004; Herek et al., 2007). At the cultural level, homo/transphobia and heterosexism are used to legitimize discrimination and violence against LGBTQ people. Herek (2004) argued that, once heterosexism constructs LGBTQ people as a threat to traditional norms and values, “hostility, discrimination and violence are thereby justified as appropriate and even necessary” (p. 15). Thus, within a heterosexist social system, the



negative treatment of LGBTQ people is considered to be necessary and instrumental to protecting traditional values (Herek, 2004).

It is critical to emphasize that homophobia, transphobia, and heterosexism intersect in complex ways with other forms of oppression (Crenshaw, 2003; Lorde, 1983). Thus, the social environments in which LGBTQ youth live and the experiences they have within those environments are influenced not only by their sexual orientation and gender identity, but also by other dimensions of identity, such as race, class, citizenship status, ability, and age. This points to the importance of conducting research with diverse LGBTQ youth that considers the intersectionality of their privileged and oppressed social identities (Crenshaw, 2003).

### **Study Purpose**

The purpose of this exploratory, sequential, mixed methods study was to address a gap in the knowledge base by examining the role of the social environment in NSSI behavior among LGBTQ youth. Few studies on NSSI have included LGBTQ youth and those that have included this population have not explicitly explored the influence of the social environment on NSSI behavior. The first phase of the study involved qualitative analysis of interview transcripts conducted with LGBTQ youth recruited from a community-based organization. The focus of the qualitative phase was to understand how LGBTQ youth described the relationship between NSSI and their social environment in their own words. The themes that emerged from the qualitative analysis were then used to develop and test quantitative research questions using survey data collected from a larger sample of LGBTQ youth from the same community-based organization. The second, quantitative, phase of the study aimed to determine whether

the social-environmental factors identified in the qualitative phase could predict engagement in NSSI among a larger sample of LGBTQ youth.

This research design privileged the qualitative phase of the study because extant research has not fully examined and identified salient social-environmental factors that might influence NSSI among LGBTQ youth. Therefore, this design was intended to draw from the voices of those who directly experienced the phenomenon to identify salient constructs and test whether these constructs would be significantly related to NSSI among a larger sample of LGBTQ youth (Creswell & Plano Clark, 2011).

### **Significance of the Study**

This study has the potential to contribute to research and practice in several areas. First, it can inform the growing body of research on NSSI among youth by focusing on the behavior among a high risk and under-represented group of young people. Second, this study can advance research on the individual and social factors that contribute to risk and resilience among LGBTQ youth. Third, this study is unique in that it aimed to understand NSSI behavior within a social context. Traditionally, NSSI researchers have applied a psychological or medical lens to the phenomenon that tends to focus on individual rather than social processes (Adler & Adler, 2007; McDermott & Roen, 2012). An additional contribution of this study is that it utilized a mixed methods design that recognized LGBTQ youth as experts on their own experiences. Since so little is known about the social environment of NSSI among LGBTQ youth, it is important to begin to understand the topic from the perspective of those who experienced it. Finally, this research has the potential to inform the development of culturally relevant NSSI interventions with a population of youth that are at greater risk for the behavior.

## **Relevance to the Social Work Profession**

Social work researchers and practitioners have an investment in gaining a deeper understanding of NSSI among LGBTQ youth. Among this population, NSSI has been associated with a range of other health, mental health, and behavioral risk factors, such as depression, suicide attempts, and victimization (Liu & Mustanski, 2012; Walls et al., 2010). Social workers and other helping professionals need to understand the relationships between NSSI and these risk factors in order to inform appropriate assessment, intervention, and prevention efforts with LGBTQ youth. Yet, in order to develop a holistic understanding of and response to this social problem, our profession needs to look beyond individual-level factors to examine the role of the social environment in NSSI. Due to our professional focus on the person-in-environment perspective as well as addressing oppression that affects marginalized groups (CSWE, 2008), social workers are well positioned to advance knowledge about the social context of NSSI among LGBTQ youth and develop effective interventions to address this behavior.

## **Chapter Summary**

This chapter provided an introduction to the social problem of NSSI among LGBTQ youth. Relevant concepts were defined and discussed in order to create a common understanding among readers. The current study aims to focus on the role of the social environment in NSSI behavior among this population of youth. Placing NSSI within a social context is an important step for research on NSSI as well as research on LGBTQ youth (Horn, Kosciw, & Russell, 2009). Though the current study is exploratory by design, it has the potential to inform further research and intervention with LGBTQ

youth who engage in NSSI. The following chapter will provide a review of the literature related to the social problem and will also present the theoretical framework that informed the current study.

## **Chapter Two: Review of the Literature**

This chapter will provide a review of the theoretical and empirical knowledge that informed this study of NSSI among LGBTQ youth. The chapter will begin with a discussion of minority stress theory, a conceptual framework that has been widely used to understand the social context of psychosocial risk among LGBTQ youth. Subsequently, the chapter will review the literature related to the phenomenology of NSSI among general youth populations, followed by a similar overview of research on the behavior among LGBTQ youth. This examination of the extant research will reveal gaps in the knowledge base about this social problem and provide a rationale for the topic and design of the current study. The chapter will conclude with a discussion of the aims and research questions that directed the current study.

### **Minority Stress Theory**

Over the past several decades, researchers have identified numerous disparities in the physical and mental health of LGBTQ youth compared to their heterosexual and cisgender peers (The Institute of Medicine [IOM], 2011). Scholars have emphasized that the problems experienced by LGBTQ youth are not indicative of inherent pathology or dysfunction (McDermott & Roen, 2012; Thompson & Johnston, 2003). Rather, these problems appear to be related to the unique social context in which LGBTQ youth navigate the developmental tasks of adolescence (Elze, 2002; IOM, 2011). LGBTQ youth are exposed to homophobia, transphobia, and heterosexism within key social

systems including families, peers, schools, religious institutions, and the media (Almeida et al., 2009; McDermott & Roen, 2012). The challenges of growing up in a social context that marginalizes them can negatively impact LGBTQ youth's sense of self and overall well-being, contributing to disparate health outcomes (Savin-Williams, 1994; Thompson & Johnston, 2003).

One conceptual framework that has been widely used to describe the relationship between sexual minority status, the social environment, and health disparities is minority stress theory (Brooks, 1981; DiPlacido, 1998; IOM, 2011; Meyer, 1995, 2003, 2007). In fact, the Institute of Medicine (2011) incorporated a minority stress lens in their recent groundbreaking report on LGBT health and recommended that the theory be applied in future research. In the following discussion, I will describe the history and key tenets of minority stress theory, review the empirical literature related to the theory, and outline the potential benefits of applying minority stress theory to research on NSSI among LGBTQ youth.

Minority stress theory draws from multiple theoretical areas, including social psychology and symbolic interaction theory, as well as theories concerning the impact of prejudice and stigma (e.g., Goffman, 1963) on individuals and groups (Meyer, 2003). Minority stress research initially focused on women, low-income people, and people of color and has demonstrated a relationship between social stigma and health problems among these marginalized groups (Meyer, 2003). Brooks (1981) was the first to adapt the theory to describe the experiences of sexual minorities in her research on health disparities among lesbian and bisexual women. Meyer (1995, 2003) expanded upon Brooks' (1981) work to develop an LGB-specific model of minority stress, which

integrated stress theory and research to explain health disparities among sexual minorities.

The central tenet of minority stress theory is that people from oppressed groups experience “unique,” “chronic,” and “socially based” stress as a result of their stigmatized social position (Meyer, 2003, p. 243). Minority stressors such as prejudice, discrimination, and violence create excess stress above and beyond typical life events (DiPlacido, 1998; Meyer, 2003, 2007). This theory suggests that exposure to minority stress in addition to general life stressors can overwhelm an individual’s coping abilities and can contribute to poor mental and physical health among people from stigmatized groups (Meyer, 2003, 2007). Minority stress theory aligns with a person-in-environment approach (Meyer, 2003) typically used in social work in that it focuses on ways in which an individual’s social context influences their stress and health.

In his theoretical model, Meyer (2003) delineated four specific types of minority stress that impact sexual minorities: (1) “prejudice events” such as anti-gay discrimination and violence, (2) constant anticipation of stressful external events, (3) managing privacy and disclosure of one’s sexual orientation, and (4) internalization of homophobic social beliefs and attitudes. Prejudice events are stressors that occur externally to an LGB person, while the other three types are considered to be internal stressors that are contingent upon an individual’s subjective appraisal (DiPlacido, 1998; Meyer, 2003). According to this model, experiencing external stressors contributes to internal stressors. Further, the more stressors a person experiences, the greater the impact on their mental health and coping (Meyer, 2003). Meyer (2003) also hypothesized that coping strategies, social support, and salience and integration of LGBT identity would act

as “stress-ameliorating factors” in the model. Thus, he proposed that these factors moderate the relationship between sexual minority status and health outcomes.

Scholars have suggested that LGBTQ youth are particularly vulnerable to experiencing minority stress (DiPlacido, 1998; Meyer, 2003; Rosario, Rotheram-Borus, & Reid, 1996; Vanden Berge, Dewaele, Cox, & Vinke, 2010; Waldo, Hesson-McInnis, & D’Augelli, 1998). In addition to the typical stressors of adolescence, LGBTQ youth experience “gay-related stress” such as negotiating self-disclosure, rejection from family and friends, and exposure to anti-LGBTQ violence (Elze, 2002; Rosario et al., 1996). LGBTQ youth are also more likely than LGBTQ adults to be isolated from positive role models and a supportive LGBTQ community (DiPlacido, 1998; Waldo et al., 1998). Experiencing minority stress coupled with lower social support may tax LGBTQ youth’s coping mechanisms and contribute to psychological distress (Rosario et al., 1996; Vincke & Van Heeringen, 2002).

**Empirical research on minority stress among LGBTQ youth.** A growing body of research provides support for minority stress theory by demonstrating the association between stigma, stress, and psychosocial problems among LGBTQ youth. Rosario and colleagues (1996) were among the first to explore the role of “gay-related stressful life events” among youth samples. In their study of racially diverse gay and bisexual male youth, experiencing gay-related stressful life events was positively associated with depression, drug use, conduct problems, and risky sexual behavior (Rosario et al., 1996). This study offers some empirical evidence for the association between the stressors of living in a heterosexist society and health disparities among gay and bisexual youth.



Many studies have shown that external minority stressors such as anti-LGBTQ violence and discrimination are associated with mental health issues among youth (e.g., D'Augelli, Pilkington, & Hershberger, 2002; Hershberger & D'Augelli, 1995; Kelleher, 2009; Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012; Savin-Williams, 1994; Williams et al., 2005). Within that body of literature, the studies that provide the strongest evidence for minority stress theory are those that examined discrimination or violence as mediators between LGBTQ status and poor health outcomes. For example, longitudinal research by Toomey and colleagues (2010) found that exposure to anti-LGBTQ violence fully mediated the relationship between being gender non-conforming in high school and later psychological distress among LGBTQ young adults. These findings support minority stress theory in that it was not the minority status but the minority stressor that accounted for psychological problems later in life among LGBTQ young adults. Furthermore, these authors found that experiencing school violence for other reasons (i.e., race, weight, etc.) was not significant in the model, suggesting that exposure to LGBTQ-specific violence rather than violence for other reasons was associated with subsequent distress (Toomey, Ryan, Diaz, Card, & Russell, 2010). Another study had similar findings whereby the relationship between sexual orientation and psychosocial problems was no longer significant when controlling for experiencing violence and social support (Williams et al., 2005). Though anti-LGBTQ discrimination has received less attention than anti-LGBTQ violence, this form of external minority stress has also been found to be a significant mediator between LGBT status and depression among youth (Almeida et al., 2009). Taken together, these findings provide

evidence that external minority stressors play an important role in understanding psychosocial problems among LGBTQ youth beyond minority status alone.

Research has also demonstrated a relationship between internal minority stressors and poor health outcomes among LGBTQ youth. These are the psychological and cognitive stressors associated with having a stigmatized identity, such as fear of being “outed” and internalized homophobia (DiPlacido, 1998; Meyer, 2003; Wright & Perry, 2008). Kelleher (2009) found that expectations of rejection and distress about sexual orientation and gender identity, along with anti-LGBTQ harassment and discrimination, significantly predicted psychological distress among LGBTQ and questioning youth. Another study conducted with LGB youth and young adults in Belgium found that internalized homophobia and awareness of social stigma were significant predictors of depression (Vanden Berge et al., 2010). Further, Waldo and colleagues (1998) aimed to empirically test minority stress theory in a sample of LGB youth. These authors concluded that “heterosexist victimization” was not directly associated with poor psychological outcomes among LGB youth, but that victimization predicted low self-esteem, which was associated with psychological distress (Waldo et al., 1998). Since this study was cross-sectional in nature, no conclusions could be drawn about directionality or causality. The findings across these studies suggest that exposure to and internalization of social stigma contributes to mental health disparities among LGBTQ youth.

Notably, one longitudinal study did not find evidence of the link between gay-related stressors and future emotional distress among LGB youth (Rosario, Schrimshaw, Hunter, & Gwadz, 2002). This finding indicates that researchers should determine whether the relationships that have been found in cross-sectional studies remain

significant when examined over time (Rosario et al., 2002). The study's authors also suggested that more work is needed to refine the measurement of gay-related stressors in order to improve the reliability and validity of research in this area (Rosario et al., 2002).

Overall, the preponderance of research on minority stress among LGBTQ youth demonstrates that stigma-related stress is associated with negative health, mental health, and behavioral issues. These relationships hold true for both external (e.g., anti-LGBTQ violence) and internal (e.g., distress about sexual orientation and gender identity) stressors, as suggested by Meyer's (2003) minority stress model. However, given the overreliance on cross-sectional survey research in this area, it is not yet possible to determine causality in these relationships. Further research is needed to explore the processes by which social stigma, minority stress, and health disparities are connected among LGBTQ youth (Hatzenbuehler, 2009; Meyer, 2003).

**Limitations of minority stress theory.** Minority stress theory has proven to be a useful framework for understanding psychosocial risk among LGBTQ youth. However, there are limitations to the theory that must be considered. One concern about this theory relates to the potential for casting LGBTQ youth as helpless victims. Minority stress theorists have been critiqued for focusing on the vulnerability of marginalized groups rather than highlighting their resilience (Meyer, 2003). In response, Meyer (2003) acknowledged the importance of exploring both risk *and* protective factors that contribute to and mitigate the negative effects of minority stress. However, he argued that a focus on resilience and coping may have unintended consequences (Meyer, 2003). He explained:

The peril lies in that the weight of responsibility for social oppression can shift from society to the individual. Viewing the minority person as a resilient actor may come to imply that effective coping is to be expected from most, if not all, of those who are in stressful or adverse social conditions. Failure to cope, failure of resilience, can therefore be judged as a personal, rather than societal, failing. (Meyer, 2003, p. 691)

Researchers and practitioners who are interested in supporting LGBTQ youth should be aware that minority stress theory, like all theories, has particular social and political implications. These implications must be carefully considered in terms of how they will impact LGBTQ youth and the social environments in which they live.

Another concern about minority stress theory is that its application to transgender, questioning, and queer people is relatively unexamined. Meyer's (2003) conceptual model of minority stress was developed to describe the experiences of lesbian, gay, and bisexual people. It does not explicitly include others within the LGBTQ community who may differ from LGB people with regard to social stigma, stress, mental health and behavior. Meyer (2007) suggested that additional minority stressors could be added to the model to account for the experiences of particular subgroups of the LGB community, though he has not explored this further. Although the model itself has not been expanded to include all members of the LGBTQ community, researchers have applied the model to diverse samples, including transgender and questioning youth (e.g., Kelleher, 2008; Toomey et al., 2010). Further research is needed to determine whether there are unique minority stressors that impact the health of transgender, queer, and questioning youth.

**Contributions of minority stress theory to the social problem.** Minority stress theory has several implications for understanding NSSI among LGBTQ youth. First, this theory may help explain why, based on the available evidence, LGBTQ youth may be

more likely than heterosexual and cisgender youth to engage in NSSI. Minority stress theory posits that LGBTQ youth experience stigma related to their sexual orientation and/or gender identity and, thus, grow up in a social environment that labels them as abnormal and deviant (Herek, 2004; Herek et al., 2007; Meyer, 2003). Therefore, the elevated rates of NSSI among LGBTQ youth might be, in part, associated with the added stressors of living in a social environment in which they are marginalized.

Applying this theory to NSSI also brings a new perspective to research that has historically viewed the behavior from medical and psychological lenses (McDermott & Roen, 2011). Rather than focusing on individual psychopathology, minority stress theory highlights the role of the social environment as a key influence on the health and well-being of LGBTQ youth. The emphasis of understanding risk within a social context makes this theory a good fit for social work values and ethics and has important implications for intervention. For example, when using this theory, researchers and practitioners would be called to explore the ways in which LGBTQ youth's NSSI behaviors are related to their experiences with social stigma as well as the internalization of that stigma. Similarly, intervention strategies would focus not only on the individual, but also on the environment(s) in which the youth experiences stigma and stress.

Finally, viewing NSSI among LGBTQ youth through the lens of minority stress theory allows for the consideration of youth's multiple oppressed identities. People with multiple minority identities typically experience unique stressors related to each identity, which may place them at even higher risk for poor coping, health, and behavioral outcomes (Brooks, 1981; Rosario et al., 1996). An understanding of the intersection of oppressions could inform culturally competent services for subpopulations of LGBTQ

youth based on differences in race/ethnicity, social class, HIV status, and other social categories.

Very few studies have explored the potential role of minority stress in NSSI among LGBTQ youth. Findings from one quantitative study offer preliminary evidence that stress plays a role in NSSI behavior among LGBTQ youth. This study found that homeless LGBTQ youth reported higher levels of “street stress,” “family stress,” and “peer/partner stress” as compared to non-LGBTQ homeless youth (Moskowitz, Stein, & Lightfoot, 2012). Further, these forms of stress partially mediated the relationship between LGBTQ identity and recent NSSI behavior (Moskowitz et al., 2012). Although this study did not specifically examine minority stress *per se*, it is reasonable to assume that prejudice, discrimination, and violence against LGBTQ people might intersect with all three forms of stress examined in the study. Additionally, in several qualitative studies that explored these subjects, LGBT youth described engaging in self-destructive behaviors (including self-harm) as a way to manage the shame and distress associated with homophobia in their social environment (McDermott, Roen, & Piela, 2013; McDermott, Roen, & Scourfield, 2008; Scourfield, Roen, & McDermott, 2008). Although there is currently little evidence that minority stress plays a role in NSSI, research on other health risks among LGBTQ youth suggests that further exploration is warranted.

### **Review of Literature on NSSI**

**Prevalence, onset, and course.** Research suggests that up to 4% of the general adult population has engaged in NSSI (Klonsky, Oltmanns, & Turkheimer, 2003), with rates as high as 25% among clinical populations (Briere & Gil, 1998). Although the

majority of studies of NSSI have focused on adults (Bakken & Gunter, 2012), a growing body of research on NSSI among adolescents and young adults suggests that they are at increased risk of NSSI as compared to adults. Research involving community samples found that between 13-26% of high school students (Laye-Gindhu & Schonert-Reichl, 2005; Muehlenkamp & Gutierrez, 2004, 2007; Plener et al., 2009; Ross & Heath, 2002) have engaged in NSSI at least once during their lifetime. One study by Lloyd-Richardson et al. (2007) found an NSSI prevalence rate as high as 46.5% among high school students. Research on older adolescents and young adults in university samples reported lifetime prevalence rates ranging from 12-17% among these groups (Heath et al., 2008; Whitlock et al., 2006, 2011). Rates are highest among clinical samples of youth and young adults, with an estimated 40-60% engaging in NSSI (Darche, 1990; DiClemente, Ponton, & Hartley, 1991).

As evidenced by the wide range of estimates in the literature, it is difficult to provide reliable data on the prevalence of NSSI. Inconsistency in the terms and definitions used to measure this social problem make it difficult to compare results across studies (Bakken & Gunter, 2012; Heath, Schaub, et al., 2009; Laye-Gindhu & Schonert-Reichl, 2005; Nixon et al., 2008). For example, some studies do not clearly distinguish between NSSI and self-injury with suicidal intent (Lofthouse, Muehlenkamp, & Adler, 2008; Nixon et al., 2008). This is a limitation of the leading international study on self-harm, the Child & Adolescent Self-harm in Europe (CASE) Study (Madge et al., 2008), which measures “deliberate self harm” in a way that confounds the intent of the behavior (Nixon et al., 2008). Studies also differ in how they measure the recency of NSSI, which adds to variability in prevalence rates across the literature (Heath, Schaub, Holly, &

Nixon, 2009). Despite these limitations, the pattern of findings across studies indicates that NSSI occurs at high rates among youth.

Popular media portrayals of NSSI have contributed to the assumption that NSSI has been increasing in prevalence in recent decades (Heath, Schaub, et al., 2009; Ross & Heath, 2002). Scholars have argued that this claim has not been empirically proven (Heath, Schaub, et al., 2009; Nock, 2010; Ross & Heath, 2002). Any indication that NSSI is on the rise may be related to the increased social acceptability of disclosing and seeking help for this behavior rather than an actual increase in the behavior itself (Heath, Schaub, et al., 2009; Ross & Heath, 2002).

NSSI onset typically occurs in early to mid-adolescence between the ages of 12 and 14 (Heath, Schaub, et al., 2009; Muehlenkamp & Guterriez, 2004; Ross & Heath, 2002; Whitlock et al., 2006), though a sizable group reports initiating the behavior in late adolescence and during their college years (Heath et al., 2008; Whitlock et al., 2006). It is commonly stated that NSSI tends to peak in mid-adolescence and decline in adulthood, but this view has not been confirmed by existing data (Jacobson & Gould, 2007; Lofthouse & Yager-Schweller, 2009). Overall, very little is known about the course of NSSI over the lifespan due to the paucity of longitudinal research in this area (Jacobson & Gould, 2007; Nock, 2010).

**NSSI functions.** Recent scholarship on NSSI has focused on understanding the function of or motivation behind the behavior. Theoretical grounding is lacking in this area of research and few scholars have attempted to conceptualize a framework that provides insight into why people self-harm (Nock, 2010). Perhaps the most influential work in this area is Nock and Prinstein's (2004) functional approach to understanding



NSSI. These scholars found statistical evidence for a four-function model of NSSI that includes intrapersonal and interpersonal dimensions and positive and negative reinforcement of the behavior. The first function is *automatic-negative reinforcement* in which a person uses NSSI to regulate, minimize, or stop negative emotions or cognitions. The second function, *automatic-positive reinforcement*, refers to using NSSI as a means of stimulating desirable feelings or cognition, including using self-harm as a way to decrease numbness. *Social-negative reinforcement* is a function in which NSSI is used to avoid unpleasant interactions or undesirable responsibilities. Finally, *social-positive reinforcement* refers to using NSSI to communicate with or elicit a response from others, such as engaging in NSSI in an attempt at help seeking (Nock & Prinstein, 2004).

The automatic negative reinforcement function is the most commonly endorsed reason for engaging in NSSI across clinical and community samples of adolescents (Jacobson & Gould, 2007; Lloyd-Richardson, Nock, & Prinstein, 2009; Nock & Prinstein, 2004, 2005; Nock, Prinstein, & Sterba, 2009). The majority of youth report using NSSI to regulate emotions and manage negative thoughts and memories (Jacobson & Gould, 2007; Nock & Prinstein, 2004, 2005). Youth in clinical settings, particularly those diagnosed with post-traumatic stress disorder (PTSD) and major depressive disorder, commonly endorse the automatic positive reinforcement function of NSSI (Nock & Prinstein, 2005). This is not surprising since numbness and anhedonia are common features of these conditions (Nock & Prinstein, 2005). Social motivations for NSSI are less commonly cited but are nonetheless reported by a sizable portion of young people (Heath, Ross, et al., 2009; Lloyd-Richardson et al., 2007; Nock & Prinstein, 2004, 2005; Nock et al., 2009). Despite this evidence, there is concern that NSSI researchers

tend to overlook or minimize social functions of the behavior (Nock, 2008; Heath, Ross, et al., 2009). Scholars have suggested that this may be due to concerns about reinforcing the popular belief that youth engage in NSSI to get attention (Nock, 2008; Heath, Ross, et al., 2009).

Taken as a whole, the existing literature indicates that the reasons youth engage in NSSI are complex and multifaceted. The vast majority of youth endorse multiple functions of NSSI behavior across automatic and social domains (Heath, Ross, et al., 2009; Lloyd-Richardson et al., 2007; Nixon et al., 2008). Thus, it appears that many youth engage in NSSI to regulate their internal emotional states *and* influence or avoid people in their social environment (Lloyd-Richardson et al., 2009). In addition to the functions discussed above, youth have also reported other reasons for NSSI that are not easily categorized into the four-function model, such as self-punishment (Laye-Gindhu & Schonert-Reichl, 2005; Heath, Ross, et al., 2009), suicide avoidance (Nixon et al., 2008), and thrill seeking (Whitlock, 2010). Further research is needed to deepen our understanding of the function of NSSI among youth, including whether reasons for the behavior vary by age, population, context, or other variables (Lloyd-Richardson et al., 2009). Moreover, additional research is needed to determine whether NSSI interventions that target specific motivations are effective in decreasing the behavior (Heath & Nixon, 2009; Lloyd-Richardson et al., 2009; Nock & Prinstein, 2004).

**Demographic trends.** Based on research with clinical samples, NSSI has historically been considered a largely female phenomenon (Ross & Heath, 2002). More recent findings from community samples of youth suggest a more complicated picture. While some studies have found higher prevalence rates among females (e.g., Nixon et al.,

2008; Ross & Heath, 2002; Whitlock et al., 2011; Wichstrøm, 2009), others have found no significant differences based on gender (e.g., Borrill, Fox, Flynn, & Roger, 2009; Garrison, Addy, McKeown, Cuffe, Jackson, & Waller; 1993; Muehlenkamp & Gutierrez, 2004; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006).

These equivocal findings may be explained by evidence that males and females engage in different types of self-harm (Heath, Schaub, et al., 2009; Ross & Heath, 2002; Whitlock et al., 2006, 2011), have different motivations for NSSI (Laye-Gindhu & Schonert-Reichl, 2005; Whitlock et al., 2011), and differ in help-seeking patterns (Evans, Hawton, & Rodham, 2005). For example, females are more likely to engage in cutting and scratching as their primary form of NSSI, while males are more likely to hit objects (Whitlock et al., 2011). Therefore, typical assessments may more readily identify females' NSSI behavior, but ignore males' NSSI behavior or wrongly classify it as general aggressive behavior (Whitlock et al., 2011). Furthermore, a recent study by Bakken and Gunter (2012) found that there were both shared and different predictors of NSSI when comparing male and female high school students in the Northeastern U.S. For example, experiencing bullying and depression both significantly predicted NSSI among both male and female students in the study. However, substance use was only a significant predictor of NSSI among males and experiencing sexual assault was only significant among females. Each of these findings lends support to the idea that there may be theoretically meaningful "classes" of self-injurers, for which gender is a significant factor (Whitlock, Muehlenkamp, & Eckenrode, 2008).

There is a dearth of research on NSSI among transgender youth or adults. Only a handful of NSSI studies have explicitly included transgender youth (e.g., Liu &

Mustanski, 2012; Moskowitz et al., 2012; McDermott & Roen, 2011; Nickels et al., 2012; Walls et al., 2007, 2010). However, due to low statistical power, these studies have not reported results for transgender young people separately from LGB youth. One notable exception to this is a study by Walls et al. (2010), which found that transgender youth were more likely than cisgender lesbian, gay, and bisexual youth to engage in cutting. These preliminary data suggest a need for further examination of NSSI among this population.

Research on racial/ethnic differences in NSSI behavior has also been equivocal (Jacobson & Gould, 2007). Several studies have found that Whites are more likely than other racial groups to engage in NSSI (Kaminski et al., 2009; Muehlenkamp & Gutierrez, 2004, 2007; Ross & Heath, 2002) while others found no significant racial differences (Deliberto & Nock, 2008; Laye-Gindhu & Schonert-Reichl, 2005; Nock & Prinstein, 2004). Lloyd-Richardson et al. (2007) identified racial differences in terms of NSSI severity, with African Americans more likely than Whites to report minor NSSI severity and Whites more likely to report moderate to severe NSSI. These mixed findings indicate that further research is needed to clarify whether racial/ethnic differences exist and, as with gender, whether there are different patterns of NSSI among Whites and people of color.

The relationship between socio-economic status (SES) and NSSI has not been well studied (Jacobson & Gould, 2009). Similar to gender and racial/ethnic demographic trends, research findings pertaining to SES and NSSI behavior have been mixed. A few studies have found that lower SES was positively associated with NSSI risk among youth and young adults (Bureau et al., 2009; Nixon et al., 2008). However, other studies have

found no significant relationship between SES and NSSI (Laye-Gindhu & Schonert-Reichl, 2005; Lloyd-Richardson et al., 2007).

As described above, the demographic patterns of NSSI have not been well defined and warrant further research. Scholars have pointed to the need for the inclusion of NSSI variables in large-scale surveys involving representative samples in order to further our understanding of ways in which gender, race/ethnicity, SES, and other demographic characteristics may influence NSSI risk (Jacobson & Gould, 2007).

**Psychosocial correlates.** NSSI was originally conceptualized as a behavior that occurred primarily among adults diagnosed with borderline personality disorder and other serious mental illnesses (Heath, Schaub, et al., 2009). Therefore, initial research on NSSI correlates tended to focus on the psychiatric co-morbidity of NSSI among adults drawn from clinical settings (e.g., Dulit, Fyrer, Leon, Brodsky, & Frances, 1994; van der Kolk, Perry, & Herman, 1991). In recent years, scholars have begun to examine the etiology and characteristics of the behavior among community samples of adults and youth. Despite this shift to diversify the populations included in NSSI research, the focus has largely remained on psychological correlates of NSSI (Deliberto & Nock, 2008). Social factors influencing NSSI behavior have received relatively little attention in the field by comparison (Deliberto & Nock, 2008). Yet, extant research suggests that both intrapersonal and social factors are associated with NSSI behavior among youth (Heath, Ross, et al., 2009; Heilbron & Prinstein 2008). Therefore, the discussion below will review the literature on both psychological and social factors that have been found to be associated with the behavior.

***Mental health problems.*** NSSI has been associated with a myriad of psychological problems among youth. Across inpatient, outpatient, and community samples of youth, the mental health conditions most commonly correlated with NSSI behavior are depression and suicidality, followed by substance use, anxiety, and anger issues (Bakken & Gunter, 2012; Lloyd-Richardson et al., 2007; Lofthouse et al., 2008; Ross & Heath, 2002). Further, NSSI has been correlated with other psychiatric disorders, including PTSD (Shenk, Noll, & Cassarly, 2010), anti-social behavior (Laye-Gindhu & Schonert-Reichl, 2005), and features of borderline personality disorder (Jacobson, Muehlenkamp, Miller, & Turner, 2008; Nock et al., 2006), though the latter has been found primarily among clinical samples of youth. Youth who engage in NSSI have also been found to have poor self-concept, reporting low self-esteem (Brausch & Gutierrez, 2010; Claes et al., 2010; Weismore & Episoto-Smythers, 2010; Wichstrøm, 2009) and high levels of self-derogation (Klonsky & Glenn, 2009). NSSI behavior has also been associated with emotional dysregulation (Heath et al., 2008; Klonsky & Glenn, 2009; Linehan, 1993; Shenk et al., 2010) and difficulties coping with emotions and stressors (Mikolajczak, Petrides, & Hurry, 2009). It is not surprising then, that emotional regulation is the most commonly cited motivation for NSSI among youth (Gratz, 2003; Nock et al., 2009). Finally, disordered eating behaviors have also been found to co-occur with NSSI among youth and young adult populations (Whitlock et al., 2006; Wichstrøm, 2009).

This discussion about mental health correlates of NSSI among youth warrants a few cautions. The research described above indicates that there is considerable diagnostic heterogeneity among youth who engage in NSSI (Nock et al., 2006). To date,

researchers have not identified a clear pattern of clinical indicators for NSSI and it is possible that some of the statistical relationships between NSSI and other psychological issues are spurious (Jacobson & Gould, 2007). It is also important to note that, although youth who engage in NSSI are more likely than those who do not to experience these mental health issues, NSSI may still occur in the absence of other emotional problems (Whitlock, 2010). Additionally, the preponderance of studies in this area is cross-sectional, which inhibits understanding of causal pathways between NSSI and psychological problems among youth. Longitudinal studies are necessary in order to establish whether any causal relationships exist (Lofthouse et al., 2008). Given that much remains unknown about the relationships between NSSI and mental health issues among youth and other factors that may influence these relationships, further research is clearly needed.

***Suicidal behavior.*** A growing body of research has identified a consistent, positive association between NSSI and suicide attempts, and it is well documented that the two behaviors frequently co-occur (Glenn & Klonsky, 2009; Nock et al., 2006). In their review of 15 studies on NSSI and co-morbid psychiatric problems, Lofthouse and colleagues (2008) found that, among adolescents who engage in NSSI, between 48-74% of inpatient samples, 57-87% of outpatient samples, and 21-41% of community samples reported a previous lifetime suicide attempt.

Given the high rates of co-occurrence, NSSI and suicide attempts are clearly inter-related, yet there is a general consensus in the field that they are distinct behaviors (Nock et al., 2006). The primary distinctions between the two behaviors are motivation and intent (Lofthouse et al., 2008; Whitlock, 2010). Put simply, NSSI is intended to be a

temporary mechanism to cope with distress, while suicide is intended to result in a permanent end to life (Muehlenkamp & Gutierrez, 2004; Whitlock, 2010). The two behaviors also differ in severity and lethality (Glenn & Klonsky, 2009; Lofthouse et al., 2008). As compared to injuries sustained through NSSI, those sustained in a non-completed suicide attempt tend to be more severe and to require medical attention (Glenn & Klonsky, 2009; Lofthouse et al., 2008).

In recent years, scholars and clinicians have grappled with the apparent contradiction of the viewing NSSI and suicide attempts as simultaneously related and distinct. One perspective that appears to unite these seemingly disparate ideas is that NSSI and suicidal behavior are distinct behaviors that fall along a continuum of deliberate self-harm (Brausch & Gutierrez, 2010; Laye-Gindhu & Schonert-Reichl, 2005). Some have argued that the development of interventions that target NSSI may prevent movement along the continuum toward suicidal behavior (Brausch & Gutierrez, 2010; Laye-Gindhu & Schonert-Reichl, 2005).

Another grey area in the field is that NSSI is considered to increase risk for *and* protect against suicide attempts (Glenn & Klonsky, 2009; Whitlock, 2010). The data on co-occurrence discussed previously provide clear evidence that NSSI is a risk factor for suicidality. Yet, NSSI can also be seen as a strategy to protect against suicide, given that NSSI is most often used as a strategy for coping with or releasing negative emotions (Nock & Prinstein, 2004) that might otherwise lead someone to become suicidal (Klonsky, 2007). A community-based study by Laye-Gindhu and Schonert-Reichl (2005) provides some empirical support for this view. The authors found that 41% of high school students endorsed suicide prevention as a motivation and function of their



NSSI behavior. Once again, the continuum metaphor may help reconcile this apparent paradox. At one end of the continuum, a youth might engage in NSSI to minimize distress, which could temporarily relieve negative emotions and cognitions, thus preventing suicidal acts. However, if the emotional distress becomes more difficult to manage, a youth might move along the continuum, where suicide could become an option (Laye-Gindhu & Schonert-Reichl, 2005). Ultimately, these complexities emphasize the need for further research that examines the mechanisms and motivations for moving from NSSI toward self-harm with the intention to die (Nock et al., 2006).

***Childhood maltreatment.*** Research on environmental correlates of NSSI has focused primarily on the relationship between NSSI and childhood maltreatment (Gratz, Conrad, & Roemer, 2002). The most consistent finding among these studies has been a significant association between childhood sexual abuse (CSA) as a specific form of childhood maltreatment and NSSI behavior (e.g., Boudewyn & Leim, 1995; Briere & Gill, 1998; Glassman, Weierich, Hooley, Deliberto, & Nock, 2007; Gratz, 2003; Gratz et al., 2002; Kisiel & Lyons, 2001; Whitlock et al., 2006; Zoroglu et al., 2003).

Despite this pattern of findings, Klonsky and Moyer's (2008) meta-analysis of 43 studies concluded that there is relatively weak relationship between NSSI and CSA. These authors suggested that the relationship between CSA and NSSI in these studies was confounded because both were likely correlated with the same mental health issues (Klonsky & Moyer, 2008). There is empirical evidence that the statistical relationship between CSA and NSSI is weakened in models that control for psychological variables. For example, in two studies, dissociation was found to be a significant mediator between CSA and NSSI behavior among youth, where dissociative behavior partially explained

the relationship between these two constructs (Kisiel & Lyons, 2001; Zoroglu et al., 2003). Nonetheless, a significant direct effect of CSA on NSSI was still present in both studies even when accounting for other variables, including other forms of childhood maltreatment (Kisiel & Lyons, 2001; Zoroglu et al., 2003). This lively discussion in the literature points to the need for further research on individual and environmental variables that influence the relationship between CSA and NSSI among youth.

Research on the link between NSSI and childhood physical abuse has been inconclusive. Some studies have identified a significant relationship between childhood physical abuse and NSSI among youth samples (i.e., Zoroglu et al., 2003). In other studies, physical abuse was related to NSSI at the bivariate level, but it was not a significant predictor in multivariate models (e.g., Gratz et al., 2002; Lipschitz et al., 1999; Whitlock et al., 2006). In their research on risk factors for NSSI among college students, Gratz et al. (2002) found that gender moderated the relationship between childhood physical abuse and NSSI. These authors reported that physical abuse did not uniquely predict NSSI among females in the study, but that it accounted for a small percentage of variance (though not statistically significant) among male students. The authors proposed that the small sub-sample of men in the study accounted for the non-significant finding for males.

The relationships between NSSI and other forms of childhood maltreatment (i.e., emotional abuse, physical neglect, and emotional neglect) are not as well studied. Based on the available research, emotional abuse and emotional/physical neglect appear to cluster with CSA as significant influences on NSSI among youth. In one study, Whitlock et al. (2006) found that emotional abuse significantly predicted one-time NSSI incidents

among a large sample of college students, while emotional abuse and sexual abuse both predicted repeat NSSI incidents. Similarly, Glassman and colleagues' (2007) study of predominantly female adolescents found that emotional abuse, sexual abuse, and physical neglect were all associated with NSSI, though emotional and sexual abuse were most strongly correlated. Research on Turkish high school students also found that emotional abuse and neglect, along with physical and sexual abuse and dissociation, significantly predicted engagement in NSSI (Zoroglu et al., 2003). Additional studies indicate that childhood neglect and/or emotional abuse, along with CSA, seem to predict risk for NSSI among youth (e.g., Briere & Gil, 1998; Lipschitz et al., 1999; Shenk et al. 2010).

Given these results, it is not surprising that experiencing more than one form of childhood maltreatment may have a compounding effect (Gratz, 2006; Higgins & McCabe, 2000). Several scholars have found that experiencing multiple forms of abuse increases risk for NSSI among youth as compared to experiencing a single form or no abuse (Gratz, 2006; Shenk et al., 2010; Zoroglu et al., 2003). Taken together, these studies suggest that it is important to examine the influence of multiple forms of childhood maltreatment on NSSI behavior.

***Family relationships.*** Aside from the literature on childhood maltreatment, the role of families in NSSI behavior has been relatively unexamined (Gratz, 2003, 2006). The research that has been conducted in this area draws from attachment theory (Bowlby, 1978) and Linehan's (1993) theoretical work on the etiology and treatment of borderline personality disorder (Bureau et al., 2010; Gratz, 2002). In a study by Gratz and colleagues (2002), gender differences were found in the association between parental attachment and NSSI among a sample of college students. Insecure paternal attachment

was a significant predictor of NSSI among female college students, and separation from a parent/guardian predicted NSSI among males in the study (Gratz et al., 2002). Bureau et al. (2010) aimed to build upon these findings by examining specific qualities of the parent-child relationship in a large sample of freshman psychology students. This study found that students who had engaged in NSSI in the previous six months described higher fear, overprotection, and alienation and lower protection, care, and trust in their parental relationships as compared to those who had not recently engaged in NSSI. When assessing the unique contributions of these relationship qualities by gender, the authors found that higher fear and alienation and poorer communication predicted engagement in NSSI among females, but none were significant among males (Bureau et al., 2010). The findings from these two studies suggest that parental attachment correlates with NSSI, but that specific attachment domains and qualities of the parent-child relationship might differ by gender.

Additional research in this area has identified other aspects of family relationships that correlate with NSSI. For example, several studies have found that hostile or critical parenting (Wedig & Nock, 2007; Yates, Tracey, & Luthar, 2008) and emotional over-involvement by parents were associated with higher risk of NSSI among youth (Wedig & Nock, 2007). Other scholars have identified general descriptors of the family environment that relate to NSSI, including low family support (Brausch & Gutierrez, 2010) and less positive family relationships (Claes et al., 2010). Conversely, family connectedness, family support, and family cohesion have been associated with lower risk for NSSI among youth (Kaminski et al., 2009; Klonsky & Glenn, 2009; Garrison et al.,

1993). Overall, this body of literature indicates the family environment and qualities of the care giving relationship are relevant to understanding NSSI behavior.

***Peer relationships.*** Peer relationships are influential in adolescent development and health behaviors (Prinstein, Boergers, & Spirito, 2001). Yet, little is known about the role of peers in NSSI behavior among youth (Brausch & Gutierrez, 2010). Research in other areas suggests that peer socialization and modeling effects have a significant influence on youth's health risk and deviant behaviors (Heilbron & Prinstein, 2008). Similarly, scholars and practitioners have suggested that NSSI has a "peer contagion effect," meaning that a youth's peer network might influence his or her own NSSI behavior and that engaging in NSSI may have social significance to youth (Heilbron & Prinstein, 2008). The peer contagion hypothesis was originally based on studies of inpatient adolescent samples (see, for example, Rosen & Walsh, 1989), though recent studies suggest that peer influence plays a role in NSSI risk among general community samples as well (Claes et al., 2010; Deliberto & Nock, 2008; Heilbron & Prinstein, 2008).

The small body of research on NSSI across peer networks provides some empirical support for the idea that youth's NSSI behaviors are related to those of their friends. In a study of high school students in Belgium, Claes and colleagues (2010) reported that youth who engaged in NSSI were more likely to know others who engaged in the behavior. Furthermore, youth who engaged in NSSI were also more likely to report knowing several people who engaged in NSSI as compared to those who did not self-injure (Claes et al., 2010). Another set of studies by Prinstein and colleagues (2010) identified significant longitudinal relationships between youth's NSSI behaviors, their

best friends' actual NSSI behaviors, and youth's perceptions of their friends' behaviors, though these relationships were only significant among females. Similarly, research on a small sample of university students who engaged in NSSI found that the majority had a friend who also self-harmed and talked to their friends about NSSI, while a small percentage engaged in NSSI in front of or with their friends (17.4% and 4.3% respectively; Heath, Ross, et al. 2009).

Each of these studies indicates that peer influence may be a factor in NSSI behavior among youth. However, the processes underlying this relationship remain unclear. Scholars have suggested that the correlation may be attributable to "selection effects," (Heilbron & Prinstein, 2008; Kandel, 1978) whereby youth choose to associate with others that are similar to them and, thus, develop friendships with others who already engage in NSSI. Another possible explanation is that youth might influence each other's attitudes towards and propensity to engage in NSSI through their own behaviors, which would imply "socialization effects" (Heilbron & Prinstein, 2008; Kandel, 1978). Nock and Prinstein (2005) offered an additional hypothesis called "priming" (p. 144). They suggested youth that observe their peers receiving desirable social responses following NSSI are more likely to initiate the behavior themselves (Nock & Prinstein, 2005). To date, there is not sufficient evidence to confirm or disconfirm any of these theories, pointing to the need for further research on the characteristics and mechanisms of peer influence on NSSI behavior (Heilbron & Prinstein, 2008).

The scant literature on peer relationships and NSSI has been noticeably biased, conceptualizing peer influence as primarily negative rather than positive. Only a few studies have examined the potential protective role of peer relationships as an influence

on youth's NSSI behavior. As with family support, social support from friends can function as a protective factor and has been associated with lower likelihood of NSSI among youth (Heath, Ross, et al., 2009; Klonsky & Glenn, 2009; Wichstrøm, 2009). A study by Claes et al. (2010) provides further evidence that positive peer support may have bearing on this behavior, finding that high school students who engaged in NSSI reported significantly less positive relationships with their peers than those who did not. On the other hand, Kaminski and colleagues (2009) reported somewhat contradictory findings in which peer connectedness was not a significant predictor of NSSI among U.S. high school students when controlling for school and family connectedness and socio-demographics. It is possible that peer connectedness was not significant due to a strong correlation with school connectedness, given that high school students have considerable peer-to-peer contact in school. Each of these studies has aimed to fill a gap in the literature regarding the pro-social and protective functions of peer relationships in NSSI behavior. The findings from these studies underscore the need for exploration of the complexities of peer influence on NSSI that includes both "peer contagion" and peer support.

***Bullying.*** To date, only a few studies have explored the relationship between bullying and NSSI behavior among youth. Preliminary data indicate that experiencing this form of violence is correlated with NSSI risk. In a recent study involving a large sample of U.S. high school students, Bakken and Gunter (2012) found that experiencing bullying at school significantly predicted increased likelihood of engagement in NSSI among boys, girls, and the full sample. O'Connor and colleagues (2009) reported similar results among a sample of secondary school students in Scotland, though the measure of

self-harm used in the study did not differentiate between NSSI and self-harm with suicidal intent. The most robust study of the relationship between bullying and NSSI was conducted by Hay and Meldrum (2010), which found that both “traditional” bullying and cyber-bullying significantly predicted engagement in NSSI among middle school and high school students in the U.S. Notably, these scholars also found that relationships between both forms of bullying and NSSI were partially explained by negative emotions, though a significant direct effect between bullying and NSSI remained (Hay & Meldrum, 2010). These initial studies suggest that bullying, whether in person or online, is a salient factor to consider in NSSI risk among youth.

### **NSSI among LGBTQ Youth**

The majority of research on self-harm among LGBTQ youth has focused on suicidal thoughts and behaviors. Relatively few researchers have examined the social problem of *non-suicidal* self-injury among LGBTQ youth (Bakken & Gunter, 2012). Since there has been so little research on this topic, it is important to emphasize that the existing knowledge about NSSI among LGBTQ youth comes from a very small body of literature (see Table 1). Notably, three of the studies on this topic (Nickels et al., 2012; Walls et al., 2007, 2010) involved samples recruited from the same urban LGBTQ youth organization that served as the recruitment site for the data used in the current study. As a result, much of our current understanding about NSSI and LGBTQ youth has been gleaned from data collected from youth at one organization. Until further research is conducted, it is not possible to determine to what extent the homogeneity of these samples might influence what we know about NSSI among LGBTQ youth. With this limitation in mind, the following discussion will provide an overview of the small body



of existing knowledge on this topic, including the prevalence of NSSI among LGBTQ youth, within-group differences in NSSI behavior, and risk and protective factors associated with NSSI among this particular population of youth.

Table 1  
*Overview of Research on NSSI among LGBTQ Youth*

<b>Authors</b>	<b>Purpose</b>	<b>Methods</b>	<b>Sample</b>
Alexander & Clare (2004)	To understand women's perspectives on the relationship between being lesbian/bisexual and self-injury	Qualitative interviews with women recruited via ads in a lesbian/bisexual magazine and community spaces	<ul style="list-style-type: none"> <li>• <math>N = 16</math> lesbian and bisexual women in Great Britain</li> <li>• 14 lesbian, gay, or dyke; 2 bisexual</li> <li>• Age range 18-50</li> <li>• 14 White, 1 White/Jewish, 1 mixed race/Jewish</li> </ul>
Almeida, Johnson, Corliss, Molnar, & Azreal (2009)	To explore whether perceived discrimination mediates LGBT identity and emotional distress	Secondary analysis of survey data from the 2006 Boston Youth Survey	<ul style="list-style-type: none"> <li>• <math>N = 1,032</math> high school students</li> <li>• 9.9% LGBT (<math>n = 103</math>)</li> <li>• Age range 13-19 (<math>M = 16.3</math>, <math>SD = 1.3</math>)</li> <li>• 58% female</li> <li>• 44.8% Black, 30.7% Latino, 13.7% White, 10.8% other race/ethnicity</li> </ul>
Bakken & Gunter (2012)	To examine gender differences in suicidal ideation and NSSI	Secondary analysis of survey data from the 2007 Delaware Youth Risk Behavior Survey	<ul style="list-style-type: none"> <li>• <math>N = 2,548</math> high school students</li> <li>• 50% female</li> <li>• 54% White, 25% Black, 10% Hispanic, 11% other race/ethnicity</li> </ul>
Deliberto & Nock (2008)	To explore correlates of NSSI among youth	Interview and survey with youth recruited from the community and outpatient mental health clinics; Matched sample of NSSI and no NSSI	<ul style="list-style-type: none"> <li>• <math>N = 94</math> youth</li> <li>• Age range 12-19 (<math>M = 17.14</math>, <math>SD = 1.88</math>)</li> <li>• 78% female</li> <li>• 73% White, 11% biracial, 6% Hispanic, 5% Asian American, 3% African American, 1% other race/ethnicity</li> </ul>
Liu & Mustanski (2012)	To examine risk and protective factors for NSSI and suicidal ideation among LGBTQ youth	Longitudinal study; Baseline interview and questionnaires and four follow-up time points; Convenience sample recruited through the Internet and LGBTQ community resources	<ul style="list-style-type: none"> <li>• <math>N = 246</math> LGBTQ youth</li> <li>• Age range 16-20 (<math>M = 18.30</math>, <math>SD = 1.32</math>)</li> <li>• 48% female, 44% male, 8% transgender</li> <li>• 57% Black, 14% White, 11% Latino, 18% other race/ethnicity</li> <li>• 34% gay, 29% bisexual, 28% lesbian, 9% questioning</li> </ul>

McDermott & Roen (2012)	To assess whether online interviews are an effective tool for studying distress, self-harm, and sexual/gender identity among diverse LGBTQ youth	Online survey and qualitative interviews with participants recruited via LGBTQ youth websites in the United Kingdom	<ul style="list-style-type: none"> <li>• <math>N = 14</math> LGBTQ youth completed the survey; Of these, <math>n = 5</math> LGBTQ youth also participated in online interviews</li> <li>• 50% queer</li> <li>• 43% transgender, genderqueer, or intersex</li> </ul> <p><i>Complete sample characteristics were not reported by the authors</i></p>
McDermott, Roen, & Piela (2013)	To explore how LGBTQ youth describe relationship between sexuality, gender, and self-harm	Qualitative analysis of data posted to online forums and weblogs	<ul style="list-style-type: none"> <li>• Total sample size estimated at 290</li> <li>• Age range 16-25</li> </ul>
McDermott, Roen, & Scourfield (2008)	To examine the relationships between marginalized LGBTQ identities and self-harm	Focus groups and qualitative interviews with youth recruited from LGBT support groups	<ul style="list-style-type: none"> <li>• <math>N = 27</math> LGBT youth</li> <li>• 100% White</li> </ul>
Moskowitz, Stein, & Lightfoot (2012)	To determine whether stress and risk behaviors mediate the relationship between psychosocial characteristics and self-injury among homeless youth	Structured interviews conducted with homeless youth recruited from social service agencies in Los Angeles	<ul style="list-style-type: none"> <li>• <math>N = 474</math> homeless youth</li> <li>• Age range 12-24 (<math>M = 19.4</math>)</li> <li>• 59% male</li> <li>• 17% White, 32.5% African American, 21.5% Hispanic/Latino, 1.5% Native American, 2 %Asian, and 25 % multiracial or other</li> <li>• 26% were LGBT</li> </ul>
Nickels, Walls, Laser, & Wisneski (2012)	To identify predictors for specific NSSI motivations among LGBTQ youth	Secondary analysis of data from a survey administered in 2007/2008 at Rainbow Alley, a community-based LGBTQ youth organization	<ul style="list-style-type: none"> <li>• <math>N = 131</math> LGBTQ youth</li> <li>• Age range 13-24 (<math>M = 17.12</math>, <math>SD = 2.17</math>)</li> <li>• 53% female, 33% male, 14% transgender or genderqueer</li> <li>• 67% White, 15% bi/multiracial, 11% Latino/a, 7% other race/ethnicity</li> </ul>
Scourfield, Roen, & McDermott (2008)	To understand the relationship between sexual orientation, self-harm, and suicide	Focus groups and qualitative interviews with youth recruited from LGBT groups and colleges	<ul style="list-style-type: none"> <li>• <math>N = 69</math> LGBT and heterosexual youth</li> <li>• Age range 16-25</li> <li>• 78% White</li> <li>• 36 heterosexual, 15 gay/lesbian, 12 bisexual, 2 transgender, 4 no response</li> </ul>

Walls, Hancock, & Wisneski (2007)	To assess differences in the social service needs of homeless and non-homeless LGBTQ youth	Secondary analysis of data from a survey administered in 2004/2005 at Rainbow Alley, a community-based LGBTQ youth organization	<ul style="list-style-type: none"> <li>• <math>N = 187</math> LGBTQ youth</li> <li>• Age range 12-21 (<math>M = 17.28</math>, <math>SD = 1.75</math>)</li> <li>• 48% female, 47% male, 5% transgender or other</li> <li>• 40% gay, 27% lesbian, 26% bi/pansexual, 7% questioning</li> <li>• 41% White, 28% bi/multiracial, 18% Hispanic, 10% African American, 3% other race/ethnicity</li> </ul>
Walls, Laser, Nickels, & Wisneski (2010)	To explore correlates of cutting behavior among sexual minority youth and young adults	Secondary analysis of data from an online survey conducted by Rainbow Alley, a community-based LGBT youth organization	<ul style="list-style-type: none"> <li>• <math>N = 265</math> LGBTQ youth</li> <li>• Age range 13-22; Mean age = 17.90 (<math>SD = 2.10</math>)</li> <li>• 54% female, 41% male, 5% transgender</li> <li>• 74% White or Asian, 11% Bi/multi-racial, 6% African American, 6% Latino/a, 3% Native American or Hawaiian Native</li> </ul>
Whitlock, Eckenrode, & Silverman (2006)	To examine the prevalence, types, and correlates of NSSI among U.S. college students	Online survey of students at two colleges/universities in the U.S.	<ul style="list-style-type: none"> <li>• <math>N = 2,875</math> college students</li> <li>• Age range 18-24</li> <li>• 56% female</li> <li>• 65% White, 17% Asian, 4% African American, 4% Hispanic, 10% other race/ethnicity</li> <li>• 92% heterosexual, 2.2% lesbian/gay, 2.9% bisexual, 2.6% questioning</li> </ul>
Whitlock et al., (2011)	To identify sex differences in and characteristics of NSSI	Online survey of students at eight colleges/universities the U.S.	<ul style="list-style-type: none"> <li>• <math>N = 11,529</math> college students</li> <li>• Age range 18-25</li> <li>• 58% female</li> <li>• 64% White</li> <li>• 76% heterosexual. 14% mostly heterosexual, 4% bisexual, 1% mostly gay/lesbian, 2% gay/lesbian</li> </ul>
Wichstrøm (2009)	To determine risk and protective factors for future NSSI and suicide attempts	Longitudinal study involving secondary analysis of survey data from the Youth in Norway Study	<ul style="list-style-type: none"> <li>• <math>N = 2,924</math></li> <li>• Mean age at Time 2 = 16.5 (<math>SD = 1.9</math>) and at Time 3 = 22.1 (<math>SD = 1.9</math>)</li> <li>• 56% female</li> </ul>

**Prevalence.** Empirical research on NSSI among LGBTQ youth is in its infancy and has been largely descriptive in nature. Scholars have focused primarily on demonstrating a relationship between NSSI and sexual orientation/gender identity (Liu &

Mustanski, 2012) and determining the prevalence rate of NSSI among LGBTQ youth. The existing literature indicates that LGBTQ youth are more likely than their heterosexual and cisgender peers to engage in NSSI, providing support for the need for research involving this population.

A small group of studies has reported on differences in NSSI behavior between heterosexual and “non-heterosexual” youth. Deliberto and Nock (2008) examined differences in NSSI prevalence by sexual orientation among 94 youth recruited from the community and from outpatient mental health clinics. The authors found that non-heterosexual adolescents were significantly overrepresented among youth who had engaged in NSSI, with 32.6% of those in the NSSI group identifying as non-heterosexual compared to 11% in the no NSSI group (Deliberto & Nock, 2008). A longitudinal study by Wichstrøm (2009) identified a similar pattern among a representative sample of Norwegian high school students. This study found that students with “non-heterosexual interest” had significantly higher rates of NSSI (5.4%) as compared to heterosexual students (4.1%; Wichstrøm, 2009). A notable limitation of Wichstrøm’s (2009) study was the measurement of NSSI. Participants were asked whether they had “taken an overdose of pills or otherwise tried to harm [themselves] on purpose?” (p. 109) and were categorized as engaging in NSSI only if they answered affirmatively to the question *and* reported no lifetime suicide attempts. Given the prior discussion of the strong correlation between NSSI and suicide attempts, the NSSI prevalence data in this study are likely conservative for both LGB and heterosexual youth. Furthermore, the NSSI item specifically mentioned one form of self-harm that is known to be more common among females (Briere & Gil, 1998), which might have led to underreporting by males and

young people of all genders who engaged in other forms of NSSI. Nonetheless, results from Deliberto and Nock (2008) and Wichstrøm (2009) indicate that rates of NSSI among LGB youth are significantly higher than those of their heterosexual peers among clinical samples and non-U.S. populations.

Only one study (Almeida et al., 2009) has examined NSSI prevalence among heterosexual, lesbian, gay, bisexual *and* transgender youth. This group of authors found that LGBT high school students reported significantly higher rates of NSSI (21.3%) as compared to heterosexual, cisgender students (5.8%). However, due to small cell sizes, no data were reported specifically for transgender students.

Several studies have explored NSSI prevalence among community samples of LGBTQ youth without including heterosexual, cisgender youth. A set of studies by Walls and colleagues (2007, 2010) and Nickels et al. (2012) examined the prevalence of cutting among LGBTQ youth who were recruited from an urban LGBTQ youth organization previously mentioned in this literature review. Across the three studies, between 39 and 47% of LGBTQ youth had engaged in cutting in the previous 12 months. These rates are considerably higher than those found among general adolescent community samples. The authors noted, however, that participants who were in some way affiliated with an LGBTQ youth program might not be representative of all youth in that they may be more likely to seek out support or have higher social service needs, possibly resulting in higher NSSI estimates (Nickels et al., 2012; Walls et al., 2010). However, considering that these studies asked only about cutting behavior, the results might actually underestimate the prevalence of NSSI among general LGBTQ youth populations.

A recent study by Liu and Mustanski (2012) also examined cutting behavior among a community sample of racially diverse LGBTQ youth. These authors found that 15.4% of LGBTQ youth in an urban setting reported cutting in the past six months. The rates of cutting reported in this study are quite a bit lower than those found by Walls and colleagues (2007, 2010) and Nickels et al. (2012). This discrepancy could be due to differences in measurement. While Liu and Mustanski (2012) assessed cutting in the previous six months, the other studies measured cutting within the previous 12 months. It is also possible that the rates in the Liu and Mustanski (2012) study were lower because their sample was not limited to youth receiving support services from an LGBT community-based organization.

**Within-group differences.** Few studies have examined within-group variability of NSSI among LGBTQ youth. This is a common gap in research involving LGBTQ youth since it is difficult to obtain sample sizes that allow sufficient power for sub-group analysis (Elze, 2005). Whitlock et al. (2011) addressed this limitation in their recent study of NSSI among a large sample of college students ( $N = 11,529$ ), of whom 76.1% were heterosexual, 14.4 % were “mostly straight,” 4.3% were bisexual, 1.3% were mostly gay/lesbian, and 2.3% were gay/lesbian. Overall, all non-heterosexual students in the study were at significantly higher risk for NSSI as compared to heterosexual students. Of all students in the sample, bisexual students were at highest risk. Bisexual students were 3.8 times more likely to engage in NSSI as compared to heterosexuals, followed by “mostly straight” ( $OR = 2.6$ ), mostly gay/lesbian ( $OR = 2.3$ ), and gay/lesbian ( $OR = 1.7$ ) students. An earlier study by this same group of researchers found that bisexual and questioning college students were more likely to report engaging in repeat NSSI behavior

as compared to heterosexuals (Whitlock et al., 2006). These findings suggest that some sub-groups of LGB youth are at higher risk of NSSI than others, pointing to the need for research that can expand our understanding of these differences.

There is also some evidence that gender differences exist in NSSI risk among LGBTQ youth. The majority of studies that have found gender differences indicate that, among LGBTQ youth, females and transgender youth are at higher risk for NSSI as compared to males. Walls et al. (2010) found that being female or transgender significantly increased the likelihood of cutting, with females three times as likely and transgender youth 14.8 times as likely as males to engage in cutting in the previous year. A similar pattern was also found in Liu and Mustanski's (2012) study in which being female or gender non-conforming (i.e., not conforming to the traditional gender binary) significantly predicted cutting in the previous six months among LGBTQ youth.

Several other studies have identified gender differences in NSSI among LGBTQ youth, but either did not measure transgender identity or combined transgender youth with LGBQ youth in their analyses. These studies also found that sexual minority females were at higher risk than males (e.g., Bakken & Gunter, 2012; Whitlock et al., 2011; Wichstrøm, 2009). Notably, one study by Almeida et al. (2009) found that GBTQ males reported higher rates of self-harm (41.7%,  $n = 10$ ) as compared to LBTQ females (14.3%,  $n = 11$ ). It is possible that the small sample size might have contributed to these contradictory findings. Overall, the results from each of these studies on gender differences should be interpreted cautiously. The measurement and analytical approaches used in these studies conflated sexual orientation and gender identity, which might have confounded the relationships between these variables and NSSI.

Almost nothing is known about racial, ethnic, and age differences among LGBTQ youth when it comes to NSSI. Only one study by Walls and colleagues (2010) included these demographic variables as potential predictors of cutting among a sample of LGBTQ youth. The authors found that there were no significant racial/ethnic differences in the likelihood of cutting among a community sample of LGBTQ youth. The same study found that younger adolescents had a greater likelihood of cutting as compared to older adolescents/young adults in the sample (Walls et al., 2010).

**Correlates.** Given the established link between LGBTQ status and NSSI, researchers have called for further study of the psychosocial risk and protective factors that influence this behavior (Liu & Mustanski, 2012; McDermott & Roen, 2012). A small body of quantitative and qualitative studies has moved beyond prevalence data to explore relationships between NSSI, sexual orientation/gender identity, and other psychosocial factors among LGBTQ youth. As with general adolescent populations, NSSI among LGBTQ youth is positively correlated with depression, previous suicide attempts, and substance use (Liu & Mustanski, 2012; Walls et al., 2010). Another finding that mirrors the general adolescent literature is that peer networks appear to play a role. Walls and colleagues (2010) found that having friends who had recently attempted suicide predicted increased risk for NSSI among LGBTQ youth. Experiencing violence, including childhood abuse and anti-LGBTQ victimization, is also associated with NSSI among this sub-group of youth (Alexander & Clare, 2004; Liu & Mustanski, 2012; Scourfield et al., 2008; Walls et al., 2010).

What appears to be unique about the experience of NSSI among LGBTQ youth is the role of homophobia and transphobia in the social environment. In Scourfield et al.'s



(2008) qualitative study of LGBTQ and heterosexual youth, participants described this role in two ways: (1) youth who had internalized negative messages about their sexuality used cutting as a form of self-punishment, and (2) homophobic treatment from others led some LGBTQ youth to cut. This same group of scholars recently conducted another study that involved analysis of online forums to understand how LGBTQ youth “talked” about NSSI in virtual environments (McDermott et al., 2013). The results from this study extended their previous findings; LGBTQ youth’s online talk about NSSI indicated that, for some, shame and distress related to homophobia and transphobia influenced their NSSI behavior (McDermott et al., 2013).

Alexander and Clare (2004) reported strikingly similar themes in their qualitative study of lesbian and bisexual women. Study participants noted that “feeling different” about their gender expression and experiencing discomfort with their sexual orientation affected their self-esteem and contributed to their NSSI behavior. Furthermore, participants explained that “bad experiences,” including experiencing homophobic violence, reduced their self-esteem and contributed to feelings of self-hatred, which led them to engage in NSSI as a form of self-punishment (Alexander & Clare, 2004). Conversely, developing a sense of pride in their sexual orientation sometimes led to NSSI cessation (Alexander & Clare, 2004). Findings from this small set of studies begin to illuminate the complex relationships between exposure to homophobia, internalized homophobia, and NSSI among LGBTQ people.

Several other studies have demonstrated a link between anti-LGBTQ discrimination and violence and NSSI among larger samples of LGBTQ youth. For example, one study of high school students found that LGBT youth were more likely than

their non-LGBT peers to have experienced discrimination based on sexual orientation and/or gender identity (Almeida et al., 2009). Those youth who had experienced such discrimination were more likely than those who had not to engage in self-harm (Almeida et al., 2009). Other studies have found that experiencing harassment at school (Walls et al., 2010) and anti-LGBTQ violence (Liu & Mustanski, 2012) were associated with cutting among LGBTQ youth.

Walls and colleagues' (2010) finding that greater openness about sexual orientation and/or gender identity was a significant predictor of cutting provides further evidence for the role of homophobia and transphobia in NSSI among LGBTQ youth. The authors suggested that openly identifying as LGBTQ might place young people at greater risk for violence, harassment, and rejection, which might, in turn, increase their risk for engaging in NSSI (Walls et al., 2010). On the other hand, the same study found that LGBTQ youth who knew an adult at school with whom they could talk about sexual orientation/gender identity significantly reduced the risk of cutting. This finding indicates that social support from accepting adults can serve as a protective factor and may help buffer the negative effects of homophobic/transphobic environments (Walls et al., 2010).

Compared to the general literature on NSSI, relatively little is known about this social problem among LGBTQ youth as a specific population. Nonetheless, this review of the small body of existing research offered evidence that NSSI among LGBTQ youth is widespread and is related to a range of negative psychosocial issues. Research in this area has found that many of the same psychological and social factors associated with NSSI among general youth populations also hold true for LGBTQ youth. However, it

appears that there are particular risk factors at play among LGBTQ youth associated with their social experiences as a marginalized group. Initial studies indicate that these unique risk factors may contribute to higher rates of NSSI among LGBTQ youth, though little is known about the processes by which these social factors might confer increased risk (Liu & Mustanski, 2012). The findings from the existing literature on this topic highlight the need for future research that explores both psychological and social factors that contribute to NSSI behavior among LGBTQ youth. These areas of inquiry can further the identification of risk and protective factors related to NSSI among LGBTQ youth, which is essential for designing interventions for this population.

### **Summary of Theoretical and Empirical Literature**

This review of the theoretical and empirical literature provided a context in which to situate future research on NSSI among LGBTQ youth. In reviewing the tenets of and evidence for minority stress theory, I suggest that this conceptual framework has the potential to advance our understanding of NSSI among LGBTQ youth, as it has with other psychosocial risks. However, this theoretical framework has not been widely applied to research on NSSI among LGBTQ youth in the past and deserves further study.

The review of research on NSSI showed that the behavior is widespread among youth and disproportionately impacts those who are LGBTQ. Since there are still very few studies on NSSI among LGBTQ youth, there are substantial gaps in our knowledge about this social problem. Existing research suggests that social stigma associated with LGBTQ status plays a significant role in this behavior and should be explored further. Future research on risk and protective factors that are unique to LGBTQ youth, including

social stigma, has the potential to inform culturally responsive interventions with this group (Liu & Mustanski, 2012).

### **The Current Study**

This mixed methods study was designed to contribute to the research on NSSI among LGBTQ youth and address several gaps that were previously described. Guided by minority stress theory, I utilized qualitative and quantitative methods to explore the influence of the social environment on NSSI behavior among LGBTQ youth. Specifically, my research aims were to examine (1) the relationship between LGBTQ youth's social environments and their NSSI behavior, and (2) whether/how specific aspects of the social environment contribute to an understanding of NSSI among LGBTQ youth.

The study was exploratory by design since little research has been conducted in this area. The qualitative phase sought to understand the ways in which LGBTQ youth described their experiences with NSSI and the social-environmental factors that influenced their behavior. The quantitative phase was designed to test whether specific social-environmental factors identified in the qualitative phase could predict NSSI in a larger sample of LGBTQ youth who completed an online survey.

This study was among the first to apply a minority stress lens to research on NSSI among LGBTQ youth. Therefore, the study's findings have the potential to situate LGBTQ youth's NSSI experiences within a particular social context. Previous research suggests that homophobia, transphobia, and heterosexism permeate LGBTQ youth's social environments and influence their NSSI behavior. It was anticipated that similar results would be found in this study. However, the study was designed to allow for new

information to emerge from youth's own words that might contradict these findings and/or highlight social-environmental factors that had not been previously considered in relation to NSSI. Ultimately, it is hoped that this focus on the unique social experiences of LGBTQ youth might inform culturally relevant NSSI prevention and intervention efforts that address the social realities of their lives.

### **Research Questions**

In order to achieve the aims described above, this study was guided by the following research questions:

#### *Qualitative phase.*

- How do LGBTQ youth describe the relationship between their social environment and their experiences with NSSI?

#### *Quantitative phase.*

- Do the social-environmental factors identified in the qualitative phase significantly predict the likelihood of engaging in NSSI among a larger sample of LGBTQ youth?
- Does depression mediate the relationship between social-environmental factors identified in the qualitative phase and NSSI among LGBTQ youth?

### **Chapter Summary**

This chapter served to lay a foundation of the relevant theoretical and empirical literature related to NSSI among LGBTQ youth. The literature review addressed the contributions and limitations of existing research in order to position the current study within the field. There is still much to learn about this social problem given that it has been relatively unexamined. This mixed methods study aimed to advance our

understanding of a specific area of inquiry: the relationship between the social environment and NSSI among LGBTQ youth. The next chapter will describe the research design and methods used in the current study, followed by subsequent chapters that will report and discuss the study's findings.

## **Chapter Three: Methodology**

### **Research Design**

This study used an exploratory, sequential mixed methods research design (Creswell & Plano Clark, 2011) to conduct analysis of two existing datasets. The qualitative phase of the study involved transcripts from interviews conducted with 44 LGBTQ youth at a community-based organization serving this population. Phenomenological qualitative analysis using the constant comparative method (Lincoln & Guba, 1985) focused on understanding how LGBTQ youth described the relationship between their social environment and their NSSI behavior. Results from the qualitative phase were used to identify key variables and refine the specification of research questions and statistical models in the second, quantitative, phase of the study. This phase involved analysis of existing data from a survey of LGBTQ youth ages 13-23 conducted by the same organization from which the qualitative data were collected. In the current study, these survey data were used to determine whether social-environmental factors identified in the qualitative phase would also be found to be significant predictors among a larger sample of LGBTQ youth. The results of each analysis were “mixed” in the interpretation phase of research in order to compare findings and explore areas of convergence and incongruence (Creswell & Plano Clark, 2011).

An exploratory, sequential mixed methods design was appropriate for this study because it provided a more comprehensive understanding of topic than could be found by

either method alone. The qualitative phase allowed me to identify aspects of the social environment that were related to NSSI among LGBTQ youth, using the “local language” (Lincoln & Guba, 1985) of participants to make sense of the phenomenon. This was important from a social justice perspective because it honored LGBTQ youth as experts in the identification of salient social factors that relate to NSSI. Consistent with an exploratory design, the qualitative phase provided a view of the context and meaning of the phenomenon while the quantitative phase was used to identify general patterns and test the qualitative findings with a larger sample (Creswell & Plano Clark, 2011). Overall, using a mixed methods approach to explore this social problem contributed to further contextual and empirical understanding of a topic about which little is known.

### **Qualitative Phase**

**Data source.** The interview data utilized in the first, qualitative, phase of this study were originally collected for a different study led by Principal Investigator (P.I.) N. Eugene Walls, Ph.D., Associate Professor at the University of Denver’s Graduate School of Social Work. The original study broadly aimed to understand how LGBTQ youth described their experiences with NSSI in their own words, with an overall goal of informing interventions. The University of Denver’s Institutional Review Board (IRB) approved the design and interview protocol used in that study. Prior to my dissertation work, I was a graduate research assistant for the P.I. and was directly involved in the design, participant recruitment, data collection, and data cleaning for that qualitative study. In this section, I will detail the sampling and data collection processes that were conducted for the original study and describe my role in Dr. Walls’ project.



**Participant recruitment.** Interview participants were recruited from Rainbow Alley, a drop-in center that is a program of the Gay, Lesbian, Bisexual, and Transgender (GLBT) Community Center of Colorado (“The Center”). Rainbow Alley provides support, advocacy, education, and youth leadership opportunities to LGBTQ youth and their allies between the ages of 12 and 21. Rainbow Alley also hosts several social events throughout the year such as drag shows, camping trips, and Queer Prom.

Three research assistants, including myself, conducted participant recruitment onsite at Rainbow Alley from February to July 2010. All of the research assistants identified as members of the LGBTQ community and one was a graduate social work intern at Rainbow Alley. Research assistants approached youth individually, made an introduction, and asked them whether they were interested in learning about a study of NSSI among LGBTQ youth. We explained to them that youth must be between the ages of 13 and 25 and identify as LGBTQ or questioning in order to participate. If a youth expressed interest and met these initial eligibility criteria, that person was invited to hear details about the study and complete further screening in a private room.

Once in the screening room, the research assistant followed a written screening interview checklist and protocol to determine each youth’s eligibility for the study (see Appendix A). The research assistant began the process by providing a detailed description of the study and an overview of the topics that would be discussed during the screening and the interview. Youth were informed that the screening and interview were completely voluntary and confidential and were assured that their participation or non-participation would not impact their ability to receive services at Rainbow Alley. Given the age of the participants and the potentially sensitive nature of the interview questions,

youth were also informed of the limits of confidentiality, such as disclosure of abuse or an immediate threat to themselves or someone else.

During the screening, youth 18 and over completed an informed consent form and were asked two sets of questions to ascertain their eligibility for the study: (1) “Have you ever thought about doing something on purpose to injure, hurt, or harm yourself or your body (but you weren’t trying to kill yourself)? And what was it that you thought about doing?” and (2) “Have you ever actually done anything on purpose to injure, hurt, or harm yourself or your body (but you weren’t trying to kill yourself)? And what was it that you actually did?” Youth who answered affirmatively to either or both screening questions were eligible for the study and were invited to complete the interview immediately or schedule an appointment for a later date.

Given the potential risks associated with obtaining parental consent for research on LGBTQ identity, an alternative consent procedure was used for youth under 18 in this study (see Appendix B). Minors who reported that telling a parent/guardian about this study would put them at risk of harm were eligible to provide their own assent to participate. Minors who provided their assent were then asked the screening questions described above. Minors who reported no potential risk were asked to have a parent/guardian complete a consent form and return it to Rainbow Alley before proceeding with the screening process. All youth who were screened, regardless of their eligibility for the study, were given a \$5 gift card, information about NSSI, and resources for seeking help for NSSI and suicidal ideation.

**Data collection.** A research team consisting of the P.I., staff from Rainbow Alley, and graduate students, including me, designed a semi-structured interview protocol

to guide the data collection process. All members of the research team identified as LGBTQ and had practice or research experience with LGBTQ youth. The interview questions were informed by existing literature on NSSI and inquired about a range of topics, including: participant demographics; experiences with homophobia and transphobia in various contexts (i.e., school, work, home, etc.); NSSI among people in their social network; onset; trajectory; recency; context; triggers; ideation; function; and desire to stop engaging in NSSI. A copy of the interview protocol is included in Appendix C. Consistent with the concept of emergent design in qualitative research, the research team modified the protocol several times throughout the study in order to add questions and increase the clarity and flow of the interview (Patton, 2002).

Another research assistant and I conducted individual interviews at Rainbow Alley with eligible youth using the semi-structured interview protocol. At the beginning of each interview, we once again reviewed the informed consent/assent materials and requested permission to audio record the interview. A total of 46 interviews were completed, of which I conducted 22. All interview participants received a \$25 gift card for their time. Two participants were dropped from the study after the interviews due to ineligibility, leaving a final sample size of 44.

**Data management.** The majority of interviews were audio-recorded and immediately uploaded into a secure, password-protected server. Handwritten notes were taken in two cases where participants did not consent to being recorded, which were later typed and uploaded to the secure server. Several research assistants transcribed the audio recordings and, subsequently, performed audibility checks in order to improve the validity of the transcribed data. Next, I de-identified the transcripts (by removing any

specific references to names, locations, schools, etc.) in order to minimize the risk of inadvertently compromising the confidentiality of any study participant. Finally, the de-identified transcripts were uploaded into ATLAS.ti (version 6.2), a computer-assisted qualitative data analysis software (CAQDAS) program. ATLAS.ti does not perform analysis, but provides the researcher a platform in which to code, group, and display large amounts of data as well as to make research memos to document the analytical process.

**Qualitative data analysis procedures.** The constant comparative method (Glaser & Strauss, 1967; Lincoln & Guba, 1985) was used to guide analysis for the qualitative phase of this study, exploring the research question, “How do LGBTQ youth describe the relationship between their social environment and their experiences with NSSI?” Glaser and Strauss (1967) originally developed this method as a systematic analytic process, with the ultimate goal of generating grounded theory. My analysis followed Lincoln and Guba’s (1985) adaptation of Glaser and Strauss’ (1967) original work, in which the constant comparative method is used to structure and guide data analysis, regardless of whether theory generation is the ultimate goal.

As with most qualitative methods, a researcher who utilizes the constant comparative method engages in inductive analysis of the data. This involves starting the analysis with the smallest units of data, such as participants’ words or phrases, and moving up the “ladder of abstraction” from codes to categories and themes (Lincoln & Guba, 1985). A distinguishing characteristic of the constant comparative method is the iterative process that the analyst employs to rigorously evaluate the *fit* of data within and across codes, categories, and themes.

Qualitative analysis using the constant comparative method begins by assigning units of data to codes. The coding process allows the analyst to reduce data into smaller units while simultaneously uncovering deeper meanings and relationships (Coffey & Atkinson, 1996). Initially, the analyst may code based on tacit knowledge—grouping data that intuitively seem to fit together under the same code (Lincoln & Guba, 1985). I began this process by carefully analyzing each transcript in ATLAS.ti, conducting in vivo and open coding based on my specific research question. In vivo coding is the process of capturing words, phrases, or longer segments of text verbatim. In vivo coding allows the researcher to stay close to the “local language” (Lincoln & Guba, 1985) of the study participants and to ensure that the analysis “preserve[s] participants’ meanings of their views and actions in the coding itself” (Charmaz, 2006, p. 55). Open coding involves linking data segments to a word or phrase that captures the researcher’s ideas about the key idea or concept that the participant is expressing. Put differently, open coding moves the analysis one rung up the ladder of abstraction from participants’ own words to the analyst’s initial interpretation of those words. Frequently, I coded a segment of data to both an in vivo code and to an open code. The former was intended to stay grounded in the participant’s own way of describing their experience and the latter, larger segment of data, was used to contextualize the in vivo code and begin to consider its meaning within and across transcripts.

In addition to in vivo and open coding, I conducted attribute coding (Saldaña, 2009) as a way to organize and track participants’ demographic and other descriptive characteristics. Attribute coding is useful for qualitative data management, particularly in research projects with a large number of participants (Saldaña, 2009). I ultimately

created attribute codes to capture multiple dimensions of the following characteristics: race/ethnicity, age of NSSI onset, school status, primary NSSI method, sexual orientation, preferred gender pronoun, gender identity, and age of self-identification as LGBTQ.

As I developed a considerable number of in vivo and open codes, I began to shift my analysis from grouping based on tacit knowledge to more rigorous discernment. Glaser and Strauss (1967) described this discernment process as the “defining rule” of constant comparative analysis. The authors advised that the analyst should determine which data to assign to which code by “compare[ing] it with the previous incidents in the same and different groups coded in the same category” (Glaser & Strauss, 1967, p. 106). In applying this approach, I began to evaluate the “fit” of data units to each open code by examining the commonalities and differences between the data and those already assigned to the code. I engaged in memo writing throughout my analysis to aid in this comparative process (Glaser & Strauss, 1967; Lincoln & Guba, 1985). This is easily done in ATLAS.ti; I regularly wrote memos on the entire body of transcripts while also making comments on individual codes to capture my thinking and to note areas of ambiguity or conflict.

It is essential to stay open to new codes or disconfirming evidence rather than allowing initial coding from first few transcripts guide the rest of the analysis (Lincoln & Guba, 1985). Therefore, I also used memo writing to determine whether to merge, separate, or create new codes based on their convergence and divergence with the data. Each time I created a new code, I reviewed previously coded transcripts to look for data related to the new code. While this was a time-intensive process, it allowed me the

opportunity to go through several coding cycles, each time with a slightly different and, ideally, more complex understanding of the data (Saldaña, 2009). The iterative process of coding and memo writing also assisted me in refining the names of open codes to more closely reflect the meaning of the data. Throughout the process, I continually revisited my research question to ensure that the codes and associated data specifically spoke to the ways in which participants described the relationship between their social context and NSSI. On occasion, I deleted codes that did not sufficiently align with the research question.

During the next phase of my analysis, I began to delineate the properties and definitions of the codes. This process is used to *systematically* determine whether data should be included in or excluded from a particular code (Glaser & Strauss, 1967; Lincoln & Guba, 1985). This is a subtle shift, where the analyst moves from comparing data to data within a code to comparing data to the *properties* of a code. Once again, I created memos and comments in ATLAS.ti to document the evolution of my thinking about the codes' properties and to explore their meanings. I regularly used the Code Manager in ATLAS.ti to generate lists of quotes assigned to a particular code and evaluate them for their fit to the properties I had developed. I also utilized the Query function in ATLAS.ti to identify data segments that were coded to two or more codes. Through these processes, I was able to uncover nuances in the data that helped me refine my conceptualization of a code's definition and properties and reassign data to other codes as necessary.

The analysis then progressed to making comparisons between codes to examine overlap and distinction. Lincoln and Guba (1985) suggested that an analyst should strive

to develop codes that are “internally as homogenous as possible and externally as heterogeneous as possible” (p. 349). Once again, I used the Code Manager and Query functions in ATLAS.ti to identify codes that were not sufficiently differentiated, which led to further refinement of code’s properties or to merging codes when appropriate. I also used the Code Manager to identify those codes with only a few data segments attached to see if they could be reasonably merged with other codes.

Once I had completed multiple coding cycles to create, define, evaluate, and differentiate my open codes and the data coded to them, my analysis shifted to focus on examining the relationships between codes. I began to group codes that had some similarity or pattern (Saldaña, 2009) by creating “families” in ATLAS.ti. Initially, I grouped codes into families based on a “feels right” or “looks right” basis as a way to get a general feel of the relationships (Lincoln & Guba, 1985, p. 340). Then, I repeated the processes described previously, such as memo/comment writing and defining the properties of each code family, to determine whether a code should be included in or excluded from a family.

It was through the process of creating and refining code families that I began to conceptualize themes in the data. A theme is defined in a myriad of ways across qualitative paradigms, but it is essentially “an implicit topic that organizes a group of repeating ideas” (Auerbach & Silverstein, 2003, p. 38). I began to view each family as a theme and each code within a family as a dimension of a theme. Each code or dimension seemed to contribute a particular nuance, perspective, or aspect of each theme, while each theme contributed to a more complex and holistic understanding of the data in relation to the research question.



At this stage, I again engaged in the constant comparative process to examine the overall cohesiveness of my analysis across quotes, codes, and themes. I reexamined the fit of data associated with each code and re-coded when necessary to ensure internal consistency of data in each code (Lincoln & Guba, 1985, p. 347). I reviewed and redefined each code to ensure that they were distinct from one another, yet still hung together as dimensions of a particular theme. Next, I further refined the names and definitions of each theme so that they clearly described the relationships between their dimensions/codes. Finally, I compared themes to each other to ensure that they were clear, distinct, and directly responsive to the research question. At the conclusion of this process, I conceptualized five main themes in the data that could best tell the story of the data in relation to the research question. These themes will be described in detail in Chapter Four.

It is important to emphasize that the analytical process described above was cyclical rather than linear. At each phase of the research process, my analysis continually moved up or down the ladder of abstraction as necessary to reexamine the fit of data to a code or to refine the properties of a theme. Ultimately, this iterative process allowed me to further refine codes and themes with each coding cycle (Saldaña, 2009). The entire process was also conducted both within and across transcripts. Each transcript had the potential to offer unique insight into the coding process and could provide both confirming and disconfirming evidence that impacted my understanding of the entire body of data. When disconfirming evidence emerged, I created new codes to capture the data or redefined the properties or dimensions of a family to account for this new information.

A common challenge facing qualitative researchers is determining when to stop data analysis. Lincoln and Guba (1985) offered four criteria to inform this decision. The first criterion, “exhaustion of sources,” (Lincoln & Guba, 1985, p. 350) was met in this study in that all 44 transcripts were analyzed multiple times throughout the iterative coding process. No additional interviews were conducted due to the reliance on secondary data. The authors described the second criterion, “saturation of categories,” as being met when the effort expended to conduct additional data processing does not yield substantially relevant findings. This criterion was assessed at numerous points in the coding process, particularly when examining the fit between new data, data assigned to a code, and the properties of a code. Ultimately, there came a point in the analysis when the codes appeared to be sufficiently saturated and when additional coding did not reveal substantial new findings. The third criterion, “emergence of regularities,” considers the degree to which the analysis uncovers patterns in a way that contributes to a sense of integration across the body of data (Lincoln & Guba, 1985). Systematic use of the constant comparative method helped to meet this criterion, maximizing the cohesive and holistic relationships between data, codes, and themes. The final criterion, “overextension,” was met upon my determination that additional coding did not lead to the identification of new insights into “core” of the data in relation to the research question (Lincoln & Guba, 1985, p. 350). Having established that these criteria had been achieved, I ended the data processing phase and determined that my analysis was complete.

**Validity and reliability of the qualitative data and analysis.** In the qualitative tradition, researchers strive for trustworthiness and authenticity of the data as opposed to

the traditional positivist notions of validity and reliability (Lincoln & Guba, 1985). According to Patton (2002), this involves “...being balanced, fair, and conscientious in taking account of multiple perspectives, multiple interests, and multiple realities” (p. 575). The trustworthiness and authenticity of the data can be strengthened or compromised in every step of the research process—from design, to data collection, through analysis (Creswell & Plano Clark, 2011; Lietz & Zayas, 2010; Patton, 2002). Several strategies were used to enhance the trustworthiness and authenticity of the qualitative phase of this research project. In regard to data collection, the majority of data were audio recorded and transcribed and audibility checks (a second comparison between each audio recording and written transcript) were performed to correct transcription errors prior to analysis. Utilizing this combination of procedures helped to maximize the likelihood that the transcripts used for analysis accurately reflected what the participants actually said. In other words, these processes assisted in establishing the trustworthiness of the data itself (Silverman, 2006).

Given that this project involved analysis of existing qualitative transcripts, most of the strategies utilized to enhance trustworthiness focused on the analytic process. First, I utilized the constant comparative method, which involved rigorous examination of and comparison between data, codes, and themes in order to identify convergence, divergence, and patterns in the data (Glaser & Strauss, 1967; Lincoln & Guba, 1985). Use of the constant comparative method contributed to the *credibility* of qualitative analysis, meaning “the degree to which the study’s findings represent the meaning of the research participants” (Lietz & Zayas, 2010, p. 191).

One of the most widely used strategies to increase the trustworthiness of qualitative research is triangulation. The concept of triangulation originated in the field of navigation, where two or more reference points are used to pinpoint a location more exactly (Patton, 2002). In research, triangulation refers to drawing upon two or more data sources, methods, and/or analysts to inform a more comprehensive understanding of the topic or research question (Drisko, 1997; Silverman, 2006). Denzin and Lincoln (2000) suggested that triangulation allows researchers to “add rigor, breadth, complexity, richness, and depth to any inquiry” (p. 5).

This research project involved several forms of triangulation designed to draw upon the benefits described above. Methods triangulation, which is inherent in mixed methods design, involves using two or more methods (i.e., survey instruments, focus groups, observation, etc.) to collect multiple types and sources of data (Creswell & Plano Clark, 2011; Patton, 2002). As previously detailed, this study involved analysis of data obtained in individual interviews as well as data from an online survey. Using a sequential design, the interview data were analyzed first and those results were used to inform the analysis of the survey data. Ultimately, methods triangulation occurred in the final phase of the study, when the results were “mixed” to examine the consistencies across qualitative and quantitative findings (Creswell & Plano Clark, 2011; Patton, 2002). Silverman (2006) cautioned against using triangulation to identify a “true” story or to “adjudicate between accounts” (p. 292). Instead, identifying areas of consistency can strengthen confidence in the results, while identifying inconsistencies can contribute to an understanding of the complexity of the phenomena under study (Patton, 2002; Silverman, 2006). In this study, a comparison of findings across two methods, two sources of data,

and two samples allowed for a more nuanced and complete picture of the social environment of NSSI among LGBTQ youth than would have been possible using either method alone.

Analyst triangulation was also used in the qualitative phase of this study to increase the consistency and credibility of the results (Creswell & Plano Clark, 2011; Patton, 2002; Saldaña, 2009). There is a myriad of ways to approach analyst triangulation, including co-conducting analysis with a research team and involving external reviewers to establish “interpretive convergence” after the analysis is completed (Saldaña, 2009, p. 27). Since this study was conducted in partial fulfillment of a doctoral degree with a goal of demonstrating my ability to conduct independent research, convening a research team was not appropriate. Therefore, I recruited two social work professors to act as independent external reviewers to assess for inter-coder agreement (Creswell & Plano Clark, 2011; Miles & Huberman, 1984) once my analysis was completed. Both reviewers were experienced researchers with some familiarity with the subject matter and sample. I provided each reviewer with two separate documents: (1) a document that outlined the name and definition of each of the five main qualitative themes; and (2) a document that listed, in random order, approximately ten to twelve quotes that I had coded to each theme. Each reviewer was instructed to carefully read the themes and definitions and use them to code each of the quotes to one or more theme(s). Analysts were also encouraged to provide additional notes or suggestions about their coding decisions if desired. The goal of this analyst triangulation was to determine whether external reviewers could reliably code quotes to themes in a similar way to my own coding using the theme definitions as a guide.

Once both reviewers submitted their coding to me, I compared their coding to my own, checking for the similarity with which quotes were coded to specific themes (Creswell & Plano Clark, 2011). I created a file in the Statistical Package for the Social Sciences (SPSS), version 21, with these results and calculated the inter-coder agreement using Cohen's (1960) Kappa. The Kappa statistic is used to calculate the percent and significance of agreement between two raters/observers while also accounting for the possibility that agreement occurred by chance (Cohen, 1960). The Kappa value of agreement between my own coding and that of the first external analyst was .96 ( $p < .001$ ), while Kappa = .91 ( $p < .001$ ) between the second analyst and myself. The average Kappa value across both pairs of raters was .94. Kappa values are interpreted as correlation coefficients; these results would be considered to indicate excellent inter-rater agreement (Watkins & Pacheco, 2001). The results of this analyst triangulation suggested that the themes were clearly defined and that they could consistently be linked back to participants' own words by multiple observers.

Another mechanism I used to increase the trustworthiness of the analysis was to consistently document my thinking and decisions throughout the analysis. This strategy is often employed by qualitative researchers to demonstrate researcher reflexivity and demonstrate the rigor of their methods (Lietz & Zayas, 2010; Lincoln & Guba, 1985; Patton, 2002). In this project, I created comments and memos to describe codes and themes, indicate areas of conflict in the data, describe the data reduction process, and document the rationale behind my analytic decisions. This type of documentation can increase the *confirmability* of the analysis, demonstrating a systematic and logical link between the data and the results (Lincoln & Guba, 1985).

Importantly, consistent use of memos in ATLAS.ti also served as a reflexive journal (Lincoln & Guba, 1985) in which I could wrestle with my own biases and assumptions in relation to the analysis. I often found myself writing memos when I was struggling to understand the data or, at times, when I realized that I was personally challenged by ideas that came through in the transcripts. This was particularly important to me since I identify as a member of the LGBTQ community and have been involved personally and professionally with LGBTQ youth who engaged in NSSI. While my identity and experience could enhance my credibility as a researcher on this topic (Patton, 2002), it was essential to engage in critical self-reflection about ways in which my positionality might have inadvertently biased the research process (Creswell & Miller, 2000; Lincoln & Guba, 1985; Patton, 2002; Sánchez, 2006). I utilized the reflexive journal, as well as conversations with colleagues and confidants, to increase the trustworthiness of my analysis and minimize the potential for bias.

**Summary of qualitative methods.** The preceding section described the design and execution of the first phase of this mixed methods research study. This phase involved analysis of interview data collected from LGBTQ youth at a community-based organization to explore how youth described the relationship between their social environments and NSSI. The constant comparative method (Lincoln & Guba, 1985) was used to conduct inductive data analysis, moving from the raw data to codes, families, and themes. The credibility and trustworthiness of this phase of the study was strengthened by the use of triangulation, documentation of the analytic process, and engagement in critical self-reflexivity throughout the analytical process.

## **Quantitative Phase**

**Data source.** The quantitative phase of the current study involved analysis of data from the 2010 Rainbow Alley survey. Rainbow Alley conducts an annual online survey of LGBTQ youth in order to understand their psychosocial needs and to inform service delivery. Staff and volunteers at Rainbow Alley invited youth to participate in the survey and emphasized that participation was voluntary and would not impact their ability to access services. Additional survey participants were recruited at social events and community programs sponsored by the organization. The link to the survey was also displayed on The Center's website, which allowed youth who were not directly connected to a program or organization to participate. All participants completed an electronic consent form before beginning the survey and data were compiled anonymously with no link to identifying information.

Since 2006, Dr. Walls has partnered with The Center to analyze their survey data in order to identify the social service and support needs of LGBTQ youth. As a member of Dr. Walls' research group, I obtained access to Rainbow Alley survey data collected between January and December 2010 for use in this study. A total of 379 participants responded to the survey during this period.

The 2010 Rainbow Alley survey was chosen for inclusion in this study based on its alignment with the sample and data from the qualitative phase. Both datasets were collected solely (in the case of the qualitative data) or primarily (in the case of the survey data) from youth who participated in Rainbow Alley programs and services during the same general time period. Furthermore, there was sufficient overlap between the topic areas addressed in the semi-structured interview protocol and the online survey. Both



instruments included questions about NSSI, LGBTQ identity, and psychosocial risks. It is possible that some youth may have participated in both the interview and the survey considering that they were conducted during the same general time period. However, since no identifying information was collected, it is not possible to determine whether or to what extent the samples may have overlapped.

**Measures.** The 2010 Rainbow Alley survey included over 100 questions regarding demographic characteristics, risk behaviors, protective factors, and service utilization. Many of the measures in the survey were based on the Youth Risk Behavior Survey (YRBS; Centers for Disease Control and Prevention, 2011) in order to enhance content validity and to allow for comparability across domains. Unlike the YRBS, however, the Rainbow Alley survey was completed by youth who were in and out of school, therefore reflecting the experiences of a broader sample of LGBTQ youth. Participants who were not in school or college at the time they completed the survey were asked to respond to any school-related items based on their most recent experiences in an educational setting.

The survey included several questions on NSSI behavior, including type of NSSI, age of onset, frequency, motivation, and NSSI among close friends. These questions were added to the annual survey in 2008 after Rainbow Alley staff identified the behavior as a concern among youth who accessed their services. In addition to the NSSI questions, the survey included several measures related to LGBTQ identity (e.g., terms used to self-identify sexual orientation and gender identity and level of openness about these characteristics) and social-environmental factors (e.g., school experiences, exposure

to violence, peer risk behaviors) that were relevant to research questions in the current study.

Consistent with the sequential mixed methods design used in this study, the results from qualitative phase were used to refine the quantitative research questions and select survey items that would be analyzed in the quantitative phase. Although it would have been ideal to develop and administer a new survey based on the qualitative themes, the Rainbow Alley dataset included a number of items that allowed for an exploration of the themes among a larger sample of LGBTQ youth. The survey data codebook was carefully reviewed to identify items that could act as proxies for some of the social-environmental factors that emerged from the qualitative analysis. Table 2 depicts a crosswalk that shows the alignment between the qualitative analysis and survey items. In the section below, I provide further detail about the measurement of these variables and discuss the rationale for their inclusion in or exclusion from the quantitative analysis.

Table 2  
*Crosswalk Comparing Qualitative Data and Survey Items*

<b>Qualitative data</b>	<b>Survey items</b>
Demographics	Age, race/ethnicity, sexual orientation, and gender identity.
Violence	Family physical abuse, family sexual abuse, physical violence at school, sexual harassment/violence at school, and feeling unsafe at school.
Misconceptions, stigma, and shame	The survey data did not include variables that could act as proxies for this theme.
Negotiating LGBTQ identity	Openness about sexual orientation and actual/perceived LGBTQ identity as reason for school harassment.
Invisibility and isolation	“I have been excluded from groups” item, “I am accepted at school” item, and “kids at school like me” item.

Peer relationships	The survey data did not include variables that could act as proxies for this theme.
Depression	Persistent sadness/hopelessness.
NSSI	Engagement in any of ten NSSI methods.

**Independent variables.**

*Demographics.* Several demographic variables were selected for inclusion in the quantitative analysis. Age in years and age squared were both tested in preliminary models since previous studies have indicated that age may have curvilinear relationship with NSSI (e.g., Walls et al., 2010; Whitlock et al., 2006; Wichstrøm, 2008). Age squared was not a significant predictor in the model, so age in years was used in the final analyses for ease of interpretation. Gender identity was initially measured as *female*, *male*, *trans/male-to-female*, *trans/female-to-male*, *gender variant/genderqueer*, and *other (please specify)*. *Other* responses were recoded into existing categories when possible or retained as *other*. Dummy variables were created and collapsed so that dummy variables for (1) females and (2) transgender, genderqueer, and other youth were included in the models with males as the reference group<sup>2</sup>. Sexual orientation was measured by asking youth to indicate, “Which of the following best describes your sexual orientation?” Response options included *bisexual*, *gay*, *lesbian*, *queer*, *heterosexual*, *not sure/questioning*, and *other (please specify)*. Once again, *other* responses were recoded into listed categories when possible. After assessing the relationship between each of these sexual orientation categories and the dependent variable, some categories were

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<sup>2</sup> Preliminary analyses indicated that there were no statistically significant differences between female and transgender/genderqueer/other youth in relation to the dependent variable, indicating that these categories could be combined. However, when both dummy variables were included in the logistic regression models with males as a reference group, significant differences were found, so both were retained.

combined so that dummy variables for (1) lesbian; (2) bisexual, pansexual<sup>3</sup>, and queer; and (3) not sure, questioning, and other were included in the models, with gay as the reference category. Response categories for race/ethnicity included *American Indian or Alaskan Native, Asian or Asian American, Black or African American, Hispanic or Latino/a, Native Hawaiian or Pacific Islander, White, Biracial/Multiracial*, and *other*<sup>4</sup> (*please specify*).

**Violence.** Multiple variables were included to assess the role of violence as a social-environmental factor influencing NSSI in the quantitative phase of this study. Survey participants were asked several questions about experiencing various forms of violence at home and at school. Rather than creating a composite variable that combined all types of violence, four separate dichotomous (yes/no) variables were created: (1) lifetime physical abuse by a family member, including being hit, slapped, or beat up; (2) lifetime sexual abuse by a family member, including being pressured or forced to engage in unwanted sexual behaviors; (3) physical violence at school (or on the way to/from school) in the previous 12 months; and (4) sexual harassment/violence at school (or on the way to/from school) in the previous 12 months, including unwanted sexual attention, unwanted sexual touch, and sexual assault/rape. This decision was informed primarily by the empirical literature, which indicates that different types of violence correlate with NSSI in different ways (Gratz, 2003; Jacobson & Gould, 2007). Therefore, I was interested in including variables that would allow me to distinguish the unique effects of

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<sup>3</sup> Pansexual refers to someone who experiences attraction to a person/people regardless of gender identity or sex (Queers United, 2008).

<sup>4</sup> No statistically significant differences were found between any of the racial/ethnic groups or between youth of color as a combined group and White youth. Further, none of race/ethnicity variables were significant predictors of the dependent variable in the logistic regression models. Therefore, race/ethnicity variables were not included in the statistical analysis for the sake of parsimony.

physical and sexual abuse at home and school on NSSI. Another variable was included to indicate how often participants felt unsafe at school (or on the way to/from school) in the previous 12 months. This variable was measured as an ordinal variable with response options ranging from *1 = Never* to *5 = All the time*.

***Negotiating LGBTQ identity.*** Aside from the demographic items measuring sexual orientation and gender identity, few questions in the Rainbow Alley dataset could be used to determine how negotiating an LGBTQ identity related to NSSI behavior in the quantitative phase of this study. Two variables related to this qualitative theme were selected for inclusion in the statistical analyses. The first variable measured participants' level of openness about their sexual orientation, with response options including *not at all open, hardly open at all, slightly open, somewhat open, and very open*. The rationale for including this variable was that the qualitative data indicated that NSSI was related in complex ways to the process of coming out to oneself and others.

A second variable related to this theme was anti-LGBTQ violence and harassment at school. Youth were asked whether or not they experienced violence or harassment at school in the previous 12 months and, if so, what they believed to be the reasons for the harassment. Response options included reasons related to LGBTQ identity (e.g., *others believe I am gay, lesbian, bisexual, or queer, others believe I am transgender, etc.*) and reasons related to other identities (e.g., *because I have a disability, because I am a person of color*). Participants also had the option to select *other* and write in a response. These responses were recoded into existing categories when possible. Then, the responses were recoded into a dichotomous variable where *0 = school harassment was not due to perceived LGBTQ status or participant did not experience harassment at school in past*

year and  $1 = \text{school harassment was due to perceived LGBTQ status}$ . Inclusion of this variable in the quantitative phase of the study was supported by the qualitative results as well as the theoretical and empirical literature. Each suggested that experiencing violence or harassment based on LGBTQ status plays a role in NSSI among youth.

***Invisibility and isolation.*** Three different items measuring social inclusion and exclusion were selected from the Rainbow Alley survey as proxies for the concepts brought forward by interview participants in the *Invisibility and Isolation* theme. The first two items, “Kids at school like me” and “I am accepted at school,” were selected from a set of nine school engagement questions in the Rainbow Alley survey. The response options for these questions ranged from  $1 = \text{strongly disagree}$  to  $4 = \text{strongly agree}$ . The third item, “I have been excluded from groups,” was drawn from a set of questions on school harassment in the previous 12 months. This item was originally measured as an ordinal variable to capture the frequency of this experience. This was recoded into a dichotomous (*yes/no*) variable due to concerns about the accuracy of self-reporting the frequency of this type of harassment. Although these three items did not capture the depth and complexity of the qualitative theme, they provided some information about how social inclusion and exclusion influenced NSSI behavior.

***Additional themes.*** After thorough review of the Rainbow Alley survey codebook, it was determined that none of the survey items could be adequately matched to the two remaining qualitative themes: (1) *Misconceptions, Stigma, and Shame* and (2) *Peer Relationships*. The survey did not include items related to stereotypes about NSSI, internalized homophobia, or shame associated with NSSI or LGBTQ identities. In regards to peer relationships, one item asked about NSSI behavior among close friends.

However, it was not included in the quantitative analysis due to measurement problems and poor fit with the qualitative results.

**Depression.** Findings from the qualitative phase suggested that depression played a role in the relationship between the social environment and NSSI for LGBTQ youth. For example, some interview participants described engaging in NSSI to deal with depression related to experiencing physical, sexual, or emotional violence. A similar pattern was found in the *Invisibility and Isolation* and *Negotiating LGBTQ Identity* themes from the qualitative analysis. Furthermore, existing literature indicates that depression is an important risk factor for NSSI among adolescent samples generally (Jacobson & Gould, 2007; Ross & Heath, 2002) and LGBTQ youth specifically (Walls et al., 2010). Therefore, a proxy for depression was included in the quantitative phase of this study to determine whether it would mediate the relationship between social-environmental factors and NSSI. This construct was measured in the Rainbow Alley survey using the following question: “During the past 12 months, did you ever feel so sad or hopeless almost every day for TWO WEEKS OR MORE IN A ROW that you stopped doing some of your usual activities?” (emphasis in original). Response options were simply *yes* or *no*. This item was drawn verbatim from the 2009 version of the YRBS (CDC, 2011).

**Dependent variable.**

**NSSI.** The outcome of interest in the current study was measured using a set of survey questions about the frequency of NSSI behaviors. Participants were asked to indicate *how often* they had ever engaged in each of ten NSSI methods: *cut yourself*, *burned yourself*, *bitten yourself*, *hit yourself*, *hit something else (like a wall)*, *rubbed your*

*skin until it hurt, ate or drank something that would hurt you, inhaled something that would hurt you, cut off the circulation to a part of your body until it hurt, and cut off some part of your body.* Response options to these questions included *0 times, 1-2 times, 3-4 times, 5-6 times, and 7 or more times.* These items were combined into a dichotomous dependent variable across all types of NSSI to indicate whether or not a participant had ever engaged in any of these NSSI methods. My decision to dichotomize the dependent variable was driven by the study's design and the quantitative research questions. This phase of the study was designed to determine whether or not social-environmental factors from the qualitative phase would be significant predictors of engagement in NSSI, not whether such factors would predict the frequency of NSSI or engagement in a certain NSSI method. While these are important questions for future research, the current study focused on social-environmental factors as predictors of lifetime engagement in any NSSI behavior, regardless of frequency or method.

#### **Quantitative data analysis procedures.**

*Data preparation and cleaning.* Data from the Rainbow Alley survey were downloaded from Survey Monkey into SPSS, version 21. Subsequently, I developed a codebook for the survey and began preliminary examination and cleaning of the data. In this first round of cleaning, eight cases were dropped because they indicated they were heterosexual and cisgender (i.e., not LGBTQ) and twelve were dropped because they did not indicate a sexual orientation. An additional eight cases were dropped because they either did not indicate an age ( $n = 6$ ) or they were older than 25 ( $n = 2$ ). Further, one case was dropped because they did not complete the consent page and 81 cases were deleted because they only completed the first few survey questions. Finally, one case was



dropped due to an inconsistent pattern of responses on the NSSI questions and one more was deleted due to missing data on the dependent variable. After initial data cleaning, 267 LGBTQ youth under the age of 25 remained in the dataset.

**Missing data analysis.** The next step in the data cleaning process involved analysis of missing data among the independent and dependent variables. Table 3 shows the number and percent of missing cases on each variable. Overall, seven variables had no missing data and seven others had no more than 2% of cases missing data. Only the anti-LGBTQ violence/harassment variable had a greater percentage of cases (7%) missing data. In general, it is preferable to have no more than 5% of cases with missing data on variables in the analysis (Tabachnick & Fidell, 2007). However, this is highly contingent on the whether the data are missing not at random (MNAR), missing at random (MAR), or missing completely at random (MCAR; Tabachnick & Fidell, 2007).

Table 3  
*Cases Missing Data on Independent and Dependent Variables*

<b>Variable</b>	<b>No.</b>	<b>%</b>
Age and age squared	0	0
Sexual orientation	3	1.0
Gender identity	0	0
Family physical abuse	3	1.0
Family sexual abuse	5	2.0
Physical violence at school	1	0.4
Sexual harassment/violence at school	0	0
Unsafe at school	3	1.0
Liked at school	1	0.4
Accepted at school	0	0
Social exclusion	1	0.4
Openness about sexual orientation	0	0

Anti-LGBTQ violence/harassment	19	7.0
Depression	0	0
NSSI	0	0

*Note.*  $N = 267$

In order to determine the pattern of missing data, I created dichotomous variables to indicate whether a case had missing data on each of the independent variables. I ran a series of correlations and found that missingness on each of the independent variables was not significantly related to the dependent variable, which indicated that the data were *not* MNAR (Schafer & Graham, 2002; Tabachnick & Fidell, 2007).

Additional bivariate correlations were conducted to determine whether missingness on any of the independent variables was significantly related to the values of the independent variables in the model. Several significant correlations were found in these analyses. Missing data on physical violence at school was significantly correlated with the transgender/genderqueer/other dummy variable ( $\phi = .158, p = .010$ ) and *Kids at school like me* ( $r = -.149, p = .015$ ). Missing data on gender identity was significantly related to anti-LGBTQ violence/harassment ( $\phi = .136, p = .033$ ) and openness about sexual orientation ( $r = -.131, p = .032$ ). Another significant correlation was found between missingness on the social exclusion variable and family sexual violence ( $\phi = .179, p = .004$ ). Finally, missing data on anti-LGBTQ violence/harassment was significantly correlated with *Kids at school like me* ( $r = -.121, p = .048$ ). In summary, the patterns of missing data for physical violence at school, gender identity, social exclusion, and anti-LGBTQ violence/harassment were not MCAR because missingness on these variables was significantly correlated with responses to certain independent variables, but not with the dependent variable (Schafer & Graham, 2002; Tabachnick & Fidell, 2007).

The patterns of missing data for these four variables indicated that they were MAR, which is considered to be “ignorable nonresponse” (Schafer & Graham, 2002; Tabachnick & Fidell, 2007, p. 62). The pattern of missing data for all of the other independent variables indicated that they were MCAR because missingness was not related to the values of the independent or dependent variables (Schafer & Graham, 2002; Tabachnick & Fidell, 2007). However, since the actual distribution of missingness of these variables was unknown, it was not possible to determine whether the data were truly MAR or MCAR (Schafer & Graham, 2002). Therefore, MAR and MCAR were assumed rather than proven based on the relationships between missingness, the independent variables, and the dependent variables (Schafer & Graham, 2002).

There are several options for dealing with missing data when they are MAR or MCAR. Cases with missing data can be deleted listwise or, if such deletion would result in a large reduction in sample size and power, another method can be used to estimate missing data (Tabachnick & Fidell, 2007). Given the low percentage of missingness on all but one of the independent variables, I elected to use listwise deletion in my analyses. The remaining variable, anti-LGBTQ violence/harassment was excluded from further analysis because it had a higher percentage of missing data than is desirable (Tabachnick & Fidell, 2007). Preliminary analyses indicated that this variable was not significantly correlated with the dependent variable at the bivariate level, nor was it a significant predictor in any of the sequential logistic regression models. Therefore, it was not included in the final models in the interest of parsimony. After excluding this variable and conducting listwise deletion, subsequent analyses involved a sample size of 252 participants.

*Assessing assumptions of logistic regression.* Logistic regression has several statistical assumptions that were examined prior to conducting the analysis. These assumptions include: (1) the ratio of cases to predictor variables, (2) adequacy of expected frequencies, (3) linearity of the logit, (4) absence of multicollinearity, (5) absence of outliers in the solution, and (6) independence of errors (Tabachnick & Fidell, 2007, pp. 442-443).

The first assumption of logistic regression is that there are an adequate number of cases in relation to the number of predictor variables included in the model. Very large parameter estimates and standard errors in logistic regression models indicate a potential violation of this assumption (Tabachnick & Fidell, 2007). Neither the parameter estimates nor the standard errors were high in models used in this study, which indicated that the ratio of cases to predictor variables in the full model (18:1) and the final, parsimonious model (28:1) were acceptable (Tabachnick & Fidell, 2007).

The second assumption, adequacy of expected frequencies and power, has to do with whether or not there is sufficient power to use the goodness-of-fit test to interpret model fit (Tabachnick & Fidell, 2007). This assumption was explored by conducting bivariate correlations between all discrete independent and dependent variables (Tabachnick & Fidell, 2007). It is recommended that no more than 20% of the expected frequencies are less than five and that all expected frequencies are greater than one (Tabachnick & Fidell, 2007). The expected frequencies of all pairs of dichotomous variables used in my models fell within the recommended ranges. These results suggested there would be no concern with interpreting goodness-of-fit results to assess model fit (Tabachnick & Fidell, 2007).

Logistic regression also assumes that there is a linear relationship between any continuous predictor variables in the model and the dependent variable. In this study, age was the only continuous predictor variable included in the logistic regression model. This assumption was tested by taking the natural logarithm of the age variable, creating an interaction term with the original variable and its natural logarithm, and then including the interaction term along with all original variables in the model (Tabachnick & Fidell, 2007). This assumption is met if the interaction term is not statistically significant (Tabachnick & Fidell, 2007). Analysis of the interaction term created with age and its natural logarithm indicated that age had a linear relationship to the dependent variable.

The next assumption, absence of outliers in the solution, was assessed by examining model fit (Tabachnick & Fidell, 2007). Evaluation of model fit statistics indicated that the full model including all of the blocks in the sequential logistic regression had a significantly improved fit over the constant-only model. Further, a non-significant Hosmer-Lemeshow statistic indicated that the full model appropriately classified cases, indicating good model fit (Tabachnick & Fidell, 2007). Therefore, there was no indication of outliers in the solution in these models.

Multicollinearity was then assessed by examining the bivariate correlations between predictor variables. Table 4 presents the correlation coefficients and statistical significance of each pair of predictor variables. Typically, very strong correlations (.90 or higher) indicate multicollinearity problems (Tabachnick & Fidell, 2007). The majority of correlations in Table 3 were weak, indicating that multicollinearity among the predictor variables was not a concern (Tabachnick & Fidell, 2007). However, two variables, "I am accepted at school" and "Kids at school like me," had a moderate

correlation,  $r = -.653$  ( $p < .001$ ). Based on this data, the variable “Kids at school like me” was excluded from further analysis in order to avoid redundancy in the logistic regression models (Tabachnick & Fidell, 2007). The variable “I am accepted at school” was retained because it appeared to be a broader construct for measuring school inclusion that was not limited to youth’s experiences with other students. Another indication of multicollinearity is very large standard errors of the parameter estimates (Tabachnick & Fidell, 2007). Large standard errors were not found, providing further support that multicollinearity was not a concern.

Table 4  
Coefficient Matrix of Correlations among Independent Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Age <sup>a</sup>	-														
2. Female	-.08	-													
3. Transgender or other	.09	.40**	-												
4. Lesbian	.01	.35**	.02	-											
5. Bi/pansexual or queer	-.03	.21**	.02	.44**	-										
6. Questioning or other	.01	.06	.05	.17*	.30**	-									
7. Family physical abuse	-.04	.06	.06	.03	.04	.03	-								
8. Family sexual abuse	.02	.07	.05	.05	.15*	.04	.33**	-							
9. Physical violence at school	-.21**	.05	.06	.01	.02	.07	.27**	.22**	-						
10. Sexual violence at school	-.05	.18*	.01	.06	.11	.00	.25**	.25**	.26**	-					
11. Unsafe at school <sup>a</sup>	-.22**	-.02	.12	-.02	-.02	.07	.24**	-.01	.43**	.20**	-				
12. Openness about SO <sup>b</sup>	-.15*	-.02	.18**	.04	.00	-.16*	.22**	.09	.02	.14*	-.05	-			
13. Exclusion from groups	-.19**	.16*	.01	.04	.06	.02	.20*	.07	.36**	.22**	.39**	.08	-		
14. Accepted at school <sup>a</sup>	.22**	-.05	-.07	.02	-.01	-.13*	-.13*	.03	-.24**	-.10	-.34**	.15*	-.29**	-	
15. Kids at school like me <sup>a</sup>	.20**	-.10	-.12	.02	-.04	-.15*	-.07	.05	-.20**	-.09	-.35**	.20**	-.32**	<b>.65***</b>	-
16. Depression	-.19*	0.11	.06	.07	.01	.03	.18*	.01	.23**	.11	.29***	.18	.16*	-.27**	-.23**

Note. Coefficients in boldface indicate a medium to strong correlation.

<sup>a</sup>Pearson Product-Moment correlations. All other correlations conducted with phi coefficients or Cramer's V. <sup>b</sup>SO = sexual orientation.

\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

The final assumption of logistic regression, independence of errors, can be a concern when a participant completes the survey instrument more than once (Tabachnick & Fidell, 2007). Examination of the unique identifiers assigned to each participant in the Rainbow Alley survey confirmed that there were no duplicate cases in the data. Therefore, this dataset met the assumption of independence of errors.

***Statistical analyses.*** In the quantitative phase of this study, logistic regression and mediation analyses were used to test whether certain qualitative findings would also be found in survey data involving a larger sample. The first research question that guided the quantitative phase was “Do the social-environmental factors identified in the qualitative phase significantly predict the likelihood of engaging in NSSI among a larger sample of LGBTQ youth?” Sequential, binary logistic regression was used to answer this question using SPSS, version 21. This statistical method involved adding blocks of predictor variables in a sequential order to determine the contribution of each block in predicting the likelihood of the dependent variable (Tabachnick & Fidell, 2007). The order in which the blocks were added to the model was determined by the relative empirical and theoretical support for each; those that had the most support from the literature were entered first (Tabachnick & Fidell, 2007).

The first block of the sequential analysis included only the demographic variables measuring *sexual orientation*, *gender identity*, and *age*. In the second block, the five violence variables (*family physical abuse*, *family sexual abuse*, *physical violence at school*, *sexual harassment/violence at school*, and *feeling unsafe at school*) were added as predictors in the model. The third block added the *level of openness about sexual orientation* as an independent variable representing the *Negotiating LGBTQ Identity*



theme. In the fourth and final block in this model, two variables, *being accepted at school* and *exclusion from groups*, were added to the model as proxies for the *Invisibility and Isolation* qualitative theme. Finally, I analyzed a final, parsimonious model that included demographics as control variables and any of the social-environmental variables that were significant in blocks one through four.

The second quantitative research question was “Does depression mediate the relationship between social-environmental factors identified in the qualitative phase and NSSI among LGBTQ youth?” True to the sequential design of this mixed methods study, this question emerged directly from the qualitative findings in which participants described using NSSI to cope with depression related to social stressors such as violence, isolation, and oppression. Furthermore, existing literature has consistently found that depression plays a significant role in NSSI behavior among youth (Jacobson & Gould, 2007; Ross & Heath, 2002). Therefore, depression was included as a mediating variable to determine whether it would influence the relationships between social-environmental factors and NSSI among LGBTQ youth in this study.

This second quantitative research question was tested using the KHB method (Karlson & Holm, 2011; Karlson, Holm, and Breen, 2010; Kohler, Karlson, & Holm 2011). The KHB method is a relatively new statistical test that can be used to distinguish between direct and indirect effects of discrete and continuous variables in nonlinear probability models, such as logistic regression (Kohler et al., 2011). The primary advantage of the KHB method is that it corrects for scaling problems that occur in nonlinear models due to the fact that a model without a mediator variable will always have a larger standard error than a model that includes a mediator (Karlson & Holm,

2011). Without addressing this scaling problem, the mediation effect would be conflated with the rescaling effect (Karlson & Holm, 2011). The KHB method solves this rescaling problem by measuring each effect on the same scale, which allows the researcher to identify an indirect effect that is not confounded by rescaling (Karlson & Holm, 2011).

In order to answer this research question, three separate KHB mediation models were analyzed. Each mediation model included all of the demographic variables as controls and one of the three social-environmental variables that were significant in the sequential logistic regression model. In other words, the three models were specified as follows: (1) Demographic variables (controls), family physical violence (predictor), and depression (mediator) predicting NSSI; (2) Demographic variables (controls), feeling unsafe at school (predictor), and depression (mediator) predicting NSSI; and (3) Demographic variables (controls), openness about sexual orientation (predictor), and depression (mediator) predicting NSSI. These analyses were conducted in Stata, version 12.1. Three different models were analyzed because the KHB method does not control for correlation among the independent variables. Therefore, including each of the significant social-environmental variables and mediator in one model would have reduced the statistical power of the analysis.

These research questions and statistical analyses aligned with the exploratory, sequential design in that the qualitative themes explicitly informed the selection of variables for the quantitative phase. The Rainbow Alley dataset was limited in that it did not adequately measure variables related to every qualitative theme. Nonetheless, these quantitative analyses provided some indication as to whether the relationships between

social-environmental factors, depression, and NSSI found in the qualitative interviews could be found among a larger sample of LGBTQ youth.

*Validity and reliability of the quantitative data and analysis.* A limitation of secondary data analysis is that the researcher has no control over the instrumentation. I had no influence over what was measured, how it was measured, or the methods used to enhance the survey's reliability and validity. In regard to reliability, the Rainbow Alley survey had not undergone testing through repeated administration or split half analysis (Singleton & Straits, 2005). Furthermore, since no scales were used to measure the variables in this study, it was not possible to assess internal consistency.

It is often difficult to determine the validity of survey data (Singleton & Straits, 2005), and this was the case with the Rainbow Alley survey. During the development of the 2010 survey, some steps were taken to improve the face and content validity of several measures included in the current study. For example, earlier Rainbow Alley surveys asked only about cutting as one type of NSSI behavior. For the 2010 survey, Dr. Walls conducted a literature review in order to identify and include a more comprehensive list of NSSI methods as response options. This was done in order to improve the content validity of the NSSI measures by capturing a broader range of youth's experiences with the behavior.

As previously mentioned, only one variable used in this study (depression) was measured using one item from a validated instrument (the YRBS; CDC, 2011). The remaining variables used in this study were measured using items that had not been empirically tested prior to their inclusion in the Rainbow Alley survey. Therefore, further research is needed to determine the validity of these items.

Another factor that may have influenced the validity of the Rainbow Alley survey is the tendency of participants to provide answers that they perceive to be socially desirable (Singleton & Straits, 2005). Considering the sensitive nature of some of the survey questions used in this study, it is possible that social desirability may have introduced systematic measurement error (Singleton & Straits, 2005). Yet, social desirability is less likely to pose a problem when questions are asked in an anonymous, self-report survey than when measurement relies on verbal reports or observation (Singleton & Straits, 2005).

These measurement issues must be considered in the context of the purpose and design of this study. The study was exploratory in nature and aimed to provide preliminary insights into the social-environmental factors related to NSSI among LGBTQ youth. Although the survey had not been rigorously tested prior to its administration, it did provide access to information from over 250 LGBTQ youth who were asked about their experiences with NSSI. As discussed earlier, the survey data also aligned well with the qualitative data, which allowed for a logical comparison of the findings from both phases of the study. Furthermore, the mixed methods design of the study had the potential to strengthen the validity and reliability of the findings from both phases because it involved triangulation across methods (Creswell & Plano Clark, 2011; Patton, 2002). This approach allowed for examination of the (in)consistencies across the qualitative and quantitative findings (Patton, 2002).

**Summary of quantitative methods.** The previous discussion outlined the methods used in the second, quantitative, phase of this mixed methods study. This phase involved secondary analysis of survey data collected by Rainbow Alley. Guided by the

sequential design of this study, the qualitative themes were used to refine the quantitative research questions and to select variables from the Rainbow Alley survey for inclusion in the statistical analyses. A sequential logistic regression model was conducted to determine whether social-environmental factors from the qualitative phase would significantly predict engagement in NSSI in the survey data. Subsequently, the KHB method was used to test whether depression would mediate the relationship between certain social-environmental factors and NSSI among LGBTQ youth. Due to the reliance on secondary data, there were several limitations to the reliability and validity of the Rainbow Alley survey. Nonetheless, including analyses of survey data in this exploratory study allowed me to examine whether the patterns identified in the qualitative phase could be found in data collected from over 250 LGBTQ youth.

### **Human Subjects Protections**

Since this study involved analysis of two existing datasets, there was little to no additional risk to research participants. The University of Denver's IRB previously approved the original studies in which the quantitative and qualitative data were collected. My research aims were consistent with those outlined in the original IRB protocols. Additionally, the university approved a separate IRB protocol outlining the particular research questions and methods used in the current study.

As described earlier, the interview data used in this study were de-identified prior to analysis. Thus, it is unlikely that a participant's confidentiality would be inadvertently violated. However, it is important to address this risk, no matter how small, particularly when research participants belong to a very small, marginalized community, as is the case for LGBTQ youth. Data suppression was used when necessary to prevent the

possibility of identifying any single participant. For example, detailed demographic and contextual information was not included when presenting direct quotes from interview transcripts to avoid inadvertently compromising a participant's confidentiality.

### **Chapter Summary**

This chapter described the methods used in this exploratory, sequential mixed methods study of the relationship between the social environment and NSSI among LGBTQ youth. The research design prioritized qualitative analysis of transcripts from interviews with LGBTQ youth in order to understand how youth themselves described the social-environmental factors that influenced NSSI. After completion of the qualitative analysis, quantitative analyses were conducted using survey data collected by Rainbow Alley. The quantitative phase of the study aimed to determine whether patterns identified in the qualitative data could be found among a larger sample of LGBTQ youth. Subsequent chapters will present the results of the qualitative and quantitative phases of the study.

## Chapter Four: Qualitative Results

This chapter will present the results from the first, qualitative, phase of this mixed methods study. Initially, the demographic characteristics of the participants who completed individual interviews at Rainbow Alley will be described. The descriptive data will also include information about types of NSSI behavior used by LGBTQ youth in the study. Subsequently, this chapter will provide an in-depth presentation of each of the five themes that emerged from the constant comparative analytic process: (1) *Violence*; (2) *Misconceptions, Stigma, and Shame*; (3) *Negotiating LGBTQ Identity*; (4) *Invisibility and Isolation*; and (5) *Peer Relationships*.

### Qualitative Sample Demographics

Demographic and other salient characteristics of study participants were collected through the screening process and semi-structured interviews. Some were asked through direct questions (e.g., “When it comes to your sexual orientation, how do you identify?”), while others were gleaned from the transcripts based on what each participant revealed during the interview.

**Age and gender identity.** The 44 study participants ranged in age from 15 to 22 years old, with a mean age of 18.46 ( $SD = 1.43$ ). The exact age was unknown for three participants; of those, one was over 18 and one was a high school senior, so was likely between the ages of 17 and 18. In terms of gender identity, 17 participants self-identified

as male (one of whom was assigned female at birth), 15 self-identified as female, 10 identified as transgender or genderqueer, one described herself as androgynous, and one identified as a person. Among those who identified as transgender or genderqueer, four described themselves as transgender males, three were genderqueer, one was a transgender female, one identified as “mostly female,” and another identified as a cross-dresser.

**Sexual orientation.** The majority of study participants described their sexual orientation as either bisexual ( $n = 15$ ) or pansexual ( $n = 8$ ). Among others, five identified as lesbian and four as gay, two described themselves as questioning their sexual orientation, and one self-identified as queer. Two participants self-identified as straight and one as “mostly straight,” though all three described themselves as transgender or genderqueer, thus meeting the eligibility requirements for this study. Other participants had slightly more nuanced ways of describing their sexual orientation. One interviewee described himself as “like[ing] guys and girls” but did not explicitly use bisexual or pansexual as labels, another self-identified as “gender straight,” and three others utilized multiple labels to describe themselves depending on the context, including queer/pansexual, gay/queer, and queer/lesbian. Another participant explained that he “feel[s] gay” but used the term bisexual because he perceived that that identity was more socially acceptable. The range of labels used by youth in this sample demonstrates the complexity and fluidity of sexual identity among LGBTQ youth. It also sheds light on the experience that some youth have as they deliberately choose words to describe themselves based on how those words will be interpreted by others in their social environments.



**Age of LGBTQ identification.** Youth in this study were asked how long they had identified as LGBTQ. On average, participants reported that they had identified their sexual orientation at age 13.51 ( $SD = 2.72$ ), with responses ranging from ages 6.0 to 17.5. All of the transgender and genderqueer youth in the study identified their gender identity later than their sexual orientation, reporting an average age of 15.45 ( $SD = 2.58$ ) and a smaller range from 12.0 to 18.5. In some cases, youth provided a year in school or an age range rather than an exact age of identification. Where a year in school was given, I used the average of the typical ages of a student in that grade (e.g., a typical high school freshman is between 14 and 15, so the participant would be coded as identifying as LGBTQ at age 14.5). Similarly, when a participant offered an age range or period of time, an average was used to determine the age of identification as LGBTQ. The age of LGBTQ identification was unknown for two study participants.

These data should be interpreted cautiously because the actual interview question was ambiguous. Specifically, participants were asked, “How long have you identified as [label]?” Youth may have interpreted this question in a variety of ways including: (1) the age at which they began to question their sexual orientation/gender identity; (2) the age at which they first knew they were LGBTQ, but had not yet told others; (3) the age at which they first “identified” to others as being LGBTQ; or (4) how long they had used that particular label (as opposed to other labels) to identify themselves. Given that most youth identify *to themselves* several years before coming out to others (D’Augelli & Hershberger, 1993), the conflation of these categories likely makes these data somewhat unreliable.

**Race/ethnicity.** The race/ethnicity of six participants was not known. Among the remaining 38 participants, over half ( $n = 22$ ) identified as White, one quarter ( $n = 10$ ) described themselves as biracial or multiracial, three identified as Hispanic/Latino, two as African American, and one was as a person of color.

**School, work, and living situation.** At the time of the interviews, over half ( $n = 26$ ) of the participants were in school or college, 16 were not in school, and one was in a General Educational Development (GED) program. School status was unknown for one participant. In terms of employment status, the majority of youth ( $n = 28$ ) were not working (though 16 of those were looking for work), 12 were employed, and the status was unknown for four participants. Regarding participants' living situations, 22 lived with one or more family members, five lived with friends/roommates, two lived alone, and three were homeless (living in a shelter or elsewhere) at the time of the interview. The living arrangements of 12 participants were unknown.

**NSSI methods.** Study participants were asked to describe the type(s) of NSSI in which they engaged. Overall, cutting was the most common NSSI behavior among youth in this study. A total of 38 youth (86% of the sample) reported a history of cutting. Nearly half ( $n = 22$ ) of participants said that cutting was their *primary* method of NSSI. Among those for whom cutting was their primary method, half ( $n = 11$ ) used cutting as their sole method of NSSI, while the remaining half also used other, secondary or tertiary methods, including: burning ( $n = 3$ ), drug and/or alcohol use ( $n = 2$ ), scratching ( $n = 2$ ), rubber band snapping ( $n = 2$ ), playing the eraser game,<sup>5</sup> piercing with pins, putting hot

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<sup>5</sup> The eraser game involves rubbing one's skin briskly with a pencil eraser until the skin becomes damaged. The game may involve rubbing the skin for a specific duration, such as the time it takes to recite the alphabet.

wax on their skin, lip-biting, choking, aggravating injuries, excessive exercise, and sleep deprivation. One person noted that biting was his primary method (with hitting/punching himself as a secondary method) and another endorsed burning as a primary method (with performing dangerous stunts as a secondary method). Notably, 20 participants did not indicate a primary method of NSSI. Among those participants, cutting was still the most commonly reported NSSI method ( $n = 16$ ). Table 5 provides further detail about the NSSI methods described by participants in this study.

Some of the methods reported by study participants may or may not be classified as NSSI by researchers and clinicians. For example, although drug/alcohol use, eating disorders, and risky behaviors such as reckless driving can be self-destructive, some scholars view these behaviors as different from NSSI (e.g., Nock, 2010; Ross & Heath, 2002). However, the aim of qualitative inquiry is to understand a phenomenon from the perspective of people who are most intimately familiar with an experience or behavior. Therefore, when youth identified drug and alcohol use or disordered eating as forms of NSSI, they were categorized as such in this study. None of the study participants indicated that drug/alcohol use or disordered eating was their sole or primary NSSI method. Youth who described those behaviors as a form of self-harm also engaged in at least one other NSSI method.

Table 5  
*NSSI Methods Reported by Interview Participants*

NSSI method	<i>Freq.</i>	%
Cutting	38	86.4
Burning	7	15.9
Scratching	7	15.9
Hitting/punching self or objects	7	15.9
Drug and alcohol use	6	13.6
Piercing or stabbing with knives, safety pins or needles	5	11.4
Choking	4	9.1
Hair pulling/picking	3	6.8
Starting fights to get injured	3	6.8
Biting	2	4.5
Performing dangerous stunts	2	4.5
Rubber band snapping	2	4.5
Excessive exercise	2	4.5
Bulimia	1	2.3
Fasting	1	2.3
Shocking with electricity	1	2.3
Driving at dangerous speeds	1	2.3
Scab picking	1	2.3
Aggravating existing injuries	1	2.3
Clawing	1	2.3
Taking extremely hot showers	1	2.3
Hyperventilating to pass out	1	2.3
Playing the eraser game	1	2.3
Putting hot wax on skin	1	2.3
Ingesting	1	2.3
Sleep deprivation	1	2.3

*Note.*  $N = 44$ . Percentages do not add up to 100 because several participants engaged in more than one NSSI method.

**Age of NSSI onset.** During the interview, all but five participants were asked to estimate the age at which they first started engaging in NSSI behavior. Of those 39 participants, the average age of onset was 12.2 ( $SD = 2.72$ ), with ages ranging from 6.0 to 17.5. As with the question about age of LGBTQ identification, some youth reported initiating NSSI during a particular school year or age range rather than a specific age. In these cases, averages were used as described in the previous section on age of identification.

### **Results of the Qualitative Analysis**

Using the constant comparative method, five themes were identified in relation to the research question: “How do LGBTQ youth describe the relationship between their social environment and their experiences with NSSI?” In the following discussion, I will present a description of each of the themes, supported by example quotations from the interview transcripts. Table 6 provides a visual display of each theme with the associated in vivo codes, open codes, and dimensions.

Table 6  
*Summary of Findings from Qualitative Analysis with Associated Codes*

<b>Theme: Violence</b>	
In vivo codes	A destructive feeling, I have flashbacks, it will go back to my childhood, teased all my life, telling me that I’m a failure, the whole cycle of being abused, there’s my mom—slice, trying to find relief.
Open codes	Bullying, family loss, family neglect, homophobia, invalidating responses to disclosure, family abuse, function: deal with abuse, function: deal with family stress, NSSI as only option, NSSI first experience, NSSI trigger, service usage, sexual abuse, and violence.
Dimensions	(1) Violence and NSSI onset, (2) violence as a trigger for NSSI, and (3) memories of violence as a trigger for NSSI.

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**Theme: Misconceptions, stigma, and shame**

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In vivo codes	A bad tattoo, highly frowned upon, horrible cycle, really socially withdrawn, I'm not wanted, I'm Satan, kill yourself a little bit at a time, I don't tell anybody, treat me like a human being, we didn't want to appear weak, what's wrong with you, you don't understand.
Open codes	Attention seeking, confidentiality/privacy, fear of others finding out, how other people do or will react, family response to NSSI, reduce isolation, social relationships, hiding it, negative messages/reactions, not understood, NSSI stigma, shame/embarrassment, NSSI negative, service usage, stress.
Dimensions	(1) People don't understand, (2) myths and stereotypes, (3) negative messages, and (4) hiding it.

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**Theme: Negotiating LGBTQ identity**

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In vivo codes	Be my own person, black hole, fixing something that was wrong, I couldn't really come out, I didn't really know who I was, I don't like the boy body, I don't want them to win, I feel better about myself, It's taken a lot of time, I was insane before, makes me feel more loved, coming out process, really confusing, the gay marriage thing, you fucking fag.
Open codes	Biphobia, body image, bullying, claiming/pride in SOGI, coming out, homophobia, internalized trans/homophobia, finding myself, self-hatred, self-punishment/destruction, identity pride, NSSI and SOGI, NSSI trigger, self-acceptance, violence.
Dimensions	(1) Coming out to self and others, (2) oppression and rejection, (3) body hatred, and (4) self-acceptance and identity integration.

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**Theme: Invisibility and isolation**

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In vivo codes	Feeling alone, I didn't fit in, I was worth it, I'm not invisible no more, I'm not wanted, I was all by myself, I was alone, I wasn't my own person, nobody to talk to, nobody's there, no one cares, outcast, treat me like a human being.
Open codes	Alone, attention seeking, being judged, family neglect, family response to SOGI, family stress, attention/be noticed, deal with family stress, externalize pain or emotions, in the closet, invisible, NSSI first experience, NSSI impact, NSSI trigger, service usage.
Dimensions	(1) Not being seen or heard, (2) feeling alone, (3) I don't belong, and (4) attention seeking.

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**Theme: Peer relationships**

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In vivo codes	A subculture and an image, come talk to me, friends that cut, gateway person, help each other, it felt like a trend, just like in a gang, kind of trendy, let's have a cutting party, online, our own support group, pact, she doesn't talk, she's going through the same thing, they just talk to me, they know my story, we can relate, we support each other, we talk, when we have urges, you can actually understand, you can come to me.
Open codes	Bond between cutters, cutting parties, NSSI in my presence, NSSI (un)common, to belong, social relationships, being judged, NSSI first experience, NSSI first learned, NSSI impact, NSSI normalizing, NSSI stigma, pact with friends/partner, peer communication about NSSI, peer help seeking/giving, shared experiences, showing and seeing scars, social contagion, "we" language.
Dimensions	(1) Peer communication about NSSI, (2) peer help seeking, and (3) peer influence.

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**Theme 1: Violence.** In exploring how youth described the relationship between their social environment and NSSI, violence was a clear and continuous theme throughout the data. This theme highlights participants' experiences with violence and describes how violence was related to their NSSI behavior. Interview participants experienced many forms of violence, including physical, emotional, and sexual violence, bullying, and neglect by family members, peers, and others. Data coded to this theme shed light on how experiencing violence, having memories or flashbacks of violence, fear of future re-victimization, and witnessing acts of violence against others related to participants' NSSI behavior.

It is important to note that not all of the interview participants reported experiencing violence. There were also some participants who talked about exposure to violence during their interviews but did not discuss whether or how violence was related to their NSSI behavior. In order to stay true to the research question, these data were not

included in the final results. The voices of LGBTQ youth who specifically described the relationship between violence in their social environment and their NSSI behavior are brought forward in this theme.

*Violence and NSSI onset.* Several interview participants explained that violence contributed to the initial onset of their NSSI behavior. In these instances, youth described their first engagement in NSSI as an attempt to deal with the overwhelming emotions associated with experiencing violence. This bisexual participant initiated NSSI to cope with growing up in an abusive and neglectful home. When asked when she first started engaging in NSSI, she explained:

I was definitely six because I was always put in my room. I was never allowed to go hang out with the family, and it was just an easier way to, like, this sounds really weird, but it was a way to pass time. And every time I heard a footstep or something, it'd just be, 'oh my god, there's my mom,'—slice. That's just how it happened. (P3)

This participant began engaging in NSSI at a very young age, not only to “pass [the] time” when she was isolated from her family, but also to manage the emotions triggered by the possibility of interacting with her abusive mother. In this segment, she explained, “That’s just how it happened,” as if it was an automatic fight or flight response to her fear of being re-victimized by her mother.

Another participant who identified as pansexual described a similar experience where cutting was first used to deal with the aftermath of rape.

I've been an ongoing on-and-off cutter since I was thirteen...after, I was sexually assaulted, and I just didn't know what to do with myself. There was just a destructive feeling, and I hadn't heard about it, I just grabbed something sharp



and went at it, and I felt better, and I just kinda sat there, like... ‘this is just what we have to do now.’ (P39)

As with the previous participant, this youth described the onset of NSSI as an impulsive, almost desperate attempt to find any way to deal with the “destructive feeling” that *ze*<sup>6</sup> experienced after being sexually assaulted. Further, the segment, “this is just what we have to do now,” conveyed a sense that this youth perceived cutting as a necessary and functional behavior to deal with the experience of sexual assault, in the absence of other effective coping mechanisms.

In another example, this bisexual youth described how she perceived the connection between being abused and the onset of cutting in her life. She stated:

See, the whole reason I started cutting was because I went to child services because my step dad was raping me and they gave me, like, they put me in a room where they showed me two pieces of paper showing the parts and stuff, asking, like, what he did. And it happened many different times, so I couldn’t remember the exact time and the exact place, so they never did anything about it, they just told me that I was lying. So I started cutting, and...my mom got a divorce because of me, and that’s when I started cutting and all that stuff...Nothing ever happened about it, so I just was trying to find relief—trying to find something that would hurt less. (P31)

For this participant, cutting was used as a way to find relief from the pain of experiencing sexual abuse at the hands of her stepfather. What is further illuminating in this segment

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<sup>6</sup> The singular gender-neutral pronoun *ze* and possessive pronoun *hir* will be used for transgender and genderqueer participants in cases where their preferred gender pronouns are unknown.

is that she described not only experiencing violence from her abuser, but also from the child protective services system that accused her of lying about the abuse and did not punish her abuser. This youth's powerful words convey her sense of confusion and disempowerment throughout the abuse investigation process, where, ultimately, the system responsible for protecting her, "never did anything about it." This participant also described a sense of self-blame for her mother and stepfather's divorce. This quote suggests that it would be an oversimplification to conclude that violence causes NSSI. Instead, this young woman described a complex relationship between experiencing abuse, disempowerment, and disruption in her social environment, and her attempt to relieve the overwhelming pain associated with those experiences through cutting.

In the following segment, a lesbian youth described a similar scenario in which she engaged in NSSI after being abused by her brother:

I was being abused, and I think that's mainly what brought it on is me being sexually abused by my...second oldest brother. That came out when I was, like, thirteen in a placement...and they really didn't do anything about it just because he was out of state so they really couldn't. So they just made us do therapy together when he would come back to visit. And he's really sorry and I'm not mad at him anyway and I don't blame him in any way just because he had it done to him...It's like everybody I've been abused by somebody's abused the person that's abused me, so it's just the whole cycle of being abused and abused and abused, over and over and around and around. (P20)

As with the previous participant, this youth shared her experience disclosing abuse to child protective services while in their custody. She described a sense of powerlessness

and also perhaps resignation, acknowledging that the system was unable to intervene in the cycle of abuse that had harmed both her and her brother. She also expressed compassion for her brother and others in her life that abused her; they had been victims as well as perpetrators in cycle of abuse. Once again, this segment illustrates the multifaceted relationship between NSSI and violence. This participant engaged in NSSI to understand and cope with the cycle of abuse that deeply affected her family.

For other participants, bullying by peers led to the onset of their NSSI behavior. In one example, this bisexual youth described how teasing ultimately led up to her first cutting experience:

I've been teased all my life for being heavy-set and being bi—like, it all comes in the same thing. It got to the point where people were just like hounding me on it. I was like, 'I can't change my body,' because I have health issues, and I was like, 'I can't change my body, and I don't want to change myself.' And it just got to the point where I'd go home crying and I still had those pieces [of broken glass].

I was like, 'eh, well, whatever,' you know, I just did it. (P18)

In this quote, this youth talked about an escalating pattern of bullying where she was targeted both because of her body size as well as her sexual orientation. Notably, she indicated that these forms of bullying were inseparable, stating, "it all comes in the same thing." She felt powerless, unable to escape the bullying and confronting the relentless peer pressure to change her appearance and identity. Yet, her profound statement, "I don't want to change myself," highlights her sense of self as well as her resistance to her tormentors. Despite this, bullying triggered overwhelming feelings, which ultimately led her to initiate cutting. Similar to participants discussed earlier, this youth noted that the

onset of NSSI was impulsive, stating, “Well...whatever...I just did it.” This quote also conveys a sense of isolation; it seems as though she was completely alone in dealing with bullying. As with previous examples, the failure of adults to effectively intervene in the violence against her may have had bearing on the relationship between violence and NSSI in her life.

*Violence as a trigger for re-engaging in NSSI.* Another way in which interview participants described the relationship between NSSI and violence was that violent incidents often triggered them to re-engage in or escalate their behavior. For example, this bisexual participant described one of several incidents in which she engaged in NSSI following abuse by a family member:

P10: My step-dad, he’s alcoholic, he’ll drink beer 24/7. And he threw a beer bottle at me, and me and him got at it, like fighting, fighting, and I almost killed him. I just left the house, and I talked to a police officer down there in [name of state] and get me a bus ticket and come back down here. And so I did.

I: And you hurt yourself that day?

P10: Mm-hm.

I: How?

P10: Uh, break a car window.

I: You just punched--?

P10: I punched a lot.

Another participant succinctly described a similar pattern of violence triggering his NSSI behavior, noting, “basically the triggers back then were being yelled at, being beaten, just being left alone” (P28).

In a similar example, one young man explained that experiencing on-going violence from his stepfather gave him the urge to seek out physical fights as a form of NSSI. He explained:

I didn't know if I was going to make it to the next stages 'cause of how abusive my stepdad was...There's been a couple of times where he's beat me to the point where I couldn't go to school the next day, or like the rest of the week, just of how badly bruised and stuff I was. But, and this stuff was reported, but because I didn't testify 'cause I was worried about what was going to happen, they just dismissed it...Instead of suicidal, I was feeling more homicidal...The person that I really wanted to hurt the most was my stepdad, just 'cause of how much he put me and my mom and my sisters through. And...like, I got into a fight when I was fifteen over like some stupid kid was just doing this shit, like just teasing me. And then I got some kind of rush outta that and I just kept doing it, and then I ended up going into, like, the hospitals and stuff. (P19)

This participant described seeking out fights as way to deal with his anger toward his abusive stepfather. Unprotected by the court system and unable to retaliate against his perpetrator, he displaced his anger onto others who mistreated him, such as the peer who teased him. It is notable that, throughout his interview, this participant described fighting as a form of NSSI, where he intentionally sought out fights in order to become injured. Later in the interview, this youth acknowledged that picking fights with stronger opponents was also his way of preparing himself to fight his stepfather. Helping professionals might mistakenly interpret his behavior as aggressive or even anti-social, when it was actually an externalizing form of harming himself (as well as others). This

participant's story points to the importance of understanding youth's motivations for and insights about their NSSI behavior in order to effectively provide support and help.

A queer participant also talked about the connection between being abused by her parents and engaging in NSSI. When asked what triggered her cutting, hair picking, and scratching behaviors, she responded:

Definitely my parents. My parents and I have always had a hard time. When I was younger, they were abusive physically and emotionally and I never told anyone. So I guess I sort was just like, 'I'm so mad that you can do this to me! Look what I can do to myself!' (P25)

In this excerpt, this youth explained that she engaged in NSSI as a way of expressing anger to her parents about the abuse they put her through. Her words also suggest that causing harm to herself was a way to challenge her parents and reclaim some control over her own body.

In addition to abuse by family members, bullying by peers was an NSSI trigger for several youth in the study. When asked about her triggers, this participant responded:

P14: Stress, bullying, just stress in the family and things like that.

I: Yeah. In terms of bullying, what kinds of bullying did you experience?

P14: I just got bullied on 'cause I was never the most popular person in the world. So I was kinda just harassed and bullied through my school life...In ninth grade I got bullied a lot, but over the years they kinda calmed down.

A questioning participant also felt that being harassed by kids at school was a trigger for his NSSI, explaining, "sometimes at school, like when the kids mess with me and bother me and all that, like, that makes it even more frustrating" (P24). It is unclear whether

these youth were harassed based on their sexual orientation, gender identity, or other attributes. Regardless of the targeted identity, bullying played a role in NSSI behavior among these LGBTQ youth.

*Memories of violence as a trigger for NSSI.* Many youth in the sample explained that reminders of violent incidents they had experienced or witnessed in the past also triggered their NSSI behavior. For example, one youth described the following as triggers for her cutting and choking behaviors: “Anybody I see who beats somebody or somebody who throws stuff. Bang! Loud noises...Like if I see somebody holding somebody down, that kinds of things are triggers for me” (P31). Similarly, another youth described her NSSI triggers as, “when I hear gunshots or when I see people that I care about fighting” (P1). Yet another participant explained “[my triggers] are basically past abuse and situations where things have happened to me that were very traumatic. Stuff like that is what triggers it” (P36). In these examples, the interview participants emphasized that specific, patterned experiences in their social environment had the potential to remind them of past violence, which could trigger their impulse to engage in self-harm.

Other participants reported that experiencing flashbacks of traumatic experiences triggered their NSSI behavior. For example, this bisexual youth described burning himself as a way to manage flashbacks of severe abuse by his stepfather:

For me, it’s [NSSI is] a big memory thing. I have flashbacks every now and then...My parents broke up before I could really remember. They had joint custody, but my dad joined the Navy, so I lived with my mother, who later married a long-haul truck driver. They started getting into meth...He’s in prison

now for killing my sister. He loved to beat the shit out of me and my brother and my mom. I was raped by him a couple times. He knocked me unconscious with a baseball bat on one occasion, at least, I'm not sure. My memory's kind of fucked up there. But I have flashbacks now and then. And, starting when I was about ten, I started, whenever I would have a flashback, I would burn myself just usually with a lighter or whatever to get myself away from [inaudible]. Well, later on I kind of got hooked on it, became a massive pyromaniac, [and] started kind of doing stunts—lightin' my arm on fire. I lit my head on fire once. My hair grew back, thank god. (P13)

In this quote, the participant explained that burning himself allowed him to escape from the flashbacks and the emotions that these memories evoked for him. He described using NSSI as an instrumental, though destructive, coping mechanism to survive unspeakable abuse. His behavior seemed to be functional initially, but, over time, he explained that he “kind of got hooked on it” and described an escalation of NSSI that seemed to be out of his control. This participant was one among several in the study that described NSSI using the language of addiction. The similarities and distinctions between NSSI and addiction are beyond the scope of this dissertation. However, this young man's story suggests that using NSSI to cope with violence may be similar in some ways to using other behaviors such as drinking and drug use to numb the pain of abuse.

In sum, youth in this study described a range of ways in which they used NSSI in the midst or aftermath of violence. Many youth in this study engaged in NSSI to cope with the violence they had experienced at the hands of their families, peers, and others. For some, their first initiation of NSSI occurred in the immediate aftermath of violence,



while others talked about ways in which experiencing violence was a trigger for their re-engagement in NSSI. In other instances, youth explained that memories or flashbacks of abuse were associated with their NSSI behavior. Though each of these stories is unique, they all shed light on ways in which LGBTQ youth use NSSI as a way to cope with violence, which for many was a pervasive social reality.

**Theme 2: Misconceptions, stigma, and shame.** This theme describes participants' experiences navigating a social context in which NSSI—and those who engage in NSSI—are often misunderstood and maligned. Data were coded to this theme when participants explained that NSSI was poorly understood or mischaracterized by people who have never self-injured. Across the data, youth often received negative messages and unhelpful responses from others, which contributed to their feelings of embarrassment and shame. This theme also includes quotes about participants' attempts to hide their NSSI behavior to avoid embarrassment, undesired attention, and other negative responses.

*People don't understand.* A common refrain across the transcripts in this study was the perception that others, particularly adults, did not understand NSSI behavior. Participants explained that many people were not able to relate to or understand their motivation for engaging in NSSI or the ways in which NSSI was used as a coping mechanism. One bisexual youth explained this from his point of view, stating, “a lot of people don't understand it because, you know, how can you relieve stress by causing harm to yourself?” (P28). As a result of this lack of understanding, others tended to respond to youth in unhelpful ways that reinforced their feelings of shame and self-blame. A lesbian participant offered further insight into this issue:

A lot of people are not very understanding, they would think, ‘Why would you cut your skin, or why would you overdose or why would you do stuff that to your body, like, what’s wrong with you?’ And it’s like, ‘This has nothing to do with the fact what’s wrong with us. You don’t understand what we’re going through.’ And [it’s important] to be talking about it and to make sure people can understand, ‘Oh, that person is really struggling, and that’s why it’s a form of their coping skill.’” And it may not be the best coping skills. But it’s a form of a coping skill for them. (P20)

In this excerpt, this young woman explained that people often pathologize youth who self-harm rather than seeking to understand and respond to what youth are “going through.” She emphasized the importance of helping others understand that NSSI is a coping behavior used to deal with difficult feelings and situations.

Several youth in the study expressed the view that people who have never engaged in NSSI were incapable of fully understanding the behavior. For example, this bisexual participant stated:

[People should] just try to be more understanding and not jump to conclusions, ‘cause my father and my parents have done that. They’re not very understanding and they jump to conclusions a lot...People who don’t cut, have never cut, will not actually, completely understand why...To me they won’t completely—they’ll understand through facts, but they won’t emotionally understand. (P2)

The same view was offered by a pansexual youth who explained,

‘Cause ‘specially if, with a lot of adults, they haven’t cut before. They don’t know how it is and it’s just like, ‘How can you relate to what I’m going through?’

Say, ‘I know you care about me, I know you love about me and everything, but, you know, seriously. Treat me like a human being! I have a brain! I’m not a monkey with a cymbal!’ (P26)

In these two excerpts, the participants shared their perceptions that only people who have engaged in NSSI can truly understand it on an emotional level. Without that understanding, these youth felt that their parents and other adults could not relate to them. These youth indicated that adults who did not understand NSSI had made harmful assumptions, perhaps despite good intentions. The latter participant further explained that adults who were unable to understand and relate to him responded in ways that were dehumanizing and that denied his personal agency.

*Myths and stereotypes.* Study participants identified several myths and stereotypes about NSSI that contributed to others’ lack of understanding about the behavior and further stigmatized people who self-harm. One myth that was harmful to some youth in the study was the view that people use NSSI to get attention. In this excerpt, a lesbian participant described how that misconception contributed to her cutting behavior. When asked what has prevented her from stopping NSSI, she explained:

Just getting too angry, where people don’t listen to me and when I talk to some people, like the staff at [name of residential treatment program], like they just say I was attention seeking or something, so that would just irritate me more and make me do it more. (P1)

In this example, this young woman tried to talk to staff at her residential treatment program, but felt they did not listen and dismissed her behavior as attention seeking. This response made her feel angrier, which perpetuated her cutting behavior.

A different lesbian youth described her own experience with the myth that those who self-harm are seeking attention. She described how the messages she received from others in her social environment contributed to feeling ashamed about NSSI:

People always talk about cutters being in search of attention, like, ‘Oh, she’s just doing it for attention. It has nothing to do with how she’s actually feeling.’ But I think that it has a lot of stigma around it, about people saying, you know, ‘It’s just something that people do for attention. It doesn’t really have to do with how they’re feeling.’ (P9)

Similar to the previous excerpt, this participant explained that the stereotype that cutters are seeking attention obscures the real experiences and emotions of people who cut. In her view, this dismissive response contributed to the stigma associated with NSSI.

It is important to note that several youth in the study did indicate that they engaged in NSSI as a way to get attention, as will be described in further detail later in this chapter. However, this was not the case for the majority of youth. The data presented here emphasize the importance of talking to young people directly to understand the motivation behind their NSSI behavior instead of making potentially harmful assumptions. These participants’ stories suggest that failure to do so can lead to further stigmatization of LGBTQ youth who engage in NSSI.

Another harmful myth about NSSI that negatively impacted youth in this study was the view that NSSI is a suicidal act. A lesbian participant described how this myth influenced the way in which others treated her:

And people also assume that cutting means you’re going to kill yourself, and then they send you to a home, and they watch everything you eat, they don’t let you

have, like, nail polish remover... That's not really the same thing—being suicidal and being self-harming. And suicide, it's like illegal nowadays. It's like, 'You can't commit suicide, it's illegal. We'll put you, we'll lock you up.' And so, self-harming, it's like, 'Oh, you must be suicidal. Let's go put you in a room with rubber walls and, you know, a bunch of teddy bears...and lambs.' (P9)

This youth emphasized that others' lack of understanding about the distinction between NSSI and suicide led them to respond inappropriately in ways that disempowered and infantilized her. A pansexual participant also shared similar experiences with this myth, stating:

I really hate the stereotypes about it [NSSI], and...[name of staff person at Rainbow Alley] actually gave me a paper on misconceptions, and something that's a big deal is that, you know, 'People that cut are suicidal.' That's not true. A lot of people that cut are trying to refrain from killing themselves. It's like, [you] just kill yourself a little bit at a time. That's a weird way to put it, but it's true. (P39)

Each of these quotes highlights specific myths or stereotypes about NSSI that were pervasive in LGBTQ youth's social environments. These participants' stories offer insights into ways in which these myths and stereotypes can be harmful to youth who engage in NSSI. According to these participants, adults who held false assumptions about NSSI tended to respond to them in misguided, unhelpful ways. Perhaps most importantly, these youth emphasized that myths and stereotypes distracted people from their real feelings and experiences, hindering the opportunity to provide effective help and support.

*Negative messages.* In addition to the myths and stereotypes discussed above, youth in this study reported hearing negative messages about NSSI. These messages permeated participants' social environments and manifested in both overt and covert ways. For example, many youth in the study learned that NSSI and those who engaged in the behavior were "bad." A bisexual participant explained that people, "tend to talk badly about it [NSSI]. They call people who cut 'emos' and all the bad names" (P2). Similarly, a genderqueer youth noted, "it's definitely one of those things that is highly frowned upon" (P41). A gay male participant simply said, "it will like make people look at you differently and all that stuff" (P4).

Many youth in the study internalized negative messages about NSSI, which led to feelings of shame and embarrassment. This gay participant explained, "I felt like it was something to be ashamed of, something you shouldn't show, something you should keep hidden, like a bad habit" (P4). A genderqueer youth talked about the shame he felt when looking at cutting scars on his body. He stated, "I'm generally very embarrassed about what it was and, like, how I feel like it was a trendy thing at the time you know? It feels like a bad tattoo" (P38). Another participant explained that religious teachings about self-harm contributed to her feelings of shame. She stated:

I was always ashamed of doing it, because again, with my Catholic raising, you know, self-harm, self-mutilation, suicide, any of that, anything that you did to harm your body that was a creation of God was bad, was evil. It was of Satan. So to be growing up in a house, being like, 'Oh, god. I'm Satan! Great!' (P25)

This queer participant also noted that embarrassment about NSSI led to a code of silence among her and her friends:

It was kinda this unspoken thing where I knew that my friends did it and my friends knew that I did it, but we didn't talk about it because it was embarrassing to talk about the fact that I'm hurting myself because I don't feel like I can deal with the emotions that I have. And, I think that a lot of us thought that it showed weakness, and we didn't want to appear weak. (P29)

Yet another youth described how embarrassment about NSSI inhibited her help-seeking behavior, stating:

I'm always really embarrassed about it, so even, like, with my therapist, I don't tell her. She'll be like, 'You seem really sad today. Have you thought about hurting yourself?' And I'm like, 'No.' Then I hide it and I try not to tell her because it's really embarrassing for me. (P9)

Each of these examples demonstrates the potentially harmful influence of negative messages about NSSI and those who engage in the behavior. These participants clearly learned and internalized messages that NSSI was wrong or taboo, which led them to feel that they were "bad" for engaging in the behavior. Feelings of shame and embarrassment about NSSI led several of these young people to remain silent about self-harm, often keeping it hidden from people in their social world.

Notably, youth in this study varied in terms of their internalization of negative messages about NSSI. Some reported learning that others perceived NSSI as wrong, but did not share that view themselves. One pansexual participant acknowledged that his friends who engaged in self-harm did not want others to know about it, "'cause self-harm can be a very embarrassing thing" (P44). Yet, he did not feel embarrassed about his own behavior, emphasizing, "I wear my scars with pride" (P44). In another example, a

lesbian participant described the disconnect she experienced when her sister caught her during her first cutting incident:

She's like, 'I'm not gonna tell Mom and Dad but don't do this again, don't do this ever again. It's bad. It's naughty. It's bad.' I'm like, 'but it felt good!'...And she's like, 'I don't care how it felt. It's bad, you don't do it.' (P20)

Another youth reported a similar experience, noting, "After I learned that, you know, it was like a bad thing shown, it was kinda like, 'well, I don't understand why'" (P39). In each of these examples, participants described a dissonance between the negative messages about NSSI and their own feelings about the behavior.

***Hiding it.*** Regardless of whether participants, themselves, perceived NSSI as negative, they described the challenges they faced navigating a social world in which this was the pervasive view. Given the misunderstanding, stereotypes, and judgments about self-harm, it was clear from the data that youth spent a considerable amount of energy managing the secrecy and disclosure of their behavior.

Many youth in the study indicated that they tried to ensure that few, if any, people in their lives knew about their NSSI behavior. A bisexual youth explained, "I didn't want anybody to see me, to see what I was doing. I wanted to keep it under wraps and generally I would...My parents don't even know about this because I kept it pretty under wraps" (P42). Another bisexual participant stated, "Some people knew I had cuts and stuff, but they didn't know the reasons. But most people were in the blue about it" (P14). In a similar example, this queer participant believed she had successfully hid her scratching, hair-picking, and cutting behavior from her parents, stating, "They have no idea that I've ever self-harmed" (P25).



Interview participants also talked about their efforts to manage privacy of NSSI among their group of friends. When asked whether his friends talked about self-harm, this participant<sup>7</sup> responded:

P8: “No. Most kids keep that to themselves.”

I: Why do you think that is?

P8: “A lot of people are very personal and like to keep a lot of things to themselves,” and be private. “Especially teenagers.”

I: Why might that be especially true for teenagers?

P8: “Because of fear.”

I: What might teenagers be afraid of?

P8: “Fear of somebody finding out. There’s a lot of different fears to it. You can’t just pinpoint it.”

In a similar example, another youth described how he and his friends tried to protect their privacy related to NSSI. He stated, “We just try to keep it between us because we know there’s always ears listening. We try not to have it that way, so we wait ‘til we’re pretty much alone and doing something that we can actually talk” (P5). Another participant put it this way: “We keep our sleeves down. We don’t want anyone to see it. We don’t do it for attention” (P33). In each of these examples, youth and their peers intentionally tried to maintain a level of privacy around NSSI to prevent other people from finding out about their behavior.

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<sup>7</sup> This participant did not consent to have his interview audio-recorded. Therefore, quotation marks are used to indicate direct quotes from the interview, as documented in writing by the interviewer.

Across the data, youth described strategies they used to hide their NSSI behavior from other people. The majority of youth in the study reported engaging in NSSI only when they were alone, in private. These youth selected particular locations at home or in public that afforded relative privacy, and most engaged in NSSI in their own bedroom or in a bathroom with a locking door. A bisexual participant who engaged in burning explained, “I would do it in a bathroom...Otherwise I would do it in, like, a backyard somewhere where the burning hair smell would go quickly. I was kind of paranoid [and] didn’t want people to find out” (P13). Similarly, a lesbian youth only cut in her bedroom because, “It was private and...I would do it at night, so everyone else was asleep, and like make sure I wouldn’t get caught kind of thing” (P32).

Another strategy used by youth in the study to hide NSSI was to choose specific methods that minimized the likelihood of detection. For example, a questioning participant bit himself instead of using other NSSI methods in order to conceal the signs. He stated, “instead of me cutting myself where the scars won’t heal up or anything, I’ll just bite myself and just leave a red mark that will, like, heal away, so no one will even notice” (P24). A different participant selected burning as a form of NSSI intentionally to hide the evidence. She said, “I used to burn candles and put candle wax on myself...so nobody would be able to tell” (P18).

A few youth shared powerful stories of trying to hide their behavior from helping professionals. These participants intentionally covered up signs of NSSI to avoid what they perceived to be negative consequences. This young woman described hiding her cutting behavior to avoid re-admission into a transitional housing program for people with mental illness. She shared:

They will throw me back in transitional housing if I cut and I don't want to be back in that place 'cause then I have no freedom to do what I want. So I cut it in a certain place to where it looked like that maybe I accidentally cut myself trying to cut something up...I don't think she believed me, but she blew it off because she had no proof, really. (P20)

In a similar example, another youth described his strategy of snapping a rubber band on his skin as a form of self-harm to avoid being "found out" by staff at his group home:

It's kinda a way to technically cut, but in a different way and everything...By the time I got back to the group home, you know there's no marks left on me. All they see is rubber bands around me and they don't really suspect any of that. So it's kind of like a way of me sneaking around the rules pretty much just because I knew it was for the best. 'Cause if they found out I was harming myself, you know, they would put me in a psych ward and think I was crazy and put me on medication...I didn't want to be on medication. (P26)

Other participants hid their NSSI behavior from counselors and therapists, even when asked directly about it. This pansexual youth shared, "I refused help for four years because my therapist was trying to force it onto me. Mind you, during this time, I was continuing to self-harm myself. Little did she know though" (P44). Similarly, a lesbian participant explained that she had not told her current therapist about her ongoing self-harm because her former counselor violated a confidentiality agreement. She explained:

When I told the school counselor when I was in ninth grade...She promised not to tell my parents, but then she told them. And I was like, you know, 'I don't care if you had told them, but you can't promise me not to tell them, and then let me tell

you something, and then tell them.’ That seems like a breach of confidence. So now I don’t tell anybody when I’m hurting myself. (P9)

As illustrated in these examples, several youth in the study took specific steps to prevent helping professionals from knowing about their NSSI behavior. In each case, participants indicated that they expected helping professionals to react negatively if they disclosed NSSI, leading to undesirable outcomes. Youth described feeling disempowered by helping professionals and lacking trust in the helping relationship. They viewed hiding their behavior as one way to retain control or agency over their lives in relation to social service systems. Clearly, these stories raise important implications for social work practice, which will be discussed in Chapter Six.

It is not surprising that, for some youth in the study, hiding their NSSI behavior became a burden. One gay/queer participant explained that trying to conceal scars from cutting, “made me a little more self-conscious, you know...It was really stressful trying to hide them sometimes” (P27). Another queer youth described her experience this way:

I became really socially withdrawn because I didn’t want people to know that I was cutting. I didn’t want to be in a situation where someone could find out that I was cutting. So I couldn’t wear short sleeve shirts and I couldn’t wear skirts because I had started cutting on my legs. It just became such an issue to have to be able to hide everything. It just became easier to not deal with people...Then being socially withdrawn caused more problems, and so I would cut more. Then there’d be the burden of, ‘How do I hide this cut?’ It was just this horrible cycle. (P29)

These excerpts highlight the challenges faced by LGBTQ youth who felt the need to hide their NSSI behavior from others in their social world. These youth faced a quandary; on one hand, making their behavior known risked judgment, stereotyping, and other potentially negative responses. On the other hand, managing the secrecy of the behavior led to isolation and further stress, which reinforced the “horrible cycle” of NSSI.

The theme *Misconceptions, Stigma, and Shame* is central to understanding the research question—how LGBTQ youth describe the relationship between their social environment and NSSI behavior. Youth in this study routinely encountered misunderstanding, judgment, and negative messages about NSSI from other people. This social climate influenced youth’s own feelings about the behavior and contributed to shame and embarrassment. Ultimately, participants felt the need to hide their behavior to avoid further stigmatization or other harmful responses from people in their lives.

**Theme 3: Negotiating LGBTQ identity.** This theme describes the implicit and explicit relationships between youth’s experiences as LGBTQ and their NSSI behavior. Many participants relied on NSSI as they came to terms with their LGBTQ identity in a social environment that was largely un-accepting. Youth engaged in NSSI to help them cope with confusion, self-hatred, and emotional distress during the coming out process. Some participants also engaged in NSSI to cope with homo/transphobic experiences such as anti-LGBT harassment and rejection. Conversely, youth also reported that developing a positive LGBTQ identity helped them reduce or abstain from NSSI.

*Coming out to self and others.* Several youth in the study said that their NSSI behavior was related to their coming out process. Some participants first initiated NSSI when they began to realize that they were LGBTQ. A pansexual participant described

her first experience with cutting this way: “Well, I think it was probably around the same age I came out to my mom, or so. Maybe 14 or 15...The first thing I did was cut myself” (P37). Similarly, this lesbian youth began cutting at age 15, when she used a steak knife to cut her leg. She stated, “I would stay up at night...[I] was kind of like coming out to myself and, like, to a couple of friends and I was just really depressed and it just kind of felt like a release” (P32). In another example, this genderqueer participant shared the following story about his first cutting experience:

I think the first time was on the bottom of my feet. I remember telling people that I had stepped on something in the creek, that’s why I was limping...I remember thinking that life was really kind of confusing. That was when I was first starting to come out to myself, so sometime in the early freshman year. I remember thinking that life was really confusing and weird. (P41)

These participants clearly identified a link between coming out as LGBTQ and the initiation of NSSI. Each of them began engaging in NSSI to cope with the stress and emotions associated with the coming out process.

One youth in this study rejected the idea that her NSSI behavior was connected to her coming out process. Although she began engaging in NSSI the same year she realized she was bisexual, this participant believed that these experiences were not significantly related. She explained:

P2: I don’t see it [the connection between NSSI and coming out] as much...‘Cause that’s when I realized I was bisexual also I was going through a rough time with my mother. So I was like realizing that, and yet I was being depressed.

I: Oh, okay. So there were a lot of things that were going on?

P2: Yes.

This youth asserted that the issues that contributed to her engagement in NSSI were complex and not uniquely associated with coming out. She experienced multiple stressors simultaneously, all of which seemed to coincide with the onset of NSSI.

For some participants, coming out was not associated with the *onset* of NSSI, but was nonetheless connected to their re-engagement in the behavior. For example, this youth engaged in cutting and burning to cope with hir feelings as ze began to identify as transgender. Ze shared:

There was a period of time when I first started identifying as trans when I was upset a lot, and I did some then. And that was just because I was trans and, you know, I'd be reminded of it sometimes and get upset. (P40)

Another youth explained that NSSI was quite common among her and her friends when they were coming out, stating:

I think that a couple of years ago, especially when we were all starting to come to terms with who we are as an individual in the LGBTQ community and figuring out our whole coming out process there was a lot more of it [NSSI]...Figuring out that they're gay or coming out to their parents and the way that their parents took it were really big triggers. (P29)

These quotes further illustrate that some LGBTQ youth in this study engaged in NSSI to deal with the challenges associated with coming out to themselves and others.

A few youth in the study felt that coming out as LGBTQ contributed to reducing or stopping their NSSI behavior. They explained that coming out relieved their

emotional distress and reduced the urge to use NSSI as a coping mechanism. One queer participant emphasized that coming out helped her stop engaging in NSSI two years prior to the interview. She said:

I think being able to be my own person definitely helped. The fact that I was finally able to like come out of the closet and be like, I've known for, I knew since freshman year that I was queer, but I couldn't really come out. (P25)

A transgender youth shared his experience this way:

It's more comfortable for me to come out as male—to use male pronouns and dress male—than it's ever has been for me to appear female. It's actually the biggest reason I harm myself is because of my gender identity. So coming out as a gay male has started my mind pretty much healing itself. (P12)

For this youth, coming out and expressing his gender identity was a healing process that helped him abstain from NSSI for a period of time. However, later in his interview, this participant said that transphobia and feeling uncomfortable in his body triggered his NSSI behavior (which will be discussed later in this chapter). While coming out helped him integrate his identity and resolve emotional pain, this youth still engaged in NSSI to cope with anti-LGBTQ oppression.

***Oppression and rejection.*** Across the data, study participants explained that homophobia and transphobia permeated their social environments and influenced their NSSI behavior. For some, exposure to oppressive rhetoric, assumptions, and behaviors triggered their urge to self-harm. In one example, this youth explained that she engaged in cutting after being the target of harmful assumptions about bisexuality:



I: What do you think was your motivation, like, in general after that?

P33: I was being picked on a little bit at school because, ‘scuse my language, but this little bitch [first name] was questioning my sexuality... ‘Cause apparently being bi at the time was a massive fashion trend or whatever. It was trendy to be bi. And, you know, I was like, ‘Dude. I’m bi.’ And she was like, ‘Are you really bi, or are you just doing it because it’s the latest trend?’ I was like, ‘For one, you can shut your mouth. And two, I am really bi. Now go away!’ I got really pissed though, ‘cause, you know, you should never question someone’s sexuality. They say they’re something, then don’t question it because it’s their choice to actually accept if they’re bisexual or gay or not.

For this participant, having the validity of her bisexual identity questioned by others angered her and contributed to her engagement in NSSI. In another example, a transgender participant noted that gender oppression triggered his NSSI behavior:

I: Do you have triggers? And if so, what are they?

P12: Anything that involves gender. If I get called female too many times in one day, I’ll have the urge again. If I’m forced to dress female when I have a mental guy day—like, when I have to dress male otherwise I break down—if I’m forced to dress female, I’ll be more likely to cut.

This youth described the pain he experienced as a result of his daily encounters with transphobic social norms that reinforce the gender binary. He explained that having other people mistake his gender and being forced to comply with others’ expectations about his gender expression gave him the urge to cut.

Another participant, who identified as pansexual, believed that homophobic speech could impact LGBTQ youth and trigger NSSI, stating:

And you know, even when people say, 'That's so gay' and they say they don't mean it that way, it can still be destructive. I mean, maybe you're saying it around people who do mean it, or maybe around someone who's still in the closet and is now even more afraid to come out. And now it's going to put them into that black hole, alone, and they're going to hurt themselves. (P37)

In this quote, this youth explained that a commonly used anti-gay phrase could create fear and isolate LGBTQ youth, which could contribute to self-harming behavior. Notably, this participant believed homophobic language was particularly destructive to youth who were still in the closet, in a "black hole, alone."

In yet another example, this bisexual participant explained that an oppressive public policy, the federal ban on same-sex marriage, was related to NSSI in his life.

When asked how he managed his triggers, he stated:

P35: I usually think about 'I don't want them to win.' Because I really think that we won't really win this, like the gay marriage thing. So I think about that [NSSI] when they won't let us get married, it makes me more worse, it makes me hate, 'cause it basically says I can't marry someone I'm in love with. So it makes me look down. But I think about more the future, like, in ten years, I guarantee you that it's gonna be legal for all of us, so I think about the positive and then I just don't do it.

I: Focus the energy somewhere else and the broader, social problems and activism and things?

P35: Yeah. 'Cause it's gonna happen.

For this youth, the hope that same-sex marriage might be legal in the future, legitimizing his loving relationship, helped him resist the urge to self-harm. He explained that abstaining from NSSI was an act of resistance against people who want to deny him the right to marry. Conversely, when he felt more pessimistic about the likelihood of achieving marriage equality, it made him more likely to engage in NSSI. This excerpt illustrates the complex ways in which homophobic social policies can influence LGBTQ youth's behavior on an individual level.

Study participants also identified ways in which anti-LGBTQ oppression influenced NSSI behavior among their friends. For example, this participant explained that her friend started engaging in NSSI after being gay-bashed by peers at school:

I have one friend who did it [NSSI] 'cause he was gay—well, he's bi, but he's more on the gay side—and people just weren't accepting him. Like they were calling him a fag and all this stuff, and like these stupid kids at our school would scream out their car windows at us when we were walking down the street.

They'd be like, 'We're going to kill you one of these days, you fucking fag!' ...So that really pushed one of them over to the side. (P18)

Although this participant shared her friend's story rather than her own, this quote serves as another powerful example of the ways in which exposure to homophobic attitudes and violence directly relate to NSSI behavior among LGBTQ youth.

In other stories, youth described how parental homophobia impacted their friends' NSSI behavior. When asked whether NSSI was common among her friends, this bisexual youth noted, "[in] my group of friends from [Rainbow Alley], it's quite common because they're always under pressure about their sexuality and their parents" (P33). Another participant explained that his ex-girlfriend engaged in NSSI after being kicked out of the house by her mother. He stated, "She came out but her mom doesn't like her that way. She's crying 'cause her mom just kinda like threw her out 'cause she came out to her" (P35). In a similar example, this bisexual participant talked about the factors that motivated his friends to engage in self-harm. He explained:

P36: Some of 'em, it's their parents because of they're nagging about their religion. Some of 'em it's because their parents just disowned 'em over it. Some of it's because their parents are just complete assholes about it and make fun of 'em and crack jokes and just stuff like that.

I: And when you say that their parents are assholes about it, do you mean about their identity or about their self-harm?

P36: Um, about both...[They're] cutting 'cause they hide their identity, but they got their cutting so it kinda gets them busted in a way.

This segment offers some insight into the ways in which oppression and rejection can influence NSSI behavior among LGBTQ youth. According to this participant, many of his LGBTQ friends had experienced verbal abuse and rejection from their parents, which were rooted in homophobia. Furthermore, he noted that his friends' parents expressed negative views about both LGBTQ identity and NSSI. He acknowledged that this created a double jeopardy for his friends. They cut to deal with the stress of being in the closet,

but doing so ran the risk of revealing their identity *and* their self-harming behavior, both of which were perceived negatively by their parents.

Given the social context of homophobia and transphobia described above, it is not surprising that some youth in this study internalized oppressive messages, leading to feelings of shame and self-hatred about their LGBTQ identities. In the following excerpt, one youth described the relationship between anti-gay oppression, internalized homophobia, and NSSI in his life. When asked about his NSSI triggers, this gay youth explained, “I really didn’t like myself because of my sexual orientation because it was beat into me that it was, like, sinful, et cetera” (P4).

Another participant also explained the connections between stigmatizing messages, self-hatred, and self-harm. When asked what triggered his urge to engage in NSSI, this participant explained:

Being called a fag. It makes me think real hard about stuff. ‘Cause sometimes, when some people say that, I kind of believe that gay people, like, we’re kind of bad. That’s why it makes me not want to come out. And it’s hard, but I hear [it] from everyone...I don’t know what to believe anymore. So sometimes when I think that, ‘Oh, how can I love a freaking guy?’ It just gets me pissed at myself... ‘Cause when they say the word fag, I just don’t think of the word, I think about what it means. ‘Cause it’s a bundle of sticks used to burn people in the olden days with the Salem Witch trials who were different, who could be colored because they acted different, but gay people got burned too...So when you call yourself a fag, I think about that. I think am I worth it, so that’s what makes me start [self-harming]. (P35)

This young person described his struggle to make sense of his identity in an environment in which anti-gay slurs were pervasive. For him, being called a fag evoked the disturbing history of the word, which created confusion and re-enforced his feelings of shame and anger. Since homophobic messages came “from everyone,” they influenced his own views about being gay and his decisions about coming out. It is important to note that this participant saw himself as gay, but told others he was bisexual because “society [is] not accepting yet” (P35). This youth began to believe that maybe gay people were “kind of bad” and that, therefore, he might deserve to be treated badly. Similar to P4 above, this youth explained that being exposed to homophobic messages and grappling with his own feelings about those messages led to feelings of self-hatred, which contributed to his desire to cut.

***Body hatred.*** Another dimension of the theme *Negotiating LGBTQ Identity* was revealed by several transgender and genderqueer youth in the study. This dimension relates to the ways in which transgender and genderqueer participants’ distress about their physical bodies influenced their NSSI behavior. In one example, this transgender youth explained that stress and body hatred fueled her motivation to engage in NSSI:

P22: [I] just decided I don’t like my body, and then I wanted to do that [NSSI]...For me, it helps me relieve stress...and then it also helps me, like, I hate my body, and it’s just another thing that helps me hurt my body...

I: Yeah. And is the, um, can you talk a little bit about what the self-hatred is about, in terms of your body?

P22: Probably since I was born biologically male and I don’t like the boy body.

For this participant, NSSI not only relieved stress, but it was also instrumental in physically hurting “the boy body” that felt foreign to her.

Another transgender participant in the study provided further insight into the issue of body hatred. In this quote, he explained that his anguish about the mismatch between his body and his gender identity triggered him to engage in cutting and clawing:

When I dream, I’m male. When I wake up, I get ghost limb sensations of having a phallus...I look down, and it’s gone. It’s not there. I freak out. I cry every time I look in the mirror almost. Like, in the shower, I have to close my eyes. I can’t stand it...hopefully I’m starting hormones soon to fix it. (P12)

This participant described a sense of powerlessness in the face of the unbearable dissonance he felt between his identity and anatomy. Notably, he talked about his desire and intention to “fix it” by starting hormone therapy in the future. At another point in the interview, this youth explained that he had to stop attending psychotherapy (which is typically a requirement for receiving hormone therapy) due to his inability to afford it. Without access to hormone therapy, he engaged in NSSI as a way to cope with the overwhelming emotions associated with his body.

In a similar example, this study participant described cutting to cope with low self-esteem and a negative body image. She explained:

Another reason why I’m genderqueer is because I have days where I feel more like a guy and I have days where I feel less like a guy. I felt more like a guy for a couple months and I was starting to have these gigantic self-esteem issues and so I ended up cutting on my chest because I was really tired of seeing my boobs in the

mirror...It made me feel better about it I guess in that it was sort of fixing something that was wrong. (P41)

As with P12 and P22, this participant described using NSSI to resolve her strong sense that her body did not match her identity. Further, she explained that she felt that cutting her chest was instrumental in “fixing something that was wrong.”

These youth’s stories imply that body hatred may be different from self-hatred, which was described in the previous section. Youth who described self-hatred explicitly talked about their exposure to homophobia in their social environments, which they internalized to some degree. On the other hand, a few transgender and genderqueer youth in this study described body hatred as a primarily internal process, characterized by intrapsychic distress about the mismatch between their bodies and identities. These participants did not directly discuss whether exposure to and internalization of negative messages about transgender people or gender variance played a role in their body hatred. Ultimately, both self-hatred and body hatred caused considerable distress among LGBTQ youth in this study and contributed to their NSSI behavior.

***Self-acceptance and identity integration.*** In the preceding examples, some study participants reported that oppression, rejection, and self-hatred contributed to their NSSI behavior. On the other hand, several youth said that learning to accept their LGBTQ identity served as a protective factor against NSSI. In one example, a transgender participant described his journey to self-acceptance this way:

It’s taken a lot of time to really claim these identities, and what it means to me to do that is, it helps with the sanity factor. I mean I was insane before I really let



myself be who I am. And being who I am now, I'm not harming myself. I'm doing what I need to do. I'm a lot healthier. (P5)

For this youth, claiming and integrating his transgender identity contributed to improved mental health and helped him stop engaging in NSSI.

Another youth also felt that identity integration positively influenced her NSSI behavior. When asked what helped her stop NSSI, she shared the following:

Being able to own that and be like, 'Hey! I'm queer! Hey!' and being able to own, 'Hey, I'm not Catholic. I think you should know this.' Being able to really be able to explore myself and figure out, 'Yes, I like this. No, I don't like this. I want to live here, I don't want to live here,' has definitely helped me. I don't feel like I need to fit into this box and sort of have this little outside part that I own. I feel like I can own my entire being now, you know. What I believe, what I don't believe—everything! (P25)

In this quote, this participant talked about the importance of claiming not just her queer identity, but also her religious identity, which went against her family's strong beliefs and values. Her ability to explore and "own" all aspects of her identity helped her develop a sense of wholeness that she had not previously experienced. From her perspective, this new sense of wholeness and self-knowledge contributed to her cessation of NSSI behavior.

In a similar example, this gay youth believed his journey to find himself would help him abstain from cutting and burning in the future. He stated:

I feel like I'm worth more now and I feel like I've really found myself more. Back when I didn't really know who I was and I was still struggling with my

orientation and being made fun of and my family not being supportive, that's when I was more lost. That's when I resorted to things like that [NSSI]. But now that I've grown as a person and really have my roots, I can look to other things when I'm not feeling happy. (P4)

For this participant, NSSI was associated with uncertainty and confusion—a period of feeling “lost.” As he began to become more grounded, he was able to improve his self-worth and stop his NSSI behavior.

A questioning participant also explained that learning to love herself was a deterrent to NSSI. She noted that Rainbow Alley played a significant role in her journey towards self-acceptance. When asked if she had continuing thoughts of NSSI, she said:

No, I think I'm better. I think being here [at Rainbow Alley] just makes me feel more loved and everything like that so I don't have to feel useless and I feel better about myself. I've learned how to accept myself for who I am and I love myself. (P11)

In each of the previous excerpts, youth emphasized that learning to understand, accept, and express their whole selves helped reduce their reliance on NSSI as a coping mechanism. Their ability to develop a positive, integrated sense of self, even when faced with homo/transphobia, served as a protective factor against this behavior.

The data associated with this theme showed that several participants engaged in NSSI as they negotiated their LGBTQ identities within an oppressive social context. Youth described using NSSI to cope with confusion, emotional distress, and reactions from others as they explored and expressed themselves. Some youth offered insight into the ways in which the internalization of oppression impacted their self-esteem and self-

hatred, contributing to their NSSI behavior. On the other side of the coin, youth also noted that accepting themselves and integrating their identities helped them decrease the use of NSSI. It is critical to emphasize that youth in this study did not engage in self-harm *because of* their LGBTQ identities. Rather, their stories suggest that they engaged in NSSI, in part, to help them navigate the challenges associated with having a stigmatized LGBTQ identity.

**Theme 4: Invisibility and isolation.** Across the data, LGBTQ youth talked about engaging in NSSI to cope with feeling invisible to and isolated from others in their social environment. The invisibility aspect of this theme describes how participants engaged in NSSI when they felt voiceless, uncared for, or ignored by their families, peers, and helping professionals. The isolation aspect of this theme highlights examples where youth engaged in NSSI to deal with profound loneliness or to cope with being an outsider. Youth's experiences of invisibility and isolation are interconnected in this theme. When someone was not seen or heard by others, it often led to feeling alone and isolated. Similarly, when one felt they did not belong or that they were alone, it contributed to a sense of invisibility.

Another dimension of this theme relates to the connection between NSSI and attention seeking behavior. Several youth in this study talked about using NSSI as way to be understood, noticed, or helped by others. Through the participants' words, attention seeking can be conceptualized as a form of resistance against isolation and invisibility. These youth engaged in NSSI to assert their existence, humanity, and voice to others when other strategies were not available or effective.

*Not being seen or heard.* Many youth in this study shared stories where they felt others in their lives did not notice or listen to them. Among those stories were several where youth talked about using NSSI when they felt invisible or voiceless. In the following example, this pansexual youth explained that NSSI was one thing that made him happy while living in an environment where he felt no one noticed or cared about him. He stated:

I mean, at the time, you have to remember that I didn't have friends, I didn't really have anybody that cared about me, so it's like there wasn't really anything negative about it [NSSI], 'cause it was just like, no one cares that I was acting different or if I wasn't talking or, even if I did, I guarantee if I would've did marks anywhere where they would be seen and everything, no one would even pay attention to it 'cause then I felt like I was invisible pretty much. So at the time, I didn't see anything negative about it at all. I was like, 'Well, I don't have any friends. I mean I don't have any friends that care. Parents don't care. Group home people have to care 'cause it's what they get paid to do, so I don't care that they care,' if that makes sense. So I didn't see anything negative about it. It made me happy, and there was few things that actually made me happy, and that was one of the things that did, so I did it. (P26)

This participant described the pervasive sense of invisibility he felt in relation to all of the people in his life, including friends, family, and staff at his group home. While NSSI helped him cope with his situation, it also seemed to reinforce his sense of invisibility. In other words, the fact that no one noticed his cutting behavior affirmed his belief that people either did not pay close attention or did not care.

Another pansexual youth explained that he often felt angry that his parents did not listen to him, which triggered his NSSI behavior. In the following excerpt, he described his feelings leading up to NSSI incidents in which he would forcefully plunge his hand into a box of sewing needles:

I: Do you have any memory of...what kinds of feelings you usually had before you would—

P44: Anger. Anger because mother wasn't listening to me, stepfather wasn't listening to me, so I'd get pissed and I'd go in my room and I'd barricade my door, because no twelve year-old needs to have a lock on their door...I'd take the box [of sewing needles] from in my dresser, I'd set it down on my bed, I'd sit on my bed, and I'd just plunge my hand in there, and then I would grope around.

For this participant, engaging in NSSI was one way to channel the anger that arose when he felt unheard by his parents.

For a different youth, feeling voiceless was connected to a sense of powerlessness. This bisexual participant explained how her lack of voice in custody proceedings led her to cut herself severely. She stated:

When I was thirteen—twelve—I was hospitalized because I cut myself so bad because my parents were trying to get back in my life. And there's [this] whole legal custody [proceeding] and I wasn't allowed to speak in it, and really it was all about me but it was nothing from me. And I was getting really, really worried and stuff that they would take me back. (P3)

This youth's powerful words convey the distress she felt when she was not allowed to speak for herself during a court process that would have a tremendous impact on her life,

possibly reuniting her with her abusive parents. Without this voice, she felt out of control and cut herself as a way to manage her worry and fear.

Some youth in the study explained that their motivation for engaging in NSSI was to decrease their own sense of invisibility. For example, one lesbian youth described her experience this way: “Before I cut, I feel like I’m just floating around like nobody notices me or anything. I’m just there. And then like I cut, and everything comes back to me and I just feel normal again” (P1). Another participant explained that her motivation for cutting was to make her pain visible, thus making her more visible to others. She explained:

I was just hurting so much on the inside, and I was thinking, ‘No one can see this pain on the inside,’ so I guess I wanted to make it more external. You know, it surprises people that I’ve hurt myself because I’ve always been a positive person...I really try to build up others and be positive. And I think at that point it was like if I show my pain on the outside, people will know that I hurt on the inside. (P37)

By externalizing her internal pain, this youth hoped that others would see underneath her positive mask and understand that she was hurting.

In a similar example, this gay transgender youth also talked about using NSSI as a way to counteract his feelings of invisibility and assert his existence, stating:

My entire life I’ve been beaten up by kids...In elementary school, I’ve been made fun of, I’ve been the butt of all jokes, I haven’t been an attractive kid. I was a fat little acne-ridden brat. And it [NSSI] made me feel like I was actually there and that I wasn’t invisible and that I was actually worth something. If I could bleed, I

was worth something. Whether they think I'm worth them or not is different, I'm worth it. (P12)

This youth explained that the bullying he experienced from others from a young age made him feel invisible and without value. Cutting and seeing his own blood allowed him to experience his own presence and self-worth. Furthermore, cutting functioned as an act of defiance against his tormentors. This quote also illustrates one of the previous themes, *Violence*, in that this participant engaged in NSSI as a way to cope with verbal and physical abuse by his peers.

Each of these study participants identified a connection between their NSSI behavior and feeling invisible or voiceless in their social world. Some youth used NSSI to cope with situations that made them feel that others did not see, listen to, or care about them. Other participants engaged in NSSI to manage emotions that surfaced in relation to not being seen or heard by people in their lives. In other instances, youth's motivations for engaging in NSSI were to feel present and alive, thus diminishing their sense of invisibility and voicelessness.

***Feeling alone.*** Across the data, study participants conveyed their sense of being and feeling alone in the world, painting a picture of isolation. These youth described engaging in NSSI as a way to cope with their loneliness and emotional distress in the absence of a social support network. In this excerpt, a bisexual participant conveyed her experience of feeling completely alone as a child. She stated:

When I grew up, I was the only child. I had nobody to talk to. My mom wasn't really there. My dad was definitely not there. So I just had me, myself, and I. I

think if I had somebody to talk to me to try to say, ‘Don’t do this,’ and try to watch out for me, then maybe I wouldn’t be half as bad. (P30)

This youth described a deep sense of solitude during childhood, when she could only rely on “me, myself, and I” for company and guidance. She explained that, if she had had people to “talk to” and “watch out” for her, she may not have relied on NSSI as a coping mechanism.

A pansexual youth shared another example of engaging in NSSI to cope with life stressors when he could not turn to family and friends. He explained:

It [NSSI] was the only thing that was helping me out at the time because I didn’t have parents to go to [and] I didn’t have friends to go to ‘cause we moved around so much. And, it was just like, you know, I was all by myself it was the only way I knew how to cope with it—depression and stress and stuff like that. (P26)

Growing up, this youth did not have a support system to help him deal with his depression and stress. For him, NSSI filled a void in the absence of other coping strategies.

In a similar example, this young man described cutting to deal with the pain of feeling alone during disruptions in his family and peer group. He stated:

My parents had gotten back together, and then they went through a bigger issue again. This time they really did go through their divorce. And there’s a lot of drama going on with school and a lot of my friends, and I just started finding myself feeling alone, so I would just cut myself to get rid of the pain that I felt there. (P17)



As with P26, this participant also talked about using NSSI to cope with his emotions when he felt he had no support.

Other participants shared stories of feeling isolated from their peers, which influenced their NSSI behavior. This bisexual participant said that not having friends at a young age triggered his desire to self-harm. He stated:

Basically, whenever I was younger, I didn't really have any friends. And having no friends was just really depressing for me because I've always seen kids go to slumber parties, talk about it at school, go to kids' birthday parties, go to, you know, have fun, go to a football game with 'em. Me, I just never did that. (P28)

In this excerpt, this participant conveyed a strong sense of loneliness and longing for peer connections that he saw among his classmates but never experienced himself. Similarly, a transgender youth explained that he engaged in cutting and burning “pretty much all the time” after his family moved to a new city (P40). In this new city, he explained, “I didn't have any friends and I was alone” (P40).

Another participant engaged in cutting and choking when she felt alone and unwanted. She stated, “When I'm alone, I tend to get the feeling like I'm alone. Like nobody's there, nobody wants to be there, nobody has the same feelings, nobody understands. I get it stuck in my head that I'm not wanted” (P31). The experience of being physically alone brought up a deeper sense of isolation for this youth, stimulating negative cognitions about being unwanted and misunderstood. As with the previous examples, this participant used NSSI in order to cope with being and feeling alone.

For many youth in this study, their NSSI behavior was linked to their sense of being alone in relation to their social environment. These youth described feeling

isolated, alienated, and rejected by peers or family members, which made them feel they had nowhere to turn for social support. In absence of a social network, these participants relied on their own coping mechanisms and turned to NSSI to deal with their loneliness, stress, and emotions.

***I don't belong.*** Several LGBTQ interview participants said that they engaged in NSSI because they did not feel they belonged or fit into their social environment. For one biracial youth in the study, this lack of belonging was related to others' perceptions of her racial identity. She explained:

Actually I had self-harmed a little bit because I was like ten years old and either I wasn't White enough to hang with the White kids or I wasn't Black enough to hang with the Black kids. So I started pulling out my hair to the point that I was like Michael Jordan bald. My dad had shaved off my hair and was like, 'Look, you need to stop.' And I would still constantly do it to a point [that] I would wear wigs and everything. (P30)

This young woman described how others' judgments about her race made her feel alienated by her peers at a young age, which led her to engage in hair pulling.

This pansexual youth also shared a story about cutting in order to deal with being a misfit among her peers. When asked about how she viewed the role of NSSI in her life, she shared:

I mean, at the time, I would say it helped give me a mindset to figure out my beliefs. It was a step in who I've become. As a kid, I struggled a lot to fit in. I never quite fit. I was diagnosed with ADHD around the first grade or so and I was put on meds...Being the loud, weird kid was not always fun, and I didn't fit

in. Then, in middle school, I was still out there, but I did have multiple friends. I was social. I got along with people. But then every once in a while, people would knock me down a notch. In high school, I came to understand that being wild and crazy is who I am. And I am a beautiful person just how I am. And nowadays, I just don't care. If someone's going to like me, they better like every part of me, or they're just a waste of my time! (P37)

From this participant's point of view, cutting helped her on her journey to find her identity and place in the world as someone who did not "fit in" to her social group.

In a similar example, this queer participant talked about using NSSI to deal with the stress she felt as someone who did not know who she was or where she belonged. She noted that having "middle child syndrome" led her to engage in scratching for the first time, stating:

So it [NSSI] was just about stress, feeling like I didn't have my own area where I really owned something, I was constantly following in someone's shadow. I guess sort of feeling like I wasn't my own person, feeling like I didn't quite belong and not knowing where to go, what to do, just sort of being stuck where I was and kind of freaking out about it. (P25)

As with the previous quote by P37, this youth struggled to differentiate and define herself in relation to other people. She expressed a sense of desperation and explained that scratching helped her cope with the stress of being "stuck" in her journey to find her place in the world.

Another youth in the study engaged in NSSI to deal with being rejected by her family. When asked where she most often engaged in NSSI, this participant explained:

It was always when I was in my room by myself when I was a kid because, like I said, I was never allowed by the family. I was like an outcast. To them, [it was] like, ‘Who’s that?’ ‘Oh yeah, that’s our daughter.’ (P3)

This youth described cutting in the context of the everyday isolation she experienced as an “outcast” from her family, in which she experienced severe neglect and abuse. Her family treated her as an outsider, not “allowed” to be part of the family unit.

***Attention seeking.*** Another dimension of the theme *Invisibility and Isolation* is the way that LGBTQ youth described engaging in NSSI in order to get attention from other people in their lives. Several participants talked frankly about attention seeking as a motivation for their self-harm behavior in a social context in which they felt ignored and alone. They explained that NSSI was a functional attempt to make them visible to and heard by people in their social environment. For example, a gay youth explained that he began to use NSSI as a way to get attention when he was in a residential treatment center. He stated:

P6: I’d see other kids do it. I’d hear staff talking about oh, he’s tying a sock around his neck or he’s doing this or that or he’s trying to do this, and I would just listen...So when I got in trouble I would do the same thing.

I: So but you would do it only when you got in trouble?

P6: Yeah, or when I just was pissed off and I just wanted someone to know I was there.

This participant quickly learned from others in the treatment center that NSSI was a way to get attention from staff. He first initiated self-harm behavior when he was “in trouble,” which he later explained meant being locked in the isolation room at the

treatment center. While in isolation, he engaged in various forms of NSSI because he “wanted to someone to know I was there.” This youth’s story illustrates the connection between invisibility, isolation, and attention seeking behavior among LGBTQ youth who engage in NSSI.

This pansexual participant provided a similar example of cutting in order to get attention from his neglectful parents. He explained:

But the whole cutting thing would be easy ‘cause you know we have a dad that’s drunk all the time and a mom who doesn’t pay you any attention anyways...No one’s going to notice that you’re sad or depressed or stuff like that. So I was just like, ‘What does it matter?’ because of the fact that no one’s going to care anyways. So that’s the mind frame I had for awhile and that’s why I actually started doing it...I guess half of me wanted attention from it, ‘cause it’s just like, ‘Hey, you know, I’m hurting myself. Pay me attention!’ And, they never did. So it was just kinda like, you know, it made me even more depressed. (P26)

This youth started cutting partly because he felt his parents would not notice, but also because he desperately hoped that they would finally pay attention to him. Ultimately, his desire for attention was not fulfilled, which further reinforced his feelings of isolation and depression.

In yet another example, this bisexual youth also talked about attention seeking as a motivation for engaging in cutting and burning. Similar to the previous participants, he described feeling neglected and ignored by his parents and others as a child:

I know that I did it some for attention...Just any kind of attention. I mean ‘cause, as I kid, I really didn’t have that much attention from parents or anybody else.

And basically I just wanted some attention, so I ended up just cutting my arms, and, ‘Hey Dad! I’m bleeding!’ I mean that got some attention. Not all the attention that I wanted, but you know it was some attention. (P28)

As with P26, this youth noted that cutting did not garner the attention he ultimately wanted, but acknowledged that any attention was an improvement.

Several youth in this study engaged in NSSI as a way to communicate their distress and as an attempt at help seeking. The concept of NSSI as a “cry for help” was expressed several times in the data, meaning that participants viewed NSSI as a desperate attempt to get help when their other strategies had failed. One participant described the motivation behind her first NSSI incident this way: “It was kind of a cry for help...I kept cutting myself until dad demanded that I get in the car” (P37).

In another example, this lesbian participant talked about cutting as a strategy to get help from her parents:

After that, when I was in ninth grade, I started self-harming again...This was when I started [saying to] my parents, like, ‘I’m really, really sad. Can you help me?’ And they were like, ‘No. You’re fine.’ And that’s when I started cutting again was my freshman year because I was like, you know, ‘They don’t notice me. Maybe if I hurt myself.’...It was kind of a subconscious thought though, but after it happened and I sort of recovered from that, I understood, like, ‘Oh, I was trying to get their attention.’ (P9)

Later in her interview, this youth explained that she was able to stop her NSSI behavior once her parents got her into counseling. She expressed a sense of relief at finally getting

the help she needed, stating, “Oh good! Now I don’t need to do it anymore ‘cause I have someone who’s going to listen to me” (P9).

The *Invisibility and Isolation* theme provides further insight to the ways in which LGBTQ youth described the relationship between NSSI and their social environments. Interview participants talked about living in social contexts in which they felt voiceless, ignored, and unwanted by others in their lives. In story after story, youth described feeling alone and out of place, with no one to talk to. Many participants engaged in NSSI to deal with their emotions when the stress of social isolation became too difficult to manage. Additionally, participants talked about using NSSI to seek attention and help from people in their lives. Youth explained that NSSI was a strategy they used, consciously or unconsciously, to reduce their invisibility and isolation.

**Theme 5: Peer relationships.** This theme emerged as a continual thread throughout LGBTQ participants’ interviews as they described their experiences with NSSI. According to youth in this study, interactions with their peers—including friends and other young people in their social network—had a significant influence on their NSSI behavior in a variety of ways. This theme includes quotes describing the patterns, content, and context of communication between participants and their peers about NSSI behavior. This theme also includes data about ways in which participants and their peers gave support and advice to help each other reduce or stop their NSSI behavior. Another aspect of this theme pertains to the ways in which participants and their peers influenced each other to engage in NSSI. Each dimension of this theme highlights the role that peer networks played in NSSI among LGBTQ youth in this study.

*NSSI behavior among friends.* During the interviews for the original qualitative study, participants were asked whether they perceived NSSI to be common among their friends, among other questions pertaining to their social network. The majority of youth ( $n = 32$ ) believed that NSSI was common among their friends. Of those, some participants estimated that between 20-75% of their friends had engaged in NSSI at some point. A smaller number of participants ( $n = 12$ ) believed that few, if any, of their friends engaged in NSSI. Participants were also asked to specify whether they were thinking of friends from Rainbow Alley, elsewhere or both. Among those who said that NSSI was common, most indicated that they were referring to NSSI among all of their friends, regardless of their affiliation to Rainbow Alley. Conversely, seven participants noted that NSSI seemed to be more common among their friends at Rainbow Alley as compared to friends from other places.

*Peer communication about NSSI.* Study participants were also asked whether their friends talked to them about NSSI. Youth's responses to this question offer insight into peer culture and social norms concerning communication about NSSI. Some said their friends were private and did not tend to talk openly about NSSI. These youth mentioned that they watched for signs of NSSI among their friends and tried to find ways to broach the subject. One bisexual participant explained, "Few of my friends talk about it a lot. Other friends usually keep it to their selves [sic] and I just kinda have to watch for symptoms of it" (P3). Similarly, a queer youth described her experience this way:

[For] most of them...they sort of told me off-handedly. It just sort of came up in conversation. I've also noticed they have obvious, like, scars on their arms, which clearly aren't from like cats or, um, you know, barbed wire. They're like



clear cuts. I've noticed that, so cuts usually. Most of them don't, like, tell me, you know, 'I'm self-harming.' It usually sort of just is one of those things I know about them. (P9)

A different queer participant said that his friends talk about it, "Very rarely. Mostly in like the past tense, not graphically like even referring to the behavior but just that they were a person who did it, you know?" (P38). In another example, this pansexual participant noted, "the ones who used to [engage in NSSI] talk about how they used to do it. The ones who do it now don't necessarily talk about it, but it's still known that they do it" (P44). A gay participant talked about his unsuccessful attempt to encourage his friend to talk to him, stating, "She doesn't talk...As a friend, I've tried to bring it up, but she shuts off, backs off. So as a friend, I back off" (P6). Each of these quotes indicates that participants often knew about their friends' NSSI behavior even when their friends did not explicitly talk about it. Youth tread carefully when broaching this sensitive subject and tried to demonstrate respect for their friends' privacy.

Many youth in the study said that their friends did talk openly about NSSI. In some instances, their friends would talk to them about it one-on-one, while others would talk about NSSI in a group of trusted friends. Participants noted that their friends sometimes disclosed NSSI in the course of casual conversation. This bisexual youth explained that, when spending time with a "select few people," his friends sometimes talked about NSSI: "All of us like to sit, hanging out sometimes, and we just start edging on the subject of it" (P17). A heterosexual transgender youth said that he was surprised to learn that his friends self-harmed when it came up in casual conversation. He stated,

I had friends that cut and I never knew that they did until we all started talking one day. And you know, it was just us. We were talking and I was kinda surprised 'cause I knew I was harming myself. I didn't know anybody who else who did. I was kind of in the dark on that. (P5)

Yet another participant described how she and her friends shared their experiences with NSSI during “pillow talk”:

You know how girls have pillow talk, like you're sitting there and one thing leads to another and you're talking about, 'When I was little, I just couldn't do this,' and 'Oh, this is what I do,' and you just put everything out on the table? A couple times it's been that. Just everybody sharing everything in their lives and things come out and it changes everything. (P25)

Each of the quotes provides further insight into communication between LGBTQ youth and their friends about NSSI behavior. Youth described mutual disclosures where they and their friends confided in one another about their NSSI behavior, among other personal topics. These youth's narratives suggest that talking about NSSI with their friends reduced their sense of isolation and strengthened the bonds of friendship.

As youth described their conversations with their peers, they identified certain relationship qualities that made it easier to talk about NSSI. Specifically, participants emphasized the importance of trust between friends when communicating about self-harm. One bisexual youth explained that her friends were, “not really open about it. Like they're not gonna go tell everybody and stuff... You know, they'll come to the people they trust, but they won't just talk to anybody about it” (P31). Some youth said that their friends perceived them to be trustworthy, which made their friends feel

comfortable enough to open up to them. When asked whom his friends talk to about NSSI, another bisexual participant responded, “They just talk to me. I’m one of those people, I mean, you get to know me and I grab trust pretty quickly because I don’t really share stories...I’m a really trustworthy guy” (P13). Another youth said that her friends talked to her about NSSI and sometimes engaged in self-harm in her presence. She felt that they trusted her, “‘cause they knew I would be supportive and not judge them for it or rat on them” (P18).

Participants also highlighted the role of openness and honesty in communication between friends. For example, this queer youth explained that having shared expectations about honesty created an environment in which she and her friends talked about NSSI behavior, among other issues. She described her experience this way:

My friends do [talk about NSSI]. We try to be really open with each other and really honest. I don’t say we have like a policy of honesty, but it’s just sort of an understanding that we don’t hide things from each other. We aren’t dishonest. We don’t tell lies, we don’t avoid the truth, and we don’t kind of hide the truth. If something’s bothering us, we say something. If we harm ourselves, we say something...It’s just sort of putting it all out there because, in my group of friends, we sort of feel like we’re more of a family to each other than our own families are because we can relate a lot more closely. So we feel that, by being honest, it sort of makes it so that it’s a safe environment no matter what...So I guess just sort of having a background. Knowing that somebody knows everything about you and still wants to stick around. (P25)

Similarly, this bisexual youth talked about modeling openness with his friends to help them feel more comfortable talking about NSSI. In this quote, he explained that he tries to share his own experiences as a way to open the door to further communication:

P42: It's kind of one of those things—like an eye for eye—I'll tell you my experiences 'cause I'm courageous enough, and then they'll tell me in a way of relating. 'Cause most of the time I'm more open about sharing things about my life 'cause I know that's not who I am anymore...and that generally sets the tone and makes 'em feel okay, like it's okay to express something like that.

I: I see. So you're modeling that openness, and then they—

P42: Right, I'm trying to cool the background in preparation, almost by sharing my experiences so you can hear theirs to kind of relate and that everyone's had some sort of a...difficult phase in their life.

These excerpts demonstrate the value that participants and their friends placed on communication with peers who could *relate* to their experiences. They confided in people with whom they had a history and whom they felt could truly understand where they were coming from. These participants actively tried to create a safe environment in which they and their friends could be themselves and talk openly about difficult issues.

***Peer help seeking.*** LGBTQ youth in this study routinely provided help to and received help from their friends regarding NSSI. While some youth talked about help seeking from adults and professionals, including Rainbow Alley staff, therapists, and school counselors, the overwhelming majority of youth talked about engaging in mutual help seeking/giving within their peer network. Participants spoke in detail about how they and their friends gave each other advice and support and, on occasion, how they

directly intervened to stop NSSI behavior. Regardless of whether they were giving or receiving help, youth emphasized the importance of knowing one's helper could understand NSSI.

*Giving help.* Study participants shared numerous stories about their efforts to help their friends reduce or abstain from NSSI. Youth frequently listened, gave advice, and provided support to their peers. In one example, a participant who described himself as “the veteran” pointed out that youth at Rainbow Alley regularly sought help from him around their NSSI behavior. He advised other youth to talk to him or someone else when they felt the urge to cut, telling them:

Just give it a break, man. Just give it a rest. Just talk to somebody, you know, you'll feel a lot better. I mean, basically, there are better things to do than cutting yourself, but if it's that bad that you need to cut, hell, just come talk to me! (P28)

This youth described his willingness to support his peers who were struggling with NSSI and to help them develop alternative coping strategies.

A pansexual participant talked about going to great lengths to help his ex-girlfriend abstain from cutting. He explained:

P15: I was appalled and scared. I was severely concerned for her. I didn't want her to bring harm to herself, just like how I didn't want others to bring harm to her. So I'd do everything in my power to try and protect her from it.

I: Yeah. Boy, that's a lot of responsibility.

P15: And it's responsibility that I gladly took upon myself.

In this excerpt, this youth described the sense of responsibility he felt to help and “protect” his ex-girlfriend from harm, even when the harm was self-inflicted.

A transgender youth explained that his friends often sought help from him via instant messaging. He described a typical scenario this way:

Usually it's online, 'cause we'll both be at home and we'll be online and a friend will just message me saying, 'I feel really bad.'...Usually talking about self-harm doesn't come into it. Like usually it's just, 'I feel upset.' And I'm like, 'Okay. Don't do anything stupid!'...That way you know you don't have to call anybody. If you're like really upset, you don't have to talk to anybody. That's why online is nice, 'cause if you're crying or something you don't like show that to people...And also, you know, it takes more time than a phone conversation, so it gives you time to cool down. (P40)

This participant described several advantages of online communication between friends when addressing emotionally charged issues such as NSSI. The Internet allowed him to provide help to his friends, while allowing them to maintain a higher level of privacy than would be possible when communicating by phone or in person.

In a few cases, participants talked about their attempts to intervene in their friends' NSSI behavior during or immediately after an incident. One participant actually took a razor from her friend and tried to get her to talk instead of cut. She explained:

When I see one of my home girls cutting herself, [I'm] like, 'What's going on?' I take the razor, and I'm like, 'Look. What's going on?' I take my time and go a step forward, 'cause I think, honestly, everybody needs somebody to talk to. (P30)

Another participant talked about providing emergency response to friends who called for help. She described her experience this way:

A couple times, it was because I got frantic phone calls from them saying, ‘You need to come over! I can’t explain it over the phone.’ And I’d go over and they’d have bloody towels wrapped around them saying, ‘It went a little bit too far. I need you to help me.’ (P25)

Both of these participants intervened in situations when friends were in the act of physically harming themselves. They attempted to reduce physical harm by personally intervening, while also providing emotional support.

Youth in the study emphasized that their own experiences with NSSI influenced their ability to help their friends. Some mentioned that their friends specifically sought help from them because of their shared experiences with NSSI. One gay participant explained that his friends would, “come to me for help...I’d see the marks, they’d tell me what they’d done, just to try and get help, ‘cause they knew I’ve been dealing with it for a long time” (P12). In other cases, youth talked about drawing upon their own NSSI behavior as a way to demonstrate their credibility and encourage their friends to seek them out when needed. For example, a pansexual participant shared this experience:

There’s a particular friend, I’m not gonna use names, but she wears a lot of things around her wrists. One time, one of my other friends went to take her hand and she just pulls back really hard, the bracelets slide up, and you just see a bunch of slices there. No, we don’t, you know, want to sit her down and talk about it because that would just stress her out more. But we’d say, ‘If you need to talk about it, you can come to me because I know what you’re going through.’ (P39)

This participant evoked his own experiences to open the door for a friend who was reluctant to talk about NSSI. Similarly, another pansexual youth said that his background

as a former cutter was advantageous to his friends who sought support from him. He explained his perspective this way:

Most of my friends that come to me and say, ‘Hey, this is what’s going on,’ [and] I can relate to it... ‘Cause they know my story, too...I think it kinda helps them out more because they know that I’ve been there, I’ve done that. You know, they want to know, ‘What did you do to finally get over it to the point where you don’t have to cut anymore?’ and all that. (P26)

These stories suggest that participants’ personal experiences played a role in providing help to their peers who were dealing with NSSI. Youth noted that they were able to relate to their friends’ feelings and behaviors, which put them in a better position to give advice and support.

*Receiving help.* In addition to providing help to their friends, youth in this study also sought and received help from friends. Participants noted time and time again that peer support was integral to reducing or stopping their NSSI behavior. As one example, this queer/lesbian participant felt that having friends check in on her helped her manage her urge to harm herself. She shared:

Having friends who keep tabs on me definitely helps, because they can be like, ‘How are you dealing with this? Do we need to check in? Is there something that I can do? How can I support you?’ And just knowing that I have that kind of support system really helps. (P29)

Another lesbian participant said that her girlfriend provided critical support that helped her with her cutting behavior. When she felt the need to cut, she explained, “I usually will talk. Like the most recent time it happened, I talked to my current girlfriend about it,



and then she kind of, you know, helped me through that. So I think just having the support” (P32). In a similar vein, this bisexual youth explained how her friends tried to help her stop engaging in NSSI:

My friends, they done it in the past and they’re trying to teach me to not to do it...They told me a lot about their past and everything, and then I realize about mine...So they’re like trying to help me to not do it like they did before, so I’m trying to quit badly. (P10)

This participant emphasized the positive influence that her friends, who formerly engaged in NSSI, had on her own efforts to abstain from self-harm. Her friends shared their past experiences with her and helped her understand her own. Taken together, each of these excerpts highlights the value that participants placed on receiving support from their peers as they tried to reduce their engagement in NSSI.

Other youth described situations in which their friends intervened on their behalf in order to prevent NSSI. A lesbian participant shared several stories about friends who knew about her cutting behavior and acted to ensure her safety. One example she shared was the following:

Like my friends, even now to this day, like my roommates, if I take more than a fifteen-minute shower, they come and bang the door open. And I don’t lock the door, so if I end up locking the door, then they’re like, busting down the door. I’ve had to replace the lock on that bathroom door because I’ve already had it busted down because I locked it. (P20)

Another participant shared this story of a time when his friend saw him bite himself and tried to intervene. He explained:

I wasn't even thinking about it. I just bit myself, stand[ing] there for awhile, and just look[ing] down to the floor and just relaxed. And one of my friends was saying, like, 'You shouldn't harm yourself and everything 'cause that's, it's just going to leave cuts on you.' And I was telling him, like, 'I'm biting myself. It's not gonna leave marks. [At] least I'm not cutting myself like other people do.'

And he's saying like, 'You still shouldn't do that.' And so I stopped that. (P24)

Both of these participants described their friends' attempts to prevent or stop their NSSI behavior. Since these friends knew about or had witnessed the participants' NSSI behavior directly, they took immediate action to intervene in each situation.

A few participants described unusual ways in which their friends tried to intervene on their behalf. One youth reported that, when she disclosed her cutting behavior to her best friend, her friend slapped her and threatened to beat her up if she ever cut again (P37). In another example, this participant described how his friends responded to his cutting and clawing behavior, stating:

My friends get mad at me a lot. They hate it when I do it. I have a friend that every time I cut, he doubles it and does it to himself. So the guilt kicks in, and I never do it again. And I have another friend who almost completely disowned me because of it. (P12)

A different participant explained her friends had threatened to end their friendship or tell her parents unless she stopped engaging in NSSI. When faced with these ultimatums, the participant decided, "Well, you know, I better stop" (P18).

Examples in which friends used threats, retaliatory behavior, and peer pressure to persuade participants to stop self-harming were atypical. In some cases, as with P18,

these types of interventions did help youth stop engaging in the behavior. Conversely, when P37 was asked how her friend's response made her feel, she responded, "It actually made me happy. But at the same time, I still felt she couldn't help me with my emotional problems." This comment implies that her friend's intervention made her feel cared for in the immediate moment, but did not help her resolve the underlying emotional issues that gave her the urge to cut. Regardless of the effectiveness of the strategies, these narratives provide further information about the different ways in which peers tried to prevent participants from engaging in NSSI.

*Mutual support.* Participants gave many examples of mutual helping relationships that benefited them and their friends. Since many of the participants' friends also engaged in NSSI, youth described how they provided help and support to each other. This bisexual youth shared his experience with mutual support among his friends, stating, "I've had a few friends in the past who also self-harmed, and together we became kind of our own support group and help each other through that" (P17). Another bisexual male in the study put it this way: "There's only a few of us that will go through that [NSSI] and we try to help each other go through that" (P21). A bisexual female shared a similar example of giving help to and receiving help from her roommate around NSSI. She said:

I have one really good friend, she lives with me, and every time I walk out by myself she comes with me and she will not leave me alone. Because she's going through the same things and she's trying to help me and I do the same thing for her...It's a constant thing that we help each other and it's really helped me through...We're trying to help each other get out of that stage. (P3)

In another example, this genderqueer participant also talked about reciprocal peer support from his perspective, stating:

After I've harmed myself, I kind of feel bad about it, and then I go and look for, you know, I talk to someone—one of my friends. And so my friends kind of do the same. So we just like, you know, will support each other. (P27)

Finally, a transgender participant explained that, “A lot of my friends were really close and we talked about that sort of thing, so, you know, with some of my friends, we support each other in that when we have urges, we talk to each other” (P40).

Youth's stories about mutual helping relationships in their social networks reinforced the importance of shared experiences. Participants explained that they and their friends were able to help each other with NSSI because they had first-hand knowledge about the behavior. For example, a queer youth emphasized the value of shared experiences this way:

I think that having friends who feel like they're in the same situation as you—giving you advice while you're giving them advice. I think having people from the same situation as you really helps 'cause you can actually understand, 'Okay, what you're saying makes sense.' (P25)

Similarly, this pansexual youth talked about the importance of seeking support from friends who have experienced NSSI. He explained:

Someone will call me in the middle of the night say, you know, 'I'm having a hard time. I'm thinking about hurting myself again.' We talk each other out of it. But I think that it's really important...if you know that your friend is self-harming and they know that you are, you need to be able to talk about [it]. And it's much

easier to get over it if you have someone else who's gone through the same thing.  
(P39)

Through these examples, study participants emphasized that peer help seeking is influenced and enhanced by youth's own history of NSSI behavior. Participants and their friends found it easier to seek help from peers who had "gone through the same thing" and could "actually understand" where they were coming from.

*Pacts and promises.* Another salient aspect of peer help seeking that emerged from the data was that several participants made commitments to their friends about stopping NSSI behavior. Youth in the study took these agreements very seriously and relied on them when faced with triggers. For many, pacts and promises were instrumental in helping them and their friends abstain from self-harm. In the following excerpt, this heterosexual transgender participant described how a pact with his friend influenced their NSSI behavior:

We've had that pact for two years and it was very simple. We can't slip up. And if we do, we're not friends with each other until we stop slipping up. And we want to keep each other as friends, so we avoid slipping up and we avoid doing the things that, you know, I mean, we call each other, we say, 'Hey, I almost cut,' or, 'Hey, I almost choked, can you just help me out? Can you just help me through this?' And that pact is very in our face. We don't want to lose each other. So we do the best we can to not lose each other. And the reason we made it was simple—that it would be a deal that we knew we could keep...So, I mean, that sounds like a pretty selfish thing to say, but...it's made us closer friends and it's made us stronger. (P5)

This participant and his friend put their friendship on the line in a pact intended to help them abstain from NSSI. Fear of losing their friendship led them to seek other ways to cope and resist the urge to self-harm. This participant also emphasized that the pact not only helped him and his friend with their NSSI behavior, it also strengthened their relationship.

Other youth in the study also shared stories about making commitments to their friends regarding self-harming behavior. This androgynous participant<sup>8</sup> referenced a pact that she had created with an alcoholic friend. He described his intention to abstain from cutting in order to keep his friend from drinking:

It's kinda like a pact that we made, because I always say that hers is a little bit worse than mine. But, my plan is to keep her sober. In order to do that, I have to put one foot forward to be sober myself. (P16)

In yet another example, a bisexual participant talked about an agreement between him and his friends that helped them stop cutting. He described the situation this way:

So sophomore year [a] couple of friends and I, we were all cutting ourselves. And then just one day, we all just sat down and we're like, 'We need to stop. So we're going to promise each other here and now that we're not going to do it again.' And pretty much that was it for a lot of us...Myself and my other friend, we had a little incident afterwards, but after that we were just done with it. (P17)

As illustrated by the preceding quotes, several youth made pacts or similar agreements with their friends as a way to hold each other accountable for ending their

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<sup>8</sup> This interview participant preferred the use of mixed gender pronouns (i.e., alternately using he/his/him and she/her) when referring to him.

NSSI behavior. Pacts and promises were an approach to mutual helping whereby youth agreed to comply with an agreement with the intention of keeping themselves and their friends safe. This strategy indicates that LGBTQ interview participants placed a very high value on their friendships. Creating a pact that either put a friendship at stake or offered the opportunity to deepen a friendship seemed to be an effective strategy for reducing self-harm.

*Peer influence.* While study participants talked at length about the ways in which their peers helped them decrease or stop NSSI, they also shared examples of how peers influenced each other's engagement in NSSI. Youth talked about several ways in which peer influence operated in their lives. Some indicated that they first learned about NSSI from their peers who engaged in the behavior. Participants also mentioned that their peers influenced their initiation of NSSI and vice versa. Additionally, youth shared stories of engaging in self-harm with their peers, either one-on-one or in a group setting. Finally, some youth shared their perspectives about the phenomenon of NSSI among youth in today's society. It is important to note that these examples of peer influence were far less common in the data than those where youth reported help-seeking and help-giving behaviors among peers. Nonetheless, these data provide important insights about the relationship between LGBTQ youth's peer relationships and their NSSI behavior.

*Peers provide first exposure to NSSI.* When youth were asked in their interviews how they first learned about self-harm, a few participants said that their friends first exposed them to the idea. Among them was this bisexual participant who said, "I had [heard] of them...doing it, and I was like, 'Hmm!' And then that just kind of sparked it"

(P14). Similarly, a queer youth said she first heard about cutting from a friend during her freshman year of high school. She explained:

She let her sleeves slip and I saw it and I asked her what it was about. And she was one of those people that would show it off and be like, ‘Look at me! I cut!’ And it...kinda sunk in that that’s something that I could do to deal with stuff.

(P29)

Both of these youth described scenarios in which their friends’ NSSI behavior introduced them to the behavior and gave them the idea that they could also engage in self-harm.

*Peers influence NSSI onset.* Study participants also mentioned that their peers influenced their first initiation of NSSI. For example, one lesbian youth talked about engaging in NSSI the first time simply to “try it out” because “everybody seemed to be doing it at school” (P20). Another participant described how his friends’ behavior impacted his decision to start engaging in NSSI. He explained:

I tried cutting myself once. I didn’t really care for it...I was thirteen. I didn’t realize, but I had cut myself really good, like it still shows right there. ‘Cause I just wanted to see what it was like—how my friends could do it so easy and just feel to relieved. (P21)

This youth explained that he first tried cutting as a form of NSSI because he perceived that it helped his friends. Notably, this participant tried the same NSSI method that his friends used in hopes of experiencing similar relief. Although he did not continue cutting, he eventually began to seek fights and engage in more externalizing forms of NSSI after this first incident.



Similarly, a few youth shared their perceptions that their own NSSI behavior influenced their friends to initiate self-harm. This questioning youth mentioned that one of her friends, “started doing it after I started, like when she found out that I was doing it” (P11). Another participant felt that her cutting behavior had negatively impacted her friends by normalizing NSSI. She stated:

I was kind of the gateway person for most of my friends to start cutting ‘cause they were like, ‘Oh! She’s doing it. I guess it’s okay for me to do it, too.’ So it kinda made the negative effect of them starting to cut. ‘Cause my best friend...she never cut—not once—before about this time last year. ‘Cause, you know, I had been cutting couple times before that and I had showed her...And then, couple months after that, she started cutting, too. (P33)

This youth’s description of being “the gateway person” is a powerful metaphor for the influence she felt she had in her peer group. From her point of view, disclosing her own experiences with cutting led her friend to initiate the same behavior.

*Engaging in NSSI with peers.* A few participants also talked about engaging in NSSI in the company of their friends and intimate partners. Though the overwhelming majority of youth in the study engaged in NSSI alone, some engaged in self-harm as part of a social experience. For example, this androgynous participant explained that her former girlfriend introduced her to cutting and that they eventually began to cut together. He shared the following story:

My first girlfriend ever, it was like her thing. And like, I just picked up on it and it was like a bonding thing for us. So we did it together and then I just decided to do it all the time...I was still trying to figure it out, so I didn’t know what I was

supposed to get out of it. I just knew that...we did it as like a blood-bonding thing. So it was like something that we did together. (P16)

This participant did not initially understand why she was cutting other than because it was something that she and her girlfriend did together as a bonding ritual. Ultimately, he seemed to engage in NSSI primarily for social functions, such as strengthening his relationship with his girlfriend.

One bisexual youth in the study offered a different perspective on engaging in NSSI with his friends. In this case, he and his friends fought each other with the intention of harming themselves. He explained:

P36: Sometimes we'll cause each other pain, like, on purpose. Like we'll fight—like punch each other, choke each other out until we pass out, and throw rocks at each other and shit—and not give a fuck if it's splits open your face or something. I don't know, we just get crazy.

I: Okay. And...how do you understand those kinds of experiences? Do you feel like it's because you all have a mutual understanding of what's happening or like-

P36: Yeah, I think we all just know we want to be hurt, so we're like, 'Fuck, let's just like fight or something.'...We don't take it to the heart when we're fighting each other. We're still friends.

This participant illuminated how he and his friends become physically aggressive with each other in order to “be hurt” themselves. Notably, he explained that he and his friends have an understanding about the purpose of the behavior and that the behavior does not imperil their friendship. This example was unique in the dataset, yet it reveals a dimension of peer influence on NSSI that may not be commonly considered.

A small number of youth in the study talked about engaging in more structured situations in which they self-harmed with their peers. Two female participants talked about participating in “cutting parties.” A lesbian youth indicated that she and her friends held cutting parties in the bathroom at their high school until administrators intervened (P20). A bisexual participant felt that cutting parties helped her friends feel less isolated. She explained that her friends, “did it in front of me so they knew that they weren’t alone” (P18). Another bisexual youth talked about participating in the eraser game with peers during middle school so they could see who was “tougher.” This participant reasoned that, “Everyone did it. It was just a stupid little game when I was in middle school” (P2). For this youth, it seemed that participating in the eraser game was a way to fit in or be part of the crowd.

These quotes indicate that a few LGBTQ youth in this study participated in structured social experiences involving NSSI. Of note, one of these youth emphasized that cutting parties were emotionally difficult for her. She acknowledged, “It was actually really hard to watch. I was doing it myself, but I mean, like, I stopped a lot of times ‘cause I was like, ‘This is really hard to watch my friends mutilate themselves’” (P18). This participant’s reflections suggest that the social experience of NSSI can be distressing for some youth and might lead them to re-evaluate the behavior.

Some study participants described particular relationship qualities that influenced their decision to engage in NSSI with their friends. For example, this lesbian youth talked about what drew her to engaging in NSSI with her “cutting buddies” (P20). She stated:

It's like we all understood, we all had the same kind of rough life. We necessarily didn't have the same life [but] we've very similar lives and we felt like the only thing we had was each other. And so if you wanted to be cool or be in that little clique, then you gotta do what you gotta do, just like in a gang. (P20)

This participant cut with friends who could understand her and with whom she had a close bond. Her words indicate that she felt compelled to cut with her friends in order to maintain and strengthen their bond. She and her friends felt they only had each other, which increased the importance and meaning of their cutting rituals.

Another youth in the study offered a similar example of the relationship qualities that led her to engage in NSSI with her peers. This bisexual participant typically engaged in self-harm when she was alone because she "didn't really want people to know" (P18). However, from time to time, she cut with her friends. When asked why she chose to cut with those particular people, she responded:

Um, the whole trust part. Like, if there's people I feel comfortable with, who I know have my back through life and are not going to judge me, and have never judged me for my sexuality or my body or my views on things. Just feeling comfortable being around them, knowing that they aren't going to narc on me.

(P18)

This participant emphasized the role of trust in situations where she engaged in NSSI with others. She felt comfortable enough to cut with these friends because she knew they accepted her, would not judge her, and would maintain her privacy. This excerpt suggests that trust is a salient aspect of engaging in NSSI with peers, just as it was with other dimensions of the *Peer Relationships* theme.

*NSSI is trendy.* When discussing peer influence, some LGBTQ participants shared the view that NSSI is a pervasive trend among youth. One lesbian youth noted, “it’s sort of a phenomenon that’s going on in kind of widespread teenage culture” (P9). Several youth believed that some of their peers engaged in NSSI because they thought it would make them hip or popular. For example, this bisexual participant said, “Having issues is kind of trendy. It’s strange to me, but it seems to be unconventional is the conventional thing to do. A lot of people brag about the problems they have, and this would be one of them” (P34). This youth went on to explain that some youth think having problems is “kind of cool” and that youth talk about their emotional problems and NSSI as a way to prove that they have “been through more” than other people (P34).

According to one genderqueer youth in the study, the Internet perpetuates the idea that NSSI is trendy. In the quote that follows, he described how NSSI was portrayed by youth on the Internet:

It was so glorified and linked to like a subculture and an image that...to a lot of people, it feels fake...At that time, it felt like a trend, and it felt like a put-on sort of behavior, if that makes sense. Because it was going around the Internet with like lyrics and MySpace graphics, you know, like it was...a whole scene in a way. (P38)

According to this youth, the Internet contributed to the growth of a “subculture” of people who engaged in and exalted NSSI behavior. He believed that, in an online environment, youth were drawn to the “image” of self-harm and did not have authentic motivations for their behavior.

It is interesting that each of these participants felt that *other* youth engaged in NSSI because it was trendy. They clearly did not count themselves among that group. It seems that these youth believed that their peers' behaviors and motivations were somehow less legitimate than their own.

In summary, this qualitative theme highlights role of peer relationships in NSSI behavior among LGBTQ youth. Study participants reported that NSSI was fairly common among their peers. In this social context, participants and their friends tried to create safe spaces to talk about NSSI, seek help from each other, and offer support to stop NSSI. LGBTQ participants and their friends often relied on each other as a support system that helped them develop alternative coping strategies. Fewer participants talked about self-harming with their peers and influencing their friends to engage in NSSI, though these narratives were certainly present in the data.

The importance of trust, openness, and shared experiences among peers resonated across each dimension of this theme. Youth and their peers were most likely to communicate with, seek help from, and influence friends who could relate to their NSSI experiences. This might explain why participants were much more likely to talk about seeking help from peers as compared to adults. Based on these data, it is evident that peers played a critical role in participants' social environment and had considerable influence on their NSSI behavior.

### **Chapter Summary**

This chapter presented the qualitative findings from the first phase of this exploratory, sequential mixed methods study. The constant comparative method (Lincoln & Guba, 1985) was used to identify five themes across 44 transcripts of interviews with

LGBTQ youth. In these themes, participants' narratives brought forward specific aspects of the social environment that related to their engagement in NSSI. These included: (1) coping with violence; (2) dealing with misconceptions, stigma, and shame associated with NSSI; (3) negotiating an LGBTQ identity in a homo/transphobic social context; (4) feeling invisible and alone; and (5) relating to and helping peers who engage in NSSI.

The findings from this phase of the study indicate that social-environmental factors played an important role in increasing and decreasing risk for NSSI among LGBTQ youth who completed interviews at Rainbow Alley. In the second, quantitative phase of this study, I aim to determine whether some of the factors identified in the qualitative analysis can predict NSSI among LGBTQ youth who completed an online survey. The results of the quantitative analysis will be presented in the subsequent chapter.

## **Chapter Five: Quantitative Results**

This chapter will share the findings from the quantitative phase of this mixed methods study. It will begin with a presentation of the descriptive statistics, including participants' demographic characteristics and the distribution of the variables used in the analyses. This chapter will conclude with the results from the inferential statistical analyses that were used to test the two quantitative research questions.

### **Descriptive Statistics**

**Demographics.** Initial analyses involved an examination of the descriptive statistics related to the variables in this study. Participants' demographic characteristics were examined first. Table 7 depicts the age, gender identity, sexual orientation, and race/ethnicity of all survey participants as well as the subset of 189 survey respondents who engaged in NSSI. This table also displays the demographic characteristics of youth who participated in the qualitative phase in order to facilitate a comparison of the samples in the current study.



Table 7  
*Demographic Characteristics of Survey and Interview Participants*

Characteristic	Survey ( <i>N</i> = 267)		Survey – NSSI only ( <i>N</i> = 189)		Interview ( <i>N</i> = 44)	
	<u>Freq.</u>	<u>%</u>	<u>Freq.</u>	<u>%</u>	<u>Freq.</u>	<u>%</u>
Age range	13-23		13-23		15-22 <sup>a</sup>	
Mean age ( <i>SD</i> )	16.75 (2.08)		16.68 (2.18)		18.46 <sup>a</sup> (1.43)	
Gender identity						
Female	134	50.2	106	56.1	15	34.1
Male	95	35.6	52	27.5	16	36.4
Transgender, gender queer, or other	35	13.1	29	15.3	13	29.5
Unknown	3	1.1	2	1.1	0	0
Sexual orientation						
Lesbian	54	20.2	47	24.9	5	11.4
Gay	71	26.6	37	19.6	5	11.4
Bisexual, pansexual, or queer	114	42.7	84	44.4	31	70.4
Questioning or other	28	10.5	21	11.1	3	6.8
Race/ethnicity						
White	183	68.5	133	70.4	22	50.0
Biracial or multiracial	34	12.7	22	11.6	10	22.7
Hispanic or Latino/a	33	12.4	21	11.1	3	6.8
Other	16	6.0	13	6.9	3	6.8
Unknown	1	0.4	0	0	6	13.7

<sup>a</sup>Exact age is unknown for three interview participants. Results are based on *n* = 41.

The average ages of survey participants and interview participants were 16.75 (*SD* = 2.08) and 18.46 (*SD* = 1.43) respectively. The survey participants were significantly younger than those who completed the individual interviews,  $t(69.14) = -6.62, p < .001$ . The subset of survey participants who engaged in NSSI had a mean age of 16.68 (*SD* =

2.18); thus, they were also significantly younger than the interview participants,  $t(69.14) = -6.51, p < .001$ .

The largest percentage of youth who completed the survey was female (50.2%), followed by males (35.6%) and transgender and genderqueer youth (13.1%). A similar pattern was found among the subset of survey participants who engaged in NSSI, of which 56.1% were female, 27.5% were male, and 15.3% were transgender or genderqueer. The distribution of gender identity in the full and NSSI-only survey samples differed from the qualitative participants, among whom the slight majority was male.

In terms of sexual orientation, bisexual, pansexual, and queer participants comprised the majority in both the quantitative (full and NSSI-only) and qualitative samples. The racial characteristics were also similar across samples. The majority all survey participants (68.5%), survey participants who engaged in NSSI (70.4%), and interview participants (50.0%) were White. When comparing White participants to participants of color in the full survey and interview samples, no significant differences were found ( $\Phi = -.077, p = .180$ ). Similarly, there was no significant difference in the proportion of White youth and youth of color when comparing only those survey participants who engaged in NSSI with the interview participants ( $\Phi = -.100, p = .132$ ).

**Independent variables.** LGBTQ youth who participated in the Rainbow Alley survey reported experiencing many forms of violence. Over one third (37.8%,  $n = 101$ ) of youth had experienced physical abuse by a family member at some point in their lives. Approximately 10.5% ( $n = 28$ ) had been pressured or forced by a family member to engage in unwanted sexual activity. In regards to school-related violence, 23.2% ( $n = 62$ )

of participants reported being physically assaulted, while nearly half (46.4%,  $n = 124$ ) experienced unwanted sexual attention, sexual touch, or sexual assault in the past year on or near school grounds. In terms of safety at school (or on the way to/from school), 28.1% ( $n = 75$ ) of survey participants reported that they had not felt unsafe in the previous 12 months. Among those who had felt unsafe at/near school in the previous 12 months, 42.3% ( $n = 113$ ) said they rarely felt unsafe, 20.6% ( $n = 55$ ) sometimes felt unsafe, 6.7% ( $n = 18$ ) felt unsafe most of the time, and a few youth (1.1%,  $n = 3$ ) felt unsafe all the time.

The variable that served as a proxy for the *Negotiating LGBTQ Identity* theme measured participants' level of openness about their sexual orientation. A small subset of participants (5.2%,  $n = 14$ ) indicated that they were not at all open about their sexual orientation. Of those who reported some level of openness, 13.9% ( $n = 37$ ) were hardly open at all, 10.9% ( $n = 29$ ) were slightly open, 31.8% ( $n = 85$ ) were somewhat open, and over one third (38.2%,  $n = 102$ ) were very open about their sexual orientation.

To measure the *Invisibility and Isolation* theme, two variables were used. The first variable was exclusion from groups at school (or on the way to/from school) in the previous year, measured dichotomously (yes/no). Just over half of the survey participants had been excluded from groups at school in the previous year (52.8%,  $n = 141$ ). The second variable included in this block was youth's level of agreement with the statement, "I am accepted at school." A few participants (5.2%,  $n = 14$ ) indicated strong disagreement with this statement, while 26.6% of youth ( $n = 71$ ) disagreed, 47.9% of youth ( $n = 128$ ) agreed, and 20.2% ( $n = 54$ ) strongly agreed that they were accepted at school.

A dichotomous variable measuring sadness or hopelessness was included in the analyses as a proxy for depression to answer the second quantitative research question. More than half (61.8%,  $n = 165$ ) of study participants reported that they felt so sad or hopeless almost every day for a two week period (in the previous year) that it interfered with their usual activities.

**Dependent variable.** The dependent variable used in the quantitative phase of this study was lifetime engagement in any of ten NSSI methods, measured dichotomously (yes/no). Among the survey participants, 70.8% ( $n = 189$ ) reported engaging in at least one of the ten forms of NSSI during their lifetime. The remaining 29.2% ( $n = 78$ ) indicated that they had never engaged in any of those NSSI methods. Table 8 displays the number and percent of survey participants who reported engaging in each method.

Table 8  
*NSSI Methods Reported by Survey Participants*

NSSI method	<i>Freq.</i>	%
Cut self	153	81.0
Hit something else (like a wall)	144	76.2
Bit self	108	57.1
Hit self	102	54.0
Rubbed your skin until it hurt	77	40.7
Burned self	74	39.2
Ate or drank something to hurt self	66	34.9
Inhaled something to hurt self	36	19.0
Cut off circulation to a body part	31	16.4
Cut off some part of your body	5	2.6

*Note.*  $n = 189$ , the subset of survey participants who engaged in some form of NSSI. Percentages do not add up to 100 because several participants engaged in more than one NSSI method.

Cutting was the most commonly endorsed NSSI method by survey participants (81.0%,  $n = 153$ ), as was the case among the interview participants (86.4%,  $n = 38$ ). Hitting something (76.2%,  $n = 144$ ), biting oneself (57.1%,  $n = 108$ ), and hitting oneself (54.0%,  $n = 102$ ) were the next most commonly reported methods among youth in this quantitative phase of the study, which were also similar to the behaviors reported in the qualitative interviews. Among survey participants who engaged in NSSI, a few youth (6.0%,  $n = 16$ ) engaged in only one method. Approximately 11.0% ( $n = 29$ ) of survey participants engaged in two methods and an equal percentage engaged in three methods ( $n = 28$ ). Just over one third of survey participants reported using four or more NSSI methods (36.2%,  $n = 97$ ).

### **Inferential Statistics**

Two research questions were tested in the quantitative phase of this study. The first question was “Do the social-environmental factors identified in the qualitative phase significantly predict the likelihood of engaging in NSSI among a larger sample of LGBTQ youth?” To answer this research question, a sequential, bivariate logistic regression was conducted to test social-environmental variables as predictors of lifetime engagement in NSSI. The demographic and predictor variables were entered into the model in four different blocks. Subsequently, a final parsimonious model including the demographic control variables and any significant predictors from the four blocks was analyzed. Table 9 illustrates the logistic regression coefficients, Wald statistics, odds ratios, 95% Confidence Intervals for the odds ratios, and pseudo  $R^2$  values for each block of the sequential and parsimonious models.

Table 9  
*Logistic Regression Models Predicting NSSI among LGBTQ Youth*

Predictor Variables	Block 1		Block 2		Block 3		Block 4		Final model	
	<i>B</i> (OR)	95% CI	<i>B</i> (OR)	95% CI	<i>B</i> (OR)	95% CI	<i>B</i> (OR)	95% CI	<i>B</i> (OR)	95% CI
Age	-0.06 (0.94)	0.82 – 1.08	0.02 (1.02)	0.87 – 1.19	0.00 (1.00)	0.86 – 1.67	0.00 (1.00)	0.85 – 1.17	-0.03 (0.97)	0.84 – 1.13
Female <sup>a</sup>	0.51 (1.67)	0.73 – 3.79	0.42 (1.52)	0.62 – 3.72	0.25 (1.28)	0.51 – 3.21	0.27 (1.31)	0.51 – 3.35	0.25 (1.28)	0.53 – 3.09
Transgender, genderqueer, or other <sup>a</sup>	0.94 (2.56)	0.88 – 7.44	0.52 (1.68)	0.53 – 5.34	0.26 (1.30)	0.39 – 4.30	0.26 (1.30)	0.39 – 4.32	0.55 (1.73)	0.55 – 5.42
Lesbian <sup>b</sup>	1.51* (4.55)	1.33 – 15.60	1.74* (5.68)	1.53 – 21.13	2.08** (7.97)	2.00 – 31.76	2.07** (7.93)	1.98 – 31.68	1.92** (6.81)	1.84 – 25.20
Bi/pansexual or queer <sup>b</sup>	0.58 (1.79)	0.78 – 4.10	0.68 (1.98)	0.81 – 4.89	0.91 <sup>†</sup> (2.49)	0.98 – 6.36	0.91 <sup>†</sup> (2.49)	0.98 – 6.37	0.95* (2.59)	1.05 – 6.37
Questioning or other <sup>b</sup>	0.60 (1.82)	0.59 – 5.61	0.66 (1.93)	0.57 – 6.61	1.03 (2.81)	0.77 – 10.31	1.01 (2.76)	0.75 – 10.16	1.10 (2.99)	0.85 – 10.54
Family physical abuse			0.98* (2.65)	1.27 – 5.55	0.86* (2.36)	1.11 – 5.00	0.86* (2.36)	1.11 – 5.01	1.12** (3.06)	1.51 – 6.19
Family sexual abuse			0.48 (1.62)	0.39 – 6.72	0.50 (1.64)	0.40 – 6.72	0.49 (1.64)	0.40 – 6.74		

Physical violence at school	0.88 (2.40)	0.84 – 6.85	0.88 (2.41)	0.83 – 6.94	0.91 (2.48)	0.84 – 7.31		
Sexual violence at school	0.32 (1.37)	0.71 – 2.66	0.24 (1.27)	0.65 – 2.49	0.25 (1.28)	0.65 – 2.51		
Unsafe at school	0.40 <sup>†</sup> (1.49)	0.99 – 2.25	0.46* (1.58)	1.04 – 2.40	0.47* (1.61)	1.04 – 2.49	0.52** (1.68)	1.15 – 2.46
Openness about sexual orientation			0.28* (1.32)	1.01 – 1.72	0.29* (1.33)	1.01 – 1.75	0.28* (1.32)	1.02 – 1.71
Excluded from groups					-0.14 (0.87)	0.43 – 1.75		
Accepted at school					-0.04 (.96)	0.63 – 1.48		
Pseudo $R^2$	.14	.28	.30	.30	.30	.27		

*Note.* The logistic regression model with Blocks 1 through 4 included  $N = 252$ . The final parsimonious model included  $N = 258$ .

<sup>a</sup>Male is the reference category. <sup>b</sup>Gay is the reference category.

<sup>†</sup>  $p < .10$ . \* $p < .05$ . \*\*  $p < .01$ .

The first block of the sequential logistic regression model included the six demographic variables. The lesbian dummy variable (using gay as a reference category) was the only significant predictor in this block. Lesbian youth in this sample were 4.56 times more likely to engage in NSSI as compared to gay youth ( $p = .016$ ). A chi square test indicated that the addition of the demographic variables significantly improved the model fit as compared to the constant-only model,  $\chi^2(6, N = 252) = 25.09, p < .001$ . The effect size (Nagelkerke  $R^2$ ) for Block 1 was .135.

In the second block, the five violence variables were added to the model, along with the demographic variables from Block 1. The lesbian dummy variable remained a significant predictor after including the violence variables; lesbian youth were 5.68 times more likely than gay youth to engage in NSSI ( $p = .010$ ). Family physical abuse was also a significant predictor in this block. Youth who experienced physical abuse by a family member were 2.65 times more likely than those who had not to report engaging in NSSI ( $p = .010$ ). One additional variable, feeling unsafe at school, was a marginally significant predictor of NSSI ( $OR = 1.49, p = .058$ ). The chi square test suggested that the inclusion of the violence variables significantly improved the ability of the model to predict the dependent variable,  $\chi^2(5, N = 252) = 30.79, p < .001$ . The Nagelkerke  $R^2$  value for Block 2 was .282.

One variable, openness about sexual orientation, was added to the model in the third block. The addition of this variable once again improved the model fit as compared to the model that included only the demographic and violence predictor variables,  $\chi^2(1, N = 252) = 4.19, p = .040$ . As in the previous block, the lesbian dummy variable ( $OR = 7.97, p = .003$ ) and family physical abuse ( $OR = 2.36, p = .026$ ) remained significant



predictors of NSSI. Additionally, with the inclusion of the openness variable, feeling unsafe at school was found to be a significant predictor of NSSI. For each categorical increase in the frequency of feeling unsafe at school, youth were 1.58 times more likely to engage in NSSI ( $p = .032$ ). Degree of openness about sexual orientation was also a significant predictor in Block 3. For each incremental increase in openness, participants were 1.32 times more likely to report NSSI behavior ( $p = .041$ ). In practical terms, an LGBTQ youth who was *very open* about his or her sexual orientation was 5.28 times more likely to engage in NSSI as compared to a youth who was *not at all open*. Further, the dummy variable for bisexual, pansexual, and queer youth (as compared to gay youth) was marginally significant ( $OR = 2.49, p = .055$ ). The overall effect size for Block 3 was .301.

In the fourth block, two variables related to the *Invisibility and Isolation* theme, (1) acceptance at school and (2) exclusion from groups, were added to the model. Neither of these variables was a significant predictor of engaging in NSSI. Not surprisingly, the chi square statistics indicated that the inclusion of these two predictors did not significantly improve the model fit,  $\chi^2(2, N = 252) = .166, p = .920$ . However, the same four predictors from the previous block remained statistically significant in Block 4. Identifying as lesbian (as compared to gay;  $OR = 7.93, p = .003$ ), experiencing family physical abuse ( $OR = 2.36, p = .026$ ), greater frequency of feeling unsafe at school ( $OR = 1.61, p = .033$ ) and greater openness about one's sexual orientation ( $OR = 1.33, p = .039$ ) all significantly predicted greater likelihood of NSSI behavior among LGBTQ youth in this sample. Being bisexual, pansexual or queer (as compared to being gay) also

remained marginally significant ( $OR = 2.49, p = .056$ ). The full model including all of the predictor variables from Blocks 1 through 4 had an effect size of .302.

A final, parsimonious logistic regression model was analyzed that included the demographic variables as controls and the three social-environmental variables that were significant predictors in Block 4 of the sequential model. The chi square results for this final model indicated that it was significantly better than the constant-only model at predicting the dependent variable,  $\chi^2(9, N = 258) = 54.905, p < .001$ . In this model, two demographic variables were significant predictors of NSSI. Lesbian youth were 6.81 times more likely than gay youth in the sample to engage in NSSI ( $p = .004$ ). Bisexual, pansexual, and queer youth were also predicted to have a higher likelihood of NSSI as compared to gay youth ( $OR = 2.59, p = .038$ ). Furthermore, both of the violence variables remained significant in the final model. LGBTQ youth who experienced physical abuse by a family member were 3.06 times more likely than those who had not experienced this form of maltreatment to engage in NSSI ( $p = .002$ ). Feeling unsafe at school also predicted a higher likelihood of NSSI in this model. For every categorical increase in feeling unsafe at school, youth were 1.68 times more likely to engage in NSSI ( $p = .007$ ). In other words, youth who felt unsafe at school *all the time* were 6.72 times more likely than those who *never* felt unsafe at school to report NSSI behavior. Finally, openness about sexual orientation, a proxy variable for the *Negotiating LGBTQ Identity* theme, significantly predicted the likelihood of NSSI among youth in this sample ( $OR = 1.32, p = .035$ ). This result indicates that youth who were *very open* about their sexual orientation were 5.28 times more likely to engage in NSSI than those who were *not at all open*. The Nagelkerke  $R^2$  for this final parsimonious model was .272.

The second quantitative research question asked, “Does depression mediate the relationship between social-environmental factors identified in the qualitative phase and NSSI among LGBTQ youth?” To answer this research question, three analyses were conducted using KHB method (Karlson & Holm, 2011; Kohler et al., 2011). Each of the three analyses tested depression as a mediator of the relationship between one of the three significant social-environmental variables from the final logistic regression model and NSSI. The demographic variables (age, gender identity, and sexual orientation) were included in the KHB analyses as control variables. The results of these analyses are displayed in Table 10.

Table 10  
*Results of KHB Analysis Testing Depression as a Mediator between Social-Environmental Factors and NSSI.*

	Model A		Model B		Model C	
	Family physical abuse		Feeling unsafe at school		Openness about sexual orientation	
	Coef (SE)	95% CI	Coef (SE)	95% CI	Coef (SE)	95% CI
Total effect	1.51*** (0.36)	0.80 – 2.22	0.60** (0.19)	0.23 – 0.97	0.29* (0.13)	0.04 – 0.54
Direct effect	1.28*** (0.36)	0.58 – 1.99	0.41* (0.20)	0.03 – 0.78	0.30* (0.13)	0.05 – 0.55
Indirect effect	0.23* (0.09)	0.04 – 0.42	0.19** (0.06)	0.08 – 0.31	-0.01 (0.04)	-0.09 – 0.07
Confounding ratio <sup>a</sup>		1.18		1.47		0.98
Confounding percentage <sup>b</sup>		15.18		31.83		-2.12

Note. *N* = 261 for Models A and B. *N* = 264 for Model C.

<sup>a</sup>The confounding ratio indicates the impact of mediation net of rescaling and is calculated by dividing the coefficient for the total effect by the coefficient for the direct effect. <sup>b</sup>The confounding percentage indicates what percentage of the total effect is explained by the mediating variable.

\**p* < .05. \*\* *p* < .01. \*\*\**p* < .001.

Model A tested whether depression mediated the relationship between family physical abuse and NSSI among LGBTQ youth survey participants. Family physical

abuse was a significant predictor of NSSI, increasing the log odds of engaging in NSSI behavior by 1.51 ( $p < .001$ ). The log odds value was calculated into an odds ratio of 4.53 for ease of interpretation. This result indicates that LGBTQ youth who experienced family physical abuse were 4.53 times more likely to engage in NSSI as compared to those who did not<sup>9</sup>. After the inclusion of depression as a mediator, the predictive effect of family physical abuse on NSSI remained significant, but was reduced to a log odds of 1.28 ( $OR = 3.60$ ). The difference between the coefficients for the total effect (including control variables and family physical abuse) and the direct effect (including control variables, family physical abuse, and depression) is considered to be the coefficient for the indirect effect of depression on the dependent variable (Kohler et al., 2011). In Model A, the indirect effect of depression on NSSI behavior was also significant ( $OR = 1.26, p = .020$ ). The total effect of family physical abuse on NSSI was 1.18 times greater than the direct effect in the mediation model, and 15.18% of the relationship between family physical abuse and NSSI was explained by depression. Since both the direct and indirect effects were significant in this model, depression was a significant, partial mediator of the relationship between family physical abuse and NSSI behavior.

Model B examined whether depression accounted for the relationship between feeling unsafe at school and NSSI among LGBTQ youth. In this model, the log odds of the total effect of feeling unsafe at school on NSSI was significant at 0.60 ( $OR = 1.82, p = .001$ ). For each categorical increase in feeling unsafe at school, participants were 1.82

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<sup>9</sup> The coefficients and odds ratios in each of the KHB analyses are slightly different than those reported in the final logistic regression model. This is due to the fact that the KHB method involves a different formula than that which is used in logistic regression (Kohler et al., 2011). Specifically, the KHB formula divides independent and mediator variables by the same scale parameter in order to compare them on the same scale, thus avoiding rescaling problems discussed in Chapter Three (Kohler et al., 2011).

times more likely to engage in NSSI. The inclusion of depression into the model reduced the predictive effect of feeling unsafe at school on NSSI to a log odds of 0.41 ( $OR = 1.51$ ), which remained statistically significant ( $p = .032$ ). The log odds of the indirect effect of depression on NSSI was .19 ( $OR = 1.21$ ), which was also a significant relationship ( $p = .001$ ). The total effect of feeling unsafe at school on NSSI was 1.47 times larger than the direct effect when controlling for depression as a mediator. In this model, depression accounted for 31.83% of the relationship between feeling unsafe at school and NSSI. These results indicate that depression was a statistically significant, partial mediator of the relationship between feeling unsafe at school and NSSI among this sample of LGBTQ youth.

Finally, Model C looked at whether depression acted as a mediator of the relationship between openness about sexual orientation and NSSI among this sample of survey participants. Looking at the total effect, openness about sexual orientation was a significant predictor of NSSI; for each categorical increase in openness about sexual orientation, LGBTQ youth in this study were 1.34 times as likely to engage in NSSI ( $p = .022$ ). When controlling for depression in the model, the direct effect of openness about sexual orientation on NSSI actually increased very slightly to an odds ratio of 1.35 ( $p = .020$ ). The indirect effect of depression on NSSI was not statistically significant in this model. Overall, the total effect of openness about sexual orientation was less predictive than the direct effect of openness on NSSI when controlling for depression. The confounding percentage was negative, indicating that depression did not account for any of the relationship between openness and NSSI. Instead, the inclusion of depression in the model increased the effect of openness on NSSI in this model. These results indicate

that depression was not a significant mediator of the association between openness about sexual orientation and NSSI among survey participants.

### **Chapter Summary**

This chapter presented the results from the analyses conducted in the second phase of this sequential mixed methods study. The purpose of this phase of the study was to determine whether certain findings from the qualitative phase could also be identified through statistical analysis of survey data collected from a sample of LGBTQ youth. A sequential logistic regression analysis was conducted and ultimately identified three social-environmental factors which significantly predicted NSSI among LGBTQ youth: (1) experiencing physical abuse by a family member, (2) feeling unsafe at school, and (3) the degree of openness about one's sexual orientation. Next, KHB analyses were conducted to determine whether depression mediated the relationships between these significant social-environmental factors and NSSI. The KHB analyses found that depression partially mediated the relationships between family physical abuse and NSSI and feeling unsafe at school and NSSI. Conversely, depression was not a significant mediator of the association between openness about one's sexual orientation and NSSI. The subsequent chapter will discuss this study's qualitative and quantitative findings as well as outline the limitations and implications for the field.

## **Chapter Six: Discussion**

The purpose of this study was to explore the role of the social environment in NSSI behavior among LGBTQ youth. Since very little research has been conducted in this area, an exploratory, sequential mixed methods design was used to understand the topic from both a qualitative and quantitative perspective. The first phase of research involved qualitative analysis of interview data using the constant comparative method (Lincoln & Guba, 1985). This phase was guided by the research question, “How do LGBTQ youth describe the relationship between their social environment and their experiences with NSSI?” Five themes that emerged from the qualitative analysis were used to guide the development of research questions, identify variables, and determine statistical analysis in the second phase of the study. In the second phase, I utilized sequential logistic regression analysis to determine whether the social-environmental factors identified in the qualitative phase would significantly predict NSSI among LGBTQ youth who completed an online survey. Finally, I conducted statistical analysis to determine whether depression acted as a mediator between social-environmental factors and NSSI as was suggested by youth during their interviews.

In this final chapter, I will synthesize the study’s findings and discuss their relationship to the existing literature. I will then describe the limitations and strengths of the study as well as implications for social work. To conclude this chapter, I will propose

directions for future research that could advance the knowledge base related to NSSI among LGBTQ youth.

### **Summary of Findings**

**Discussion of qualitative findings.** In the qualitative phase of this study, five themes were identified to describe the relationship between LGBTQ youth's social environments and NSSI. These themes included: (1) *Violence*; (2) *Misconceptions, Stigma, and Shame*; (3) *Negotiating LGBTQ Identity*; (4) *Invisibility and Isolation*; and (5) *Peer Relationships*. As a whole, these themes align with existing literature and suggest new ways of thinking about NSSI among LGBTQ youth. In this section, I will discuss each theme individually in relation to the knowledge base about NSSI.

Subsequently, I will describe how the relationships between the qualitative themes contribute to a more comprehensive understanding of NSSI among LGBTQ youth.

***Violence.*** The first theme, *Violence*, described the ways that LGBTQ youth used NSSI to cope with exposure to violence in their social environment. Youth in this study reported experiencing physical, sexual, verbal and emotional violence at the hands of family members, peers, social service systems, and others. For some, experiencing violence coincided with the onset of NSSI; for others, violence triggered their re-engagement in the behavior. In both cases, participants described NSSI as a functional behavior that helped them deal with traumatic experiences.

These findings align with the empirical literature on NSSI and violence among LGBTQ youth in several ways. First, these findings are consistent with a growing body of research that suggests that LGBTQ youth are at high risk for experiencing violence at home, school, and on the streets (Kosciw et al., 2012; Pilkington & D'Augelli, 1995;



Saewyc et al., 2006; Tyler, 2008). Second, the data support previous research linking childhood maltreatment and anti-LGBTQ violence to NSSI among LGBTQ youth (Alexander & Clare, 2004; Liu & Mustanski, 2012; Scourfield et al., 2008; Walls et al., 2010). Finally, several LGBTQ youth in this study described engaging in NSSI as a way of grounding themselves when they experienced traumatic memories or flashbacks in the aftermath of abuse. These findings are similar to those in previous studies that found an association between NSSI and symptoms of PTSD among adolescent samples (Shenk et al., 2010; Weirich & Nock, 2008). Taken together, the alignment between youth's narratives and the existing literature suggests that (a) exposure to disproportionately high rates of violence, (b) experiencing many types of violence across social settings, and (c) difficulties coping with emotional distress associated with violence may contribute to higher NSSI risk among LGBTQ youth. However, given that the qualitative nature of this phase of the study, these findings are not generalizable beyond the study participants. Further research is needed to improve our understanding of the association between violence and NSSI in this population of youth.

Beyond simply corroborating previous research, the qualitative data associated with this theme also contribute depth, context, and meaning to the relationship between NSSI and violence among LGBTQ youth. Several youth in this study explained that their NSSI behavior was linked to the violence they experienced *and* the powerlessness they felt within systems that purported to protect them from violence. This aspect of the theme was brought forward by youth who had been involved in systems such as child protective services and residential treatment facilities. These findings suggest that LGBTQ youth who are most at the margins may be at particularly high risk of engaging

in NSSI to deal with violence within social systems that disempower them. These data highlight new dimensions of the relationship between NSSI and violence that have not been previously explored.

*Misconceptions, stigma, and shame.* In the second theme, *Misconceptions, Stigma, and Shame*, LGBTQ participants described how people in their social environment misunderstood and pathologized NSSI. Youth explained that myths, stereotypes, and lack of understanding about NSSI contributed to their feelings of shame, which often reinforced their NSSI behavior. Some study participants internalized negative messages about NSSI and believed they were bad or wrong for engaging in the behavior. Regardless of whether participants believed that NSSI was wrong, social stigma surrounding the behavior led them to hide the behaviors from others. Several youth specifically talked about hiding their behavior from adults, including helping professionals. Participants believed that adults' misconceptions about NSSI led to unhelpful responses, which further disempowered youth and created barriers to accessing help.

These findings contribute to the body of literature on stigma surrounding NSSI and those who engage in the behavior. For example, a qualitative study by Brown (2009) involving eleven youth and young adults (one of whom was gay) identified a similar theme titled "Self-Harm is Misunderstood." Participants in her study described feeling misunderstood and rejected by others in their social environment, including families, schools, and professionals, in relation to their NSSI behavior. As with the current study, participants in Brown's (2009) study felt that the misconceptions and stigma surrounding NSSI exacerbated their sense of isolation and made it difficult to seek help. Fortune and

colleagues (2008) reported similar results in their research on help seeking among a representative sample of youth in the United Kingdom. In that study, youth indicated that stigma, shame, and fear of how others would react to disclosure of NSSI were considerable barriers to help seeking among youth who engaged in NSSI (Fortune, Sinclair, & Hawton, 2008).

Some scholars have argued that NSSI has become less stigmatized in recent decades due to the increased prevalence and visibility of the behavior (Adler & Adler, 2007, 2011; Heath, Ross, et al., 2009). The findings from the current study both support and challenge this view. On one hand, study participants indicated that NSSI was commonly practiced and discussed by their peers, suggesting that the behavior was normalized to some degree within their social networks. On the other hand, participants described feeling stigmatized by pervasive judgments and stereotypes about NSSI in their social environment. The prevalence of NSSI did not necessarily de-stigmatize the behavior. In fact, exposure to social stigma around NSSI led some LGBTQ youth in the study to escalate their behavior and further withdraw from potential support systems. This tension in which NSSI is perceived as common *and* abnormal may explain why trusted friends played such a primary role in study participants' narratives. LGBTQ youth in this study carefully sought out people whom they felt would understand them and the reasons for their behavior, which tended to be other youth who engaged in NSSI.

*Negotiating LGBTQ identity.* Another theme that emerged from the qualitative data analysis was *Negotiating LGBTQ Identity*. Although none of the questions in the interview protocol explicitly asked youth whether their sexual orientation, gender identity, or anti-LGBTQ oppression was related to their NSSI behavior, participants

raised these connections. Homophobia and transphobia permeated youth's social environments and influenced their NSSI behavior in a myriad of ways. Study participants described using NSSI to cope with the internal and external stressors related to being LGBTQ in a social environment where these identities are marginalized.

Some youth in this study initiated NSSI as a way to manage the confusion and emotions they felt while coming to terms with their sexual orientation and/or gender identity. This is consistent with research on identity formation that suggests LGBTQ people often experience distress, denial, and shame as they become aware of having a marginalized identity (e.g., Burgess, 2000; D'Augelli, 1994; Ryan & Futterman 1998). This thread also supports previous work by Alexander and Clare (2004) where lesbian and bisexual women described a connection between developing self-awareness of their same-sex attraction and engaging in NSSI. Like the participants in the current study, these women engaged in NSSI to cope with the confusion and shame they felt as they began to understand that they were "different" (Alexander & Clare, 2004).

Interview participants also talked about the relationship between coming out to other people and their NSSI behavior. For some youth, the stress associated with coming out contributed to NSSI. For others, being open about their identity helped them alleviate emotional distress and contributed to a reduction in their NSSI behavior. Although these youth's narratives are seemingly disparate, the existing literature suggests that coming out can be both a risk and a protective factor for psychosocial problems among LGBTQ youth. From a risk perspective, negotiating concealment and disclosure of a stigmatized identity can be a chronic stressor that contributes to negative health outcomes (Meyer, 2003). Being "out" may also expose youth to greater risk for violence (D'Augelli,

Hershberger, & Pilkington, 1998; D'Augelli et al., 2002; Kosciw et al., 2012; Toomey et al., 2010), which can increase their risk for NSSI (Almeida et al., 2009; Liu & Mustanski, 2012; Walls et al., 2010). Conversely, coming out has also been associated with lower psychological distress among sexual minorities (Kosciw et al., 2012; Toomey et al., 2010; Wright & Perry, 2006), though it has not been thoroughly explored in relation to NSSI behavior.

To date, only one study has explicitly examined the relationship between “outness” and NSSI among LGBTQ youth. This study found that LGBTQ youth who were more open about their sexual orientation and/or gender identity were at increased risk of cutting as compared to those who were less open (Walls et al., 2010). Though my findings were similar to those of Walls and colleagues (2010), further research is needed to understand the relationship between coming out and NSSI among representative samples of LGBTQ youth.

Another dimension of this theme showed that some participants engaged in NSSI to cope with homo/transphobic oppression, rejection, and violence. These data support previous research that identified a link between anti-LGBTQ discrimination (Almeida et al., 2009), homophobic violence (Liu & Mustanski, 2012; Scourfield et al., 2008; Walls et al., 2010), and NSSI among LGBTQ youth. The findings from the current study reinforce current thinking that exposure to violence and discrimination based on a targeted LGBTQ identity plays an important role in NSSI.

This study also extends the knowledge by providing examples of the types of oppression that participants associated with their NSSI behavior (such as anti-LGBTQ slurs, exclusionary social policies, and binaristic gender norms). Each of these forms of

oppression has been found to adversely impact the mental health of LGBTQ people (Levitt et al., 2009; Meyer, 2003; Nadal, Rivera, & Corpus, 2010; Nadal et al., 2012), though none have been explicitly examined in NSSI research. Thus, these findings may be useful in developing survey items or interview questions in future studies that examine the influence of anti-LGBTQ oppression on NSSI behavior.

Study participants also shared stories that highlighted a relationship between internalized oppression and NSSI. Some youth explained that exposure to social stigma contributed to feelings of shame and self-hatred, which influenced their NSSI behavior. These findings mirror the results from Alexander and Clare's (2004) qualitative study on NSSI among lesbian and bisexual women. Women in this study described engaging in NSSI in order to punish themselves or deal with their feelings of self-hatred related to their sexual orientation. A pair of studies by McDermott and colleagues (2012, 2013) also found that LGBTQ youth engaged in NSSI as a way to cope with internalized homophobia. Each of these findings suggests that internalization of social stigma is salient to understanding NSSI behavior among LGBTQ youth.

Finally, data from this theme brought forward the voices of transgender and genderqueer participants whose experiences have not been well documented in previous NSSI research. Though transgender and genderqueer youth shared many of the same experiences as cisgender participants, they also wrestled with stressors that were unique to having a marginalized gender identity/expression. Some transgender and genderqueer participants stated that being perceived as the wrong gender or being forced to comply with gender norms contributed to their NSSI behavior. These findings resonate with research by Nadal and colleagues (2010, 2012) who found that social expectations

regarding gender non-conformity and having one's gender mislabeled were systemic forms of oppression regularly experienced by transgender people. When applying a minority stress lens to these results, it is possible that the chronic nature of these external stressors might contribute to the higher rates of cutting that have been documented among transgender youth (Liu & Mustanski, 2012; Walls et al., 2010). However, further research is needed to determine whether these forms of gender oppression have bearing on NSSI among a representative sample of transgender and genderqueer youth.

This study also found that some transgender and genderqueer participants engaged in NSSI to intentionally harm parts of their bodies that felt "wrong." The existing literature has documented cases where transgender people self-injured their breasts or genitals out of distress related to the dissonance between their identities and bodies (e.g., Burgess, 2008; McGovern, 1995; Mizok & Lewis, 2008; Spicer, 2010). These studies, as well as my own, raise the question of whether these behaviors serve a different function than those that are typically described in NSSI literature. A few transgender and genderqueer participants in this study suggested that they used NSSI not just to cope with distress, but also to change the source of their distress (their bodies). Additional research is clearly needed to learn more about the forms, functions, and meanings of NSSI among transgender and genderqueer youth. Nonetheless, the existing data highlight the need to increase access to health care services such as hormone replacement therapy and gender re-assignment surgery for those who desire such care.

This data associated with this theme indicate that negotiating a marginalized social identity is related to NSSI among a small, convenience sample of LGBTQ youth. Youth's narratives demonstrate the importance of examining NSSI within a social

context that acknowledges the role of oppression and stigma. Furthermore, their stories speak to the relevance of minority stress theory as a framework for understanding NSSI among LGBTQ youth. More in-depth discussion about the connections between this study's findings and minority stress theory is presented later in this chapter.

***Invisibility and isolation.*** The fourth theme that emerged from the qualitative analysis described how participants' NSSI behavior was connected to feeling invisible and isolated in their social environments. Youth described feeling rejected by and disconnected from their families, peers, and helping professionals, which fueled their profound sense of loneliness. These participants reported using NSSI as a way to cope with the pain associated with feeling unwanted, unnoticed, and uncared for by others.

These threads in the data reinforce existing literature on social isolation and social support among youth who engage in NSSI. Several studies have found that youth who are alienated from their parents and peers are more likely to engage in NSSI than those who have stronger support systems in place (Bureau et al., 2010; Claes et al., 2009; Heath, Ross, et al., 2009; Klonsky & Glenn, 2009; Wichstrøm, 2009; Yates et al., 2008). Wichstrøm (2009) suggested that youth who lack social support might feel they cannot rely on others to help them cope with life stressors. Therefore, these youth may be at higher risk for using NSSI as a way to deal with emotions that overwhelm their ability to cope on their own (Wichstrøm, 2009). The narratives of LGBTQ youth in my study support these assertions. Several participants felt they had no one to turn to when faced with life's challenges. In absence of social support, they used NSSI as a way to help them cope with negative emotions and experiences.



Though there has been little research on social isolation and NSSI among LGBTQ youth specifically, there is a good deal of evidence to suggest that homo/transphobia significantly reduces social support among this population of youth (Grossman & D'Augelli, 2006; Radkowsky & Siegel, 1997; Sullivan & Wodarski, 2002). Therefore, it seems reasonable to assume, as youth in the current study suggested, that social isolation and social support are important factors in understanding NSSI among LGBTQ youth. However, one quantitative study that examined this construct found that social support was not significantly associated with cutting among LGBTQ youth (Liu & Mustanski, 2012). It is unclear why Liu and Mustanski's (2012) findings differ from the current study and previous research on general adolescent samples. It is possible that the relationship between social support and NSSI was explained by another variable in their model, such as hopelessness, which was found to be a significant predictor of cutting (Liu & Mustanski, 2012). Since this discrepancy could not be reconciled in the qualitative phase of the current study, proxies of social isolation were tested in the quantitative phase to determine whether they significantly predicted NSSI in a sample similar to the one in Liu and Mustanski's (2012) study. The results of that analysis will be discussed later in this chapter.

Another dimension of this theme related to participants' experiences using NSSI when they felt invisible and voiceless. Participants talked about interactions with parents, peers, and social service organizations that made them feel invalidated. These youth engaged in NSSI to deal with their sense of powerlessness when others would not listen to or acknowledge them. Notably, Alexander and Clare (2004) found very similar results in their study on NSSI among lesbian and bisexual women. These authors identified a

theme called “Invisibility and Invalidation” in which participants described using NSSI to deal with feeling discounted by other people, including helping professionals. The resonance among the findings from their study and my own indicate that experiencing a lack of power, visibility, and voice in relation to one’s social environment can play a role in NSSI among LGBTQ samples.

Several LGBTQ youth in the current study characterized their NSSI behavior as attention seeking or as a “cry for help” when other strategies were ineffective. These findings align with research on the social-positive reinforcement function of NSSI, which suggests that some people engage in this behavior to communicate with or elicit attention from others (Nock & Prinstein, 2004). Historically, this function has been considered to be a form of manipulation and has been used to dismiss those who engage in NSSI (Nock, 2008; Nock & Prinstein, 2004). These youth’s narratives provide a new lens through which this function can be understood. They described engaging in NSSI as a form of resistance against the invisibility, isolation, and invalidation they experienced in social relationships. Their experiences suggest that “attention seeking” may be less about manipulation and more about asserting their voice and humanity in a social context that marginalized them. In this way, participants’ stories brought forward a different interpretation of the social-positive function of NSSI focused on the dysfunctional social context rather than on the pathology of the individual who self-harms.

***Peer relationships.*** The fifth and final theme that was identified in the qualitative phase of this study focused on the role of peer relationships in NSSI behavior among LGBTQ youth. In some cases, study participants indicated that peer relationships contributed to or encouraged their NSSI behavior. However, the preponderance of the

data suggested that youth's relationships with close peers were primarily supportive and helped them reduce or stop their NSSI behavior. Considering the primacy of peer relationships in adolescence (Brown, 1990), the finding that peers influence NSSI is not surprising. Nonetheless, participants' narratives can provide insight into the complex ways that peer relationships can influence NSSI behavior.

A few LGBTQ youth in the current study indicated that their peers played a role in their initiation or continuation of NSSI. Some also described engaging in NSSI with their peers as a way to bond or fit in with others. Others shared their perceptions that NSSI was "trendy" among youth in general. These youth's stories align with current thinking about the "peer contagion effect," which suggests that some youth emulate their peers' NSSI behavior, potentially leading to the spread of the behavior among social networks (Heilbron & Prinstein, 2008, p. 169). Certainly, study participants described ways in which peer contagion played a role in their NSSI behavior. However, this qualitative theme indicates that peer influence on NSSI may be more complex than the peer contagion research suggests.

LGBTQ youth in this study shared many stories of seeking help from and providing help to their peers around NSSI. Peers played a critical role in helping participants decrease their reliance on NSSI as a coping mechanism. These findings connect to the existing literature in three areas. First, these results support previous findings that peer support is a significant protective factor associated with a decreased likelihood of engaging in NSSI (Heath, Ross, et al., 2009; Klonsky & Glenn, 2009; Wichstrøm, 2009). Second, this study's findings reinforce results by Walls and colleagues (2010) who found that nearly half (49.6%,  $n = 62$ ) of LGBTQ youth in the

study who engaged in cutting said that “talking to friends” helped them resist their desire to cut. Third, these results contribute to the body of literature on help seeking among youth who self-harm. Specifically, they corroborate earlier research that found that youth who self-harm are more likely to seek help from friends than to talk to professionals because they expect their peers to be more supportive (Evans et al., 2005; Nixon et al., 2008). LGBTQ youth’s narratives also extend the knowledge in these three areas by identifying specific ways peers can provide positive support to each other around NSSI. Some helping strategies discussed by participants included listening/talking, helping each other develop new coping mechanisms, providing distraction, modeling harm reduction, making pacts and promises, and intervening directly to interrupt NSSI acts.

In this study, LGBTQ youth’s experiences indicate that their relationships with peers had the potential to negatively *and* positively influence their NSSI behavior. These findings, along with literature on peer contagion and support, suggest that additional research is needed to determine why certain peer relationships promote or discourage NSSI among this group of youth. This area of inquiry seems particularly important for intervention research considering that participants often turned to their peers to communicate about, seek help for, and engage in NSSI.

**Synthesis of qualitative results.** In addition to looking at each qualitative theme individually, it is informative to look across themes to examine how the relationships between them can inform the knowledge base. In the discussion that follows, I will identify four key findings about the relationship between NSSI and the social environment among LGBTQ youth that emerged across the qualitative themes.

Additionally, I will describe how these findings align with and contribute to the existing knowledge about NSSI among this sub-population of youth.

*Minority stressors are associated with NSSI.* The findings from the qualitative phase of this study suggest that minority stress is related to NSSI among LGBTQ youth. Many study participants reported negative social experiences related to their LGBTQ identities that caused emotional distress and contributed to NSSI. Across the interview data, youth addressed each of the four minority stressors that Meyer's (2003) theory suggested would influence adverse outcomes among LGBTQ populations. For some youth, experiencing "prejudice events" (Meyer, 2003), such as bullying at school, triggered their NSSI behavior. Others encountered subtler minority stressors, such as oppressive social policies or being perceived as the wrong gender, which created unsafe environments where they expected poor treatment. As Meyer's (2003) model predicted, study participants linked their anticipation of stressful events to NSSI behavior.

LGBTQ youth in this study also described how another form of minority stress, negotiating the coming out process, contributed to NSSI. Several participants engaged in NSSI to cope with the confusion, fear, and stress associated with discovering their own identity and disclosing it to others. Finally, some interview participants described internalizing negative attitudes about LGBTQ people. These participants engaged in NSSI to relieve the shame and self-hatred associated with living in a social environment that denigrates LGBTQ people.

It is important to note that LGBTQ-specific stressors were not the only types of stress associated with NSSI behavior among interview participants. Youth named many other adverse social experiences such as childhood abuse and neglect, family conflict,

and social isolation that contributed to their engagement in NSSI. These data further support minority stress theory, which suggests that LGBTQ stressors cause *excess stress in addition to* that experienced by others who do not share the same minority status (Meyer, 2003). In other words, the interview data imply that LGBTQ youth share many of the same risk factors for NSSI as non-LGBTQ youth. However, the excess stress that LGBTQ youth experience as members of a stigmatized group may partially explain the high NSSI rates among this group.

The qualitative findings from this study also align with Meyer's (2003) theory that certain "stress-ameliorating factors" would lessen the influence of minority stressors on the health and mental health of LGBTQ people. Interview participants identified several protective factors that bolstered their ability to cope with minority stressors. Youth explained that being able to integrate their LGBTQ identity into a positive, holistic sense of self alleviated their distress and reduced their use of NSSI. Furthermore, participants noted that being able to count on social support from trusted peers and staff at Rainbow Alley helped them improve their coping skills and decrease NSSI.

This study contributes to the literature on minority stress and NSSI by providing insight into the types of minority stressors that were related to NSSI among a convenience sample of LGBTQ youth. Additionally, this study highlights LGBTQ youth's own words to describe the relationship between social stigma, emotional distress, and NSSI. Though minority stress theory has not been widely applied to NSSI research, findings from the current study indicate that this theoretical framework is relevant and meaningful to understanding NSSI among LGBTQ youth.

*LGBTQ youth who self-harm experience multiple forms of social stigma.* When looking across the qualitative themes, it is apparent that youth who engaged in NSSI faced social stigma on at least two fronts. Study participants clearly described feeling misunderstood and maligned due to their LGBTQ identity as well as their self-harming behaviors. The similarities between both forms of stigma were striking. Youth explained that they were exposed to pervasive negative messages about both their identities and their NSSI behavior. In both cases, these messages led youth to feel more powerless and isolated. Several interview participants internalized the stigma related to their NSSI behavior and their identities to some degree. They began to see their behavior and their sexual orientation/gender identity as bad or wrong, which contributed to their feelings of shame and self-hatred.

Regardless of the degree to which youth in this study internalized the stigma associated with NSSI and/or being LGBTQ, they described grappling with difficult choices about whether to hide their behaviors and identities or risk negative reactions from others by “coming out.” Interview participants used a variety of strategies to manage their privacy on both fronts in order to negotiate this reality. Some youth described further isolating themselves for fear of being found out; others carefully managed their social interactions, only disclosing to a few trusted friends. In other cases, youth took the risk to be open about their NSSI or LGBTQ identities, which had both positive and negative repercussions. Ultimately, the stress that participants felt in relation to both sources of stigma contributed to their NSSI behavior. The burden of hiding, the fear of others finding out, and the experiences of rejection led some youth to initiate or re-engage in NSSI.

These parallels raise the question of how stigma associated with LGBT identity and NSSI might function together in the lives of LGBTQ youth. This could operate in several ways. First, it is possible that experiencing multiple sources of stigma compounds the stress they experience (Crenshaw, 1991; Deacon, 2006; Meyer, 2003). If that were the case, this would also potentially exacerbate the health and mental health problems associated with those stressors (Meyer, 2003). Another possibility is that the dual stigmatization might erect further barriers to help seeking among LGBTQ youth who engage in NSSI. LGBTQ youth who self-harm may be less likely to seek help for this behavior out of fear that their sexual orientation/gender identity will be judged negatively. They might also hesitate to seek support related to their LGBTQ identities if they are concerned that people might find out about their NSSI behavior. This pattern has been found among LGBTQ people who have other stigmatized health issues such as HIV (Brooks, Etzel, Hinojos, Henry, & Perez, 2005). As a result, a great deal of attention has been paid to reducing stigma and creating culturally competent programs to address HIV among gay and bisexual men (Brooks et al., 2005; Nyblade, 2007). The findings from the current study suggest that a similar approach may be beneficial in meeting the needs of LGBTQ youth who are at risk for or engage in NSSI.

***Social isolation and support are potential areas for intervention.*** Another common thread across the qualitative themes is the role of social isolation and social support in NSSI among LGBTQ youth. Youth's narratives highlight a tension between isolation and support, where the former was a risk factor for NSSI and the latter served a protective function. It is notable that many of the participants who talked about feeling alone and isolated also shared examples of supporting and being supported by their peers.



While these findings may appear to be contradictory, I would argue that they illuminate the complexity of these youth's experiences in relation to their social environment. Participants' interviews suggest that their experiences with social isolation and support were not linear or static. Rather, their stories brought forward a range of social experiences; they struggled with feeling alone *and* they were able to experience healing connection with trusted friends. Both types of experiences influenced their NSSI behavior. Perhaps one of the most poignant examples of this complexity was shared by several youth who talked about using NSSI to cope with their own experiences of isolation and subsequently reached out to their friends who self-harmed to provide a listening ear.

Considering these findings, increasing social support, especially peer support, stands out as a potential area for intervention to reduce NSSI among LGBTQ youth. Peer-based support programs such as gay-straight alliances (GSAs) have been among the primary interventions for LGBTQ youth in school and community settings for many years. However, scholars have discouraged the use of peer-based interventions for NSSI due to concerns about social contagion and iatrogenic effects (Bubrick, Goodman, & Whitlock, 2010). The findings from the qualitative phase of this study encourage a shift in thinking about the role of peers as a potential source of pro-social support for LGBTQ youth, rather than solely as a risk for social contagion. New interventions may be able to promote pro-social peer support, reduce anti-social peer influence, and help equip youth who are already acting as natural helpers to their friends.

***Social and psychological factors play a role in NSSI among LGBTQ youth.***

Another consistent finding across the qualitative themes was the influence of social and

psychological factors on NSSI behavior among LGBTQ youth. Though this study focused primarily on understanding the relationship between social-environmental factors and NSSI, youth's narratives clearly indicated that psychological factors played an important role in the behavior. Data coded to all of the themes suggested that social stressors often exacerbated their emotional distress, and youth engaged in NSSI to deal with the social *and* psychological triggers. For example, many interview participants engaged in NSSI to manage overwhelming emotions in the aftermath of violence. These youth described NSSI as a functional behavior that was instrumental to surviving abuse and neglect. According to these participants, violence *and* their emotional response to violence played an important role in their NSSI behavior.

These findings highlight the importance of understanding the function of NSSI within a social context. Though many of the interview participants described using NSSI as a way to regulate their emotions (the automatic negative function; Nock & Prinstein, 2004), these emotions arose in relation to a social context in which they felt isolated, invisible, victimized, and stigmatized. My findings and those of other scholars point to the need to conceptualize NSSI as a strategy for coping with difficult emotions or interactions *within a particular social context* (Alexander & Clare, 2004; Shenk et al., 2010). This shift in thinking has important implications for research and practice, particularly with marginalized groups such as LGBTQ youth. To define NSSI as primarily a problem with individual ability to cope or emotionally regulate is to ignore the aversive situations that LGBTQ youth encounter on a daily basis that may contribute to poor coping or dysregulation. Further research is needed to understand how psychological and social-environmental factors influence NSSI behavior among LGBTQ

youth. This type of research will be instrumental in designing effective interventions that respond to risks and promote resilience on multiple levels.

**Discussion of quantitative findings.** The second phase of this exploratory, sequential mixed methods study aimed to determine whether certain patterns found in the qualitative data would also be found in the analysis of survey data. Consistent with the study's design, the two research questions that guided the quantitative phase were refined after the completion of the qualitative phase. Below, I will discuss the findings from the analysis of the Rainbow Alley survey data, compare the findings to those from the qualitative phase, and contextualize the findings in relation to the relevant literature.

**Prevalence of NSSI.** Just over 70% of LGBTQ youth who completed the Rainbow Alley survey indicated that they had engaged in NSSI during their lifetime. This prevalence rate was much higher than those found in other studies involving community samples of youth, where estimates have ranged from 13 to 26% (Heath et al., 2008; Laye-Gindhu & Schonert-Reichl, 2005; Muehlenkamp & Gutierrez, 2004, 2007; Plener et al., 2009; Ross & Heath, 2002; Whitlock et al., 2011). This rate was also considerably higher than those found in studies that analyzed prior versions of the Rainbow Alley survey. These studies found that between 39 and 47% of LGBTQ youth had engaged in cutting in the previous year (Nickels et al., 2012; Walls et al., 2007, 2010). There are two factors that might explain why the prevalence rate in the current study was higher than those found in these earlier studies involving similar samples. First, prior versions of the Rainbow Alley survey asked only about cutting as one form of NSSI, while the version used in this study included ten NSSI methods. Second, the measures used in this study asked youth to report NSSI at any point during their lifetime,

while previous versions of the survey measured only NSSI within the previous 12 months. These differences in measurement likely account for the higher NSSI rates found in my study.

The finding that seven out of ten LGBTQ youth in this sample engaged in NSSI during their lifetime is clearly cause for concern. This study adds to the growing body of evidence that this population of youth appears to be at higher risk for NSSI than their peers. Despite this evidence, few scholars have examined the unique experiences of NSSI among LGBTQ youth. The high NSSI prevalence rates found in this and previous studies highlight the need to understand and address this health disparity.

*Which social factors predict the likelihood of NSSI among LGBTQ youth?* The first research question in the quantitative phase asked whether social-environmental factors that emerged from the qualitative phase would predict NSSI in survey data collected from LGBTQ youth. A sequential logistic regression analysis was conducted to determine the relative influence of four blocks of demographic and social-environmental variables. A final, parsimonious model was then analyzed; this final model included the demographic variables and three predictor variables that were significant in the sequential model.

Of the demographic variables, only those measuring sexual orientation were significant predictors of NSSI in the final model. Lesbian youth (as compared to gay youth) were at highest risk for NSSI in this study. Bisexual, pansexual, or queer youth were also at significantly higher risk than gay youth for engaging in NSSI. No significant gender differences were found in this analysis. These findings are quite interesting when compared with those from other quantitative studies on NSSI that involved LGBTQ

youth samples. Those few existing studies found that females, transgender youth, and gender non-conforming youth were at higher risk for cutting (Liu & Mustanski, 2012; Walls et al., 2010). Yet, those studies did not include sexual orientation variables in their inferential analyses.

It is possible that there is a significant interaction between gender and sexual orientation when predicting risk for NSSI. This was the case in two studies involving LGB and heterosexual youth, which found that being LGB was a significant risk factor for NSSI among females, but not males (Bakken & Gunter, 2012; Whitlock et al., 2011). Unfortunately, the findings from the qualitative phase of the current study cannot help clarify these results, since all of the interview participants engaged in NSSI. The small body of literature in this area indicates that further research is needed to understand the relationships between gender identity, sexual orientation, and NSSI among LGBTQ youth.

Several variables were included in the sequential logistic regression model to determine whether experiencing violence at home or school significantly predicted the likelihood of engaging in NSSI. Similar to the qualitative findings, the quantitative analyses found that being physically abused by a family member was related to NSSI behavior. In the final logistic regression model, LGBTQ youth who experienced physical abuse by a family member were three times more likely than those who had not to engage in NSSI.

Although there have been equivocal findings on the relationship between physical abuse (as a specific form of childhood maltreatment) and NSSI in general samples of youth (Jacobson & Gould, 2007; Whitlock et al., 2006; Zoroglu et al., 2003), this study's

findings indicate that it is associated with greater risk among LGBTQ youth. Walls and colleagues (2010) previously found that family physical abuse was only a marginally significant predictor of cutting among LGBTQ youth. My results extend the knowledge in this area by suggesting that family physical abuse significantly predicts NSSI when a broader range of methods is measured. This finding also aligns with the qualitative data from this study, in which several participants shared stories of using NSSI to cope with physical abuse from family members.

Experiencing sexual abuse by a family member did not significantly predict NSSI among LGBTQ youth in the quantitative phase of this study. This finding is at odds with the qualitative findings and the preponderance of literature, which suggest that childhood sexual abuse is significantly associated with NSSI (e.g., Briere & Gill, 1998; Glassman et al., 2007; Gratz, 2003; Kisiel & Lyons, 2001; Whitlock et al., 2006). It is possible that some combination of predictor variables included in the sequential logistic regression analysis obscured the relationship between sexual abuse by a family member and NSSI, given that many of the predictors were significantly correlated (see Table 4 in Chapter Three). To determine whether this might have been the case, a post hoc logistic regression analysis was conducted,<sup>10</sup> which found that family sexual abuse became a marginally significant predictor of NSSI when the other four violence variables were excluded from analysis ( $OR = 3.312, p = .067$ ). This post hoc analysis seems to suggest that the correlation between family sexual abuse and the other violence variables

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<sup>10</sup> This post hoc logistic regression model excluded family physical abuse, school physical violence, school sexual harassment/violence, and feeling unsafe at school, and included all of the other independent variables that were tested in the sequential logistic regression model, predicting NSSI.

weakened the association between sexual abuse and NSSI in the sequential logistic regression model.

Another possible factor influencing this result was the relatively small number of youth in this study who reported experiencing sexual abuse by a family member ( $n = 28$ , 10.5%). A study involving a larger sample of LGBTQ youth might be able to detect a stronger predictive relationship between these variables. The current study was the first to use quantitative analyses to explore the role of family sexual abuse on NSSI behavior among LGBTQ youth. More research is needed to determine whether the association between sexual abuse and NSSI that has been found among general samples of youth holds true in LGBTQ youth samples.

Among the variables measuring violence at school, feeling unsafe at school predicted an increased likelihood of NSSI, but neither physical nor sexual violence at school were significant predictors. As with the family sexual abuse variable, it is possible that physical and/or sexual violence at school are significantly related to NSSI, but that these relationships were obscured by the inclusion of multiple variables measuring school violence/safety in the sequential logistic regression model. To explore this, another post hoc analysis was conducted in which feeling unsafe at school was excluded, but all of the other predictor variables used in the sequential logistic regression model were included. In this analysis, experiencing physical violence at school emerged as a significant predictor of NSSI among youth in the sample ( $OR = 3.201$ ,  $p = .029$ ), while experiencing sexual harassment/violence at school remained non-significant.

It could also be the case that feeling unsafe at school mediates the relationship between physical or sexual violence at school and NSSI, though this has not been

previously explored in the literature. Testing this relationship was beyond the scope of the current study. Yet, these results suggest that the associations between experiencing violence at school, feeling unsafe, and NSSI among LGBTQ youth warrant further examination.

A variable measuring openness about sexual orientation was added to the third block of the sequential logistic regression model. This variable was included to represent the *Negotiating LGBTQ Identity* theme that emerged in the qualitative findings. As in previous research involving a similar sample that was also recruited from Rainbow Alley (e.g., Walls et al., 2010), openness was a significant predictor of NSSI among LGBTQ youth in the quantitative phase of this study. Specifically, youth who were more “out” about their sexual orientation had a greater likelihood of engaging in NSSI.

This finding is consistent with some aspects of the qualitative data, in which several participants said that their coming out process led to confusion, shame, and distress, which contributed to NSSI. However, it is inconsistent with the stories shared by some interview participants who felt that coming out resolved their distress and reduced NSSI. This apparent contradiction across the two data sources may be explained by the fact that all of the interview participants had engaged in NSSI, while approximately 30% of survey participants had not. Considering the findings from both phases of this study, it is possible that coming or being out may be linked to a higher likelihood of ever engaging in NSSI, but that certain psychological and social processes related to coming out may decrease engagement in this behavior over time. This idea is supported by the empirical and theoretical literature that suggest that coming out can act



as both a risk and protective factor for LGBTQ youth (D'Augelli et al., 1998, 2002; Kosciw et al., 2011; Meyer, 2003; Toomey et al., 2010; Wright & Perry, 2006).

The final block in the sequential logistic regression model included two variables representing the *Invisibility and Isolation* theme: exclusion from groups at school and acceptance at school. Neither of these variables was found to be a significant predictor of NSSI in the quantitative phase of this study. As with the violence variables, it is possible that the correlation between exclusion from groups and acceptance at school contributed to these non-significant results. Post hoc analyses were conducted to determine whether including only one of the two variables at a time in the logistic regression model (along with all of the other predictors in the sequential model) would have similar results. However, both variables remained non-significant in the post hoc tests.

One possible reason for the divergence between the qualitative and quantitative findings could be that the two variables measured social exclusion and inclusion *specific to the school environment*. This may not have been the most appropriate approach considering that the survey was conducted by an LGBTQ youth serving organization. Even those survey participants who experienced social exclusion at school may have benefited from positive social support at Rainbow Alley or elsewhere, which was not captured by these variables. In other words, survey participants might have experienced a high degree of social inclusion (and a lower degree of social exclusion) than was indicated by the school-related variables alone. Therefore, these two variables may have been insufficient for predicting the relationships between social inclusion/exclusion and NSSI that were found in the qualitative data.

*Does depression mediate the relationship between social-environmental factors and NSSI?* The second quantitative research question aimed to determine whether depression mediated the relationship between significant social-environmental factors and NSSI in the survey data. This question was posed because interview participants' narratives indicated that negative social experiences contributed to depression and that depression played a role in their NSSI behavior. The KHB method (Karlson & Holm, 2011) was used to conduct three different mediation models testing this research question.

Depression partially mediated the relationship between family physical abuse and NSSI among LGBTQ survey participants. In this model, depression accounted for approximately 15% of the relationship between family physical abuse and NSSI. These results, coupled with the qualitative findings, indicate that exposure to physical abuse in the home *and* the psychological impact of abuse are both associated with NSSI risk among LGBTQ youth.

Similarly, depression was a significant, partial mediator of the relationship between feeling unsafe at school and NSSI, accounting for 32% of this relationship. This finding suggests that both social and psychological factors influence NSSI among LGBTQ youth who feel unsafe at school. Youth who feel unsafe at school might engage in NSSI to cope with a hostile school climate as well as to deal with depression related to feeling unsafe.

The third mediation analysis had non-significant results. Depression was not found to be a mediator of the relationship between openness about one's sexual orientation and NSSI. In fact, including depression in the model actually increased the

direct effect of openness on NSSI. A post hoc analysis was conducted to determine whether openness about sexual orientation was negatively correlated with depression, which might explain these results. In fact, there was a non-significant, weak, positive correlation between openness and depression, ( $\Phi = .179, p = .072$ ). Therefore, the negative correlation between openness and depression was ruled out as an explanation for the findings of this mediation analysis. Alternatively, adding depression to the model might have reduced some of the variance in openness about sexual orientation that was unrelated to the dependent variable, which increased the predictive ability of openness in the model (K. B. Karlson, personal communication, May 6, 2013; Lynn, 2003).

The non-significant result from this mediation analysis might be best understood from a theoretical, rather than empirical, perspective. In the qualitative data, some LGBTQ youth said that coming out contributed to their depression and NSSI, whereas others felt that coming out alleviated both issues to some degree. The relationships between outness, depression, and NSSI are clearly complex, and might depend on other theoretically meaningful factors (such as length of time since coming out, self-esteem, connection to positive LGBTQ support, etc.) that were not examined in this study.

The results of each of the mediation analyses indicate that different social-environmental factors impact NSSI in different ways. Some social-environmental risk factors seem to operate at least partly through psychological risk (e.g., depression), while others do not. This finding is important in terms of determining the appropriate points of intervention for NSSI among LGBTQ youth. Since depression partially mediated the relationship between feeling unsafe at school and NSSI, it seems appropriate to focus interventions on improving school climate *and* individual youth's mental health issues

associated with being in an unsafe school environment. Similarly, efforts to address NSSI among LGBTQ youth who have been physically abused by a family member might target the family system in addition to treating a youth's depression. However, depression did not mediate the relationship between openness about sexual orientation and NSSI; openness predicted NSSI independent of depression. In this case, interventions focused on the social context in which LGBTQ youth live may be more beneficial than addressing NSSI as a mental health issue.

### **Limitations of the Study**

There are several limitations that should be taken into consideration when interpreting this study's findings. The first limitation was the use of secondary data sources for the qualitative and quantitative phases of the study. Although I assisted in conducting the individual interviews, the original study for which these data were collected did not focus specifically on the social environment of NSSI among LGBTQ youth. Therefore, I was unable to integrate interview questions or prompts that might have allowed me to explore this specific topic in greater depth.

I faced similar challenges in the quantitative phase of the survey. Using the Rainbow Alley survey data rather than creating a new survey meant that I had no control over which constructs were included in the survey or how they were measured. This limited my ability to align the qualitative findings with the quantitative design. For example, there were two qualitative themes (*Misconceptions, Stigma, and Shame* and *Peer Relationships*) that could not be adequately measured using items from the Rainbow Alley survey. Therefore, they were not included in the quantitative analysis.

Despite these limitations, the data from these secondary sources were useful in gaining a preliminary understanding of the relationship between the social environment and NSSI among LGBTQ youth. The data were collected from similar samples (e.g., both samples were from the same geographic area and were both associated with the same LGBTQ youth-serving organization) and included information about youth's identities, social experiences, and NSSI behavior that could be analyzed in this exploratory mixed methods study.

A second limitation of the study pertains to the sampling approach. The interview and survey data used in this study were collected using convenience sampling of LGBTQ youth in community settings. The interview participants were recruited exclusively from Rainbow Alley, using purposive sampling to identify any LGBTQ-identified youth who had engaged in NSSI. The survey participants were recruited from this same organization as well as through other sources, including various websites and other youth-serving organizations. Since participants in both phases of the study were connected in some way to physical or online resources for LGBTQ youth, the findings from this study should not be generalized to LGBTQ youth who do not have access to such resources. Additionally, the two data sources used in this study included only those youth who *self-identified* as LGBTQ. Thus, their experiences may be different from those who experience same-sex attraction or who engage in same-sex sexual behavior, but do not label themselves as LGBTQ (Savin-Williams, 2001).

The use of convenience sampling contributed to the under-representation of certain groups of participants in this study. Interview and survey participants were predominantly White and the number of participants from some racial/ethnic groups,

such as Native Americans and Blacks/African Americans, was very small. Although the racial/ethnic characteristics of youth in this study are similar to those found in previous research on Rainbow Alley youth (e.g., Walls et al., 2007, 2008, 2010), they nonetheless limit the ability to understand NSSI among LGBTQ youth of color.

Furthermore, the minor consent procedures appear to have contributed to the under-representation of youth under 18 years old in the qualitative interviews. None of the minors who were required to seek parental consent at the screening phase returned to complete an interview. The minors who completed an interview were those that were not required to seek parental consent for fear that doing so would jeopardize their safety. Therefore, the subset of youth under 18 who participated in the interviews might represent a higher risk group as compared to those who felt they would be able to obtain parental consent but did not ultimately participate. In the future, researchers might consider implementing follow-up procedures to increase the participation of LGBTQ youth under 18 when parental consent is required.

Finally, a potential limitation of this study is my own influence as a researcher. As one of the research assistants who conducted the qualitative interviews, I was keenly aware of my social identities and position relative to those of the study participants. Though we shared a common identity as members of the LGBTQ community, our social experiences in relation to that identity were vastly different. It is quite likely that my privileged positions as a White adult with social class and education privilege influenced the information that the interview participants chose to share or withhold. Although I attempted to establish a comfortable environment for the interviews and develop rapport

with the participants, response effects may have compromised the credibility and trustworthiness of the qualitative data (Patton, 2002; Singleton & Straits, 2005).

In a similar vein, my choices at each stage of the study had considerable influence on the findings and interpretation of results. In recognition of this, I utilized several strategies, such as documenting my own reactions and biases in research memos and calculating inter-coder agreement, to minimize my influence on the qualitative research phase. This was more difficult to do in the quantitative phase. However, I consulted with the members of my dissertation committee throughout the quantitative analysis to invite different perspectives on the data. Nonetheless, it is important to acknowledge that research is subjective no matter how hard the researcher strives minimize their influence on the process.

### **Strengths of the Study**

Despite the limitations discussed above, this study has several strengths. To my knowledge, this is the first study to specifically explore the role of the social environment on NSSI among LGBTQ youth samples. This study builds upon previous research that found that social-environmental factors significantly influence NSSI among this population above and beyond psychological issues (Liu & Mustanski, 2012; Walls et al., 2010). By exploring this behavior within a social context, this study offers a new perspective on the LGBTQ youth's engagement in NSSI.

Another strength of this study is the exploratory, sequential mixed methods design that aimed to understand the social environment of NSSI among LGBTQ youth from qualitative and quantitative perspectives. I prioritized the qualitative phase in this study to gain a deeper understanding of NSSI from LGBTQ youth's perspectives. This design

choice reflects my epistemological viewpoint that LGBTQ youth are the experts on their own experiences; therefore their voices should be valued in the research process. The quantitative phase was then used to build upon the findings from the qualitative phase by testing whether similar patterns could be found in the survey data. Comparing and contrasting the findings from both phases of the study contributes to a more comprehensive understanding of a topic that has not been well studied.

A final strength of this study is the application of minority stress theory to the social problem. Minority stress theory has been widely incorporated in research on LGBTQ health disparities (e.g., Kelleher, 2009; Rosario et al., 1996; Toomey et al., 2010); thus, it is reasonable to explore whether the theory might be relevant to understanding NSSI. According to the qualitative and quantitative findings, certain minority stressors appear to be associated with LGBTQ youth's NSSI behavior. Though LGBTQ-specific issues were not the only social-environmental factors related to NSSI, this study's findings suggest that minority stress plays a role in the behavior.

### **Theoretical Implications**

From a theoretical standpoint, the convergent findings from this study demonstrate that the minority stress model is relevant for understanding the risk factors associated with NSSI among LGBTQ youth. LGBTQ youth in this study experienced stressors unique to being LGBTQ that significantly influenced their engagement in NSSI. Moreover, the quantitative results indicated that one minority stressor—the level of openness about one's sexual orientation—was a significant predictor of NSSI above and beyond the depression that these youth experienced. As a whole, these findings suggest



that negative social experiences related to having a stigmatized identity may be associated with high rates of NSSI among LGBTQ youth.

This study's findings should not be interpreted to imply that youth self-harm because they are LGBTQ, but rather that they are LGBTQ in an intolerant society. This is one of the strengths of using a minority stress lens to understand this topic. The theory places NSSI within a specific social context that acknowledges the chronic stress and social stigma that LGBTQ youth experience (Meyer, 2003). In other words, minority stress theory applies a social justice lens to a behavior that has historically been viewed as a psychological problem (McDermott & Roen, 2012). The convergence of the results from the current study indicates that this lens is relevant to LGBTQ youth's experiences and has the potential to deepen our understanding about NSSI among this population.

### **Practice and Policy Implications**

Though this study was exploratory by design, the findings point to several implications for social work practice and policy change. The qualitative and quantitative findings from this study indicate that both individual and social factors play an important role in NSSI among LGBTQ youth. Consequently, prevention and intervention efforts should target the behavior at multiple levels.

**Implications for practice with LGBTQ youth.** Due to the high rates of NSSI among LGBTQ youth, practitioners who work with this population should conduct routine screening and assessment for NSSI. Considering the stigma associated with being LGBTQ *and* engaging in NSSI, social workers should do their best to create a safe environment for disclosure and convey a supportive, nonjudgmental attitude.

Practitioners should keep the door open to future disclosures since youth may not feel

comfortable sharing information about their identities or behavior early in the relationship. Youth should be fully informed about confidentiality policies so that they can determine what, when, and to whom they disclose. This study's findings also emphasize the need for social workers to develop specialized knowledge and skill to provide effective interventions to LGBTQ youth who engage in NSSI. This would involve seeking out training and supervision to develop LGBTQ cultural competency as well as an advanced understanding of NSSI.

This study highlights the importance of addressing NSSI among LGBTQ youth in a way that acknowledges their experiences with stigma and oppression. It may be beneficial to incorporate feminist and multicultural therapeutic approaches when working with this group. These approaches involve: (a) attending to power dynamics in the therapeutic relationship, (b) actively engaging clients in identifying the role of oppression in their lives, (c) bolstering clients' skills for coping with stigma and internalized oppression, and (d) increasing clients' social support by encouraging connections with people who share similar experiences (Dominelli, 2002; Saulnier, 1996; Sue, 2006). These components could be integrated into cognitive behavioral therapy, which is the most commonly used treatment approach for NSSI behavior (Muehlenkamp, 2006).

Professionals need specific expertise to work effectively with transgender and genderqueer youth who engage in NSSI. Some transgender and genderqueer youth might engage in NSSI as a way of coping with body hatred when they are unable to access hormone replacement therapy or gender re-assignment surgery. Social workers and other helping professionals can play a critical role in helping youth access transition-related health care. Therefore, these professionals should develop an understanding of the

various standards of care for health care transition (e.g., Center of Excellence for Transgender Health, 2011; Coleman et al., 2011). In cases where youth are not interested in or able to access transition-related care, social workers could help youth develop coping skills to manage stressors related to having a marginalized gender identity.

This study's findings indicate that many LGBTQ youth who engage in NSSI have experienced childhood maltreatment, bullying, and other forms of violence. Practitioners should inquire about youth's exposure to violence as part of the routine assessment process. It may be beneficial to integrate a trauma-informed model of care (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d., para. 1) when working with this population of youth. Trauma-informed care models are well-suited to help empower LGBTQ youth who have felt invisible, voiceless, and invalidated in various social systems and to address risk behaviors that are associated with trauma (SAMHSA, n.d., para. 3). Social workers who serve youth in child protective services can play an important role in helping youth have a voice in the system and advocating for policy changes that help youth feel a greater sense of control over their lives. These approaches may help LGBTQ youth who engage in NSSI cope with violence and decrease their sense of powerlessness.

**Implications for social systems.** In addition to addressing NSSI at the individual level, interventions should also target various aspects of youth's social environments. There is currently little evidence about the effectiveness of family-based interventions for NSSI (Vale, Nixon, & Kucharski, 2009). Yet, since familial risk factors contributed to LGBTQ youth's NSSI behavior in this study, there may be situations in which family therapy would be beneficial. Family therapy should not be pursued when LGBTQ youth

believe that involving family members would jeopardize their physical or emotional safety or when child maltreatment is ongoing (Vale et al., 2009). If safety issues are not a concern, family therapy to address NSSI may involve assessing family history, providing psychoeducation about NSSI, and improving communication and dynamics in the family (Vale et al., 2009). It may also be beneficial to draw upon the work of the Family Acceptance Project (n.d.), which has developed resources designed to decrease rejection and increase support of LGBTQ youth by their families.

The qualitative results from this study suggest that supportive peers are an important but overlooked resource. Many LGBTQ youth in this study relied on their friends for positive support around their NSSI behavior. Study participants also served as a resource for their friends who sought help from them. Since these findings emerged from the qualitative data and were not tested quantitatively, they cannot be generalized beyond this study's sample. Nonetheless, these preliminary findings indicate that engaging peers as informal helpers might be an area for NSSI intervention with LGBTQ youth.

Scholars that have examined help seeking among youth who self-harm concluded that more effort should be focused on preparing youth to provide help to their peers (Evans et al., 2005). Many youth are already helping their friends with NSSI, but may not be adequately equipped to serve in this capacity (Evans et al., 2005). Peer-based interventions could educate youth about NSSI and help them develop skills to respond to their friends and refer to a trusted adult (Evans et al., 2005). One such intervention, the Signs of Self-Injury Prevention Program (Jacobs, Walsh, McDade, & Pigeon, 2009), showed promising results in a quasi-experimental study. This study found that

participation in the program was associated with a significant increase in youth's knowledge about NSSI and their desire to provide help to their peers as well as a significant decrease in youth's discomfort with and avoidance of NSSI among their peers (Muehlenkamp, Walsh, & McDade, 2010). Moreover, the program did was not associated with an increase in NSSI thoughts or urges among those who participated (Muehlenkamp et al., 2010). Though this type of intervention has not been tested with LGBTQ youth and their social networks, these findings imply that this could be a promising area for future work.

The findings from this study also point to implications for schools. LGBTQ youth in this study experienced bullying, isolation, and fear in the school environment, which were associated with their NSSI behavior. Though a great deal of progress has been made in recent years to improve school climate for LGBTQ youth, more work is clearly needed (Kosciw et al., 2012). School social workers can advocate for LGBTQ non-discrimination and anti-bullying policies as well as resources, such as GSAs, to improve the safety of LGBTQ youth (Kosciw et al., 2012).

Social workers can also influence school policies regarding the assessment of and response to NSSI. A thorough discussion of school-based responses to NSSI is beyond the scope of this dissertation. However, this study did identify a few potential areas where school social workers could address NSSI among LGBTQ youth. Since LGBTQ youth appear to be at higher risk for NSSI than their peers, it may be beneficial to conduct targeted prevention and intervention efforts with this population rather than universal approaches with the entire student body (Whitlock & Knox, 2009). If a targeted approach is taken, school social workers could advocate that: (a) school

personnel receive training to identify and respond to NSSI; (b) school personnel involved in responding to NSSI are knowledgeable about and skilled in working with LGBTQ youth; (c) confidentiality policies, particularly related to parent/guardian involvement, are clearly written and communicated to students; and (d) programs offer resources for friends of youth who self-harm to promote positive peer support and discourage social contagion (Lieberman, Toste, & Heath, 2009). School professionals involved in targeted efforts should avoid profiling or labeling LGBTQ youth. Instead, they should aim to create messaging, resources, and opportunities that encourage LGBTQ youth to seek help.

Finally, organizations that serve LGBTQ youth, such as Rainbow Alley, can play an important role in addressing NSSI. The findings from both phases of this study suggest that youth who are involved with such organizations are likely to be dealing with their own NSSI behavior or know someone who self-harms. Similar to the school setting, staff and volunteers at LGBTQ youth organizations should receive training about how to identify and respond to NSSI. If individual counseling or medical services are not provided onsite, staff should develop a referral network of LGBTQ-competent mental and medical health service providers. These organizations may be particularly well suited to pilot programs that address the risk factors associated with NSSI and other psychosocial issues among LGBTQ youth. Such programs could focus on (a) helping youth name and cope with the impact of stigma, (b) bolstering coping and problem-solving skills, (c) increasing youth's ability to respond to and refer friends who self-harm, or (d) engaging youth in activism to address oppression within their schools or communities. Though further studies are needed to determine the appropriate focus for

interventions, researchers could benefit from partnering with staff and participants at LGBTQ youth organizations to assist in the design, implementation, and evaluation of these programs.

### **Implications for Social Work Education**

Schools of social work can help prepare practitioners to develop the competencies and skills necessary for addressing NSSI among LGBTQ youth. Content about sexual orientation, gender identity, homo/transphobia, and the diversity of LGBTQ communities could easily be integrated into courses on human behavior and the social environment (HBSE), sexuality, and multicultural social work practice. Schools of social work could offer in-depth courses on anti-oppressive practice for students who want further development this area. Social work programs could also offer specific courses or certificate programs aimed at developing competency in working with LGBTQ populations. Regarding NSSI, social work courses could include information about the etiology, function, and correlates of this behavior in a way that acknowledges its relationship to and distinction from suicide. Education about NSSI could also help social workers examine their biases and assumptions about the behavior to prepare them to provide effective interventions.

### **Future Research**

The findings from the current study point to several areas for future research. Below, I will highlight four areas of inquiry that could advance our understanding of the social context of NSSI among LGBTQ youth. The first line of inquiry relates to the theoretical model, minority stress theory. Since this was an exploratory study, it was not my aim to test minority stress theory as a framework for predicting NSSI among LGBTQ

youth. Nonetheless, this study's findings suggest that further research on minority stress and NSSI among LGBTQ youth could inform the field. Future research could examine: (a) whether each type of minority stress conceptualized by Meyer (2003) is associated with NSSI, (b) whether certain minority stressors have greater influence on NSSI, (c) whether there are additional minority stressors related to this behavior that have not yet been identified in the literature, (d) what "stress-ameliorating factors" (Meyer, 2003) reduce the likelihood of this behavior, and (e) whether minority stressors are jointly predictive of NSSI and other risk behaviors among LGBTQ youth. Additionally, longitudinal studies could be beneficial to determine the directionality of the relationships between minority stressors and NSSI.

The second line of inquiry pertains to the role of peer relationships in NSSI among LGBTQ youth. Future research could examine whether certain characteristics or qualities of LGBTQ youth's peer relationships are associated with increased or decreased risk for NSSI. This type of research might be particularly useful for designing interventions that engage peers as an important part of LGBTQ youth's social environment.

Another important area to examine in future research is the relationship between homelessness and NSSI among LGBTQ youth. I was not able to explore this in the current study because interview participants were not routinely asked whether they had previously been homeless. Although the Rainbow Alley survey did measure homelessness, it was not included in the statistical analyses because the variables in the quantitative phase were selected based upon the findings from the qualitative phase. Considering that (a) a disproportionate number of homeless youth are LGBTQ (Kruks,



1991; Walls, Potter, & Van Leeuwen, 2008); (b) homeless LGBTQ youth appear to be more likely than LGBTQ youth who have not experienced homelessness to engage in cutting (Walls et al., 2007, 2010); and (c) among homeless youth, those who identify as LGBTQ are at higher risk for NSSI (Moskowitz et al., 2012), further research in this area seems warranted.

Given the multiple health disparities that LGBTQ youth experience (IOM, 2011), it makes sense to consider how NSSI research can draw from and contribute to research on other psychosocial issues. A fourth line of inquiry could focus on identifying the common risk and protective factors between NSSI and other psychosocial issues among LGBTQ youth. This information could be gleaned from a meta-analysis of existing research and from novel studies designed to identify shared risk and protective factors. The next step would be to conduct intervention research aimed at improving outcomes for LGBTQ youth across multiple psychosocial domains. An advantage of this type of research is that it takes a more holistic approach to understanding and improving LGBTQ youth's experiences. Since youth negotiate multiple challenges simultaneously, it makes sense to design interventions that address their reality.

Scholars interested in this area of research are encouraged to consider including LGBTQ youth as partners in the research process. Engaging youth in participatory action research has the potential to draw upon youth's firsthand knowledge about the issues facing their communities and to empower youth in resisting oppressive social systems (Ginwright, Noguera, & Cammarota, 2006). Previous participatory action research involving LGBTQ youth found that this approach was effective in reducing psychosocial risk, promoting assets, and encouraging community engagement among youth-

researchers (DeCastell & Jenson, 2006; Morsillo & Prilleltensky, 2007). Considering that LGBTQ youth who engage in NSSI experience multiple risks and sources of stigma, participatory action research may be a promising approach with this population.

### **Conclusion**

This study explored the relationship between the social environment and NSSI among LGBTQ youth. To briefly summarize this study's results, the social context of NSSI matters for LGBTQ youth. Youth's experiences with NSSI cannot be separated from the social context in which they are exposed to homo/transphobia, violence, invalidation, and stigma that influence their psychological functioning and interpersonal relationships. Therefore, efforts to address NSSI should engage the social system in addition to LGBTQ youth, themselves. The findings from this study contribute to a small body of literature on this topic and highlight the need for future research to expand our understanding of the factors related to NSSI among LGBTQ youth.

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## Appendix A

### Screening interview checklist (before screening)

1. To prepare for the screening interview, get the following:
  - A) Risk Assessment Form (blank)
  - B) Two copies of the Consent/Assent Form (blank)
  - C) Screening Protocol Answer Sheet (blank)
  - D) Appointment Reminder Card (blank)
  - E) NSSI Referral List handout
  - F) SIB Distraction handout
  - G) SIB Misconceptions handout
  - H) One \$5.00 Target Gift Coin
  - I) Screening Gift Card Receipt form (blank)
  - I) Screening Gift Card Control Form
  - J) Pen
  - K) Clipboard
  - L) Laminated Screening Protocol & Laminated Screening Interview Checklist (this list)

### Screening interview steps

2. After introductions, determine if potential participant is age is 18 or older. If yes, GO TO STEP # 8.
3. If participant is not yet 18 years old, then conduct RISK ASSESSMENT to determine if they are eligible for Alternative Consent Procedure:
  - A. Give them RISK ASSESSMENT FORM (or read it to them if needed).
  - B. Based on information provided by youth determine if youth is eligible for Alternative Consent Procedure. If not, GO TO STEP #4
  - C. If youth is eligible for Alternative Consent Procedure, place a check next to “Individual is eligible for alternative consent/assent procedure.” and sign and date form. GO TO STEP #5.
4. If under age and **NOT** eligible for Alternative Consent Procedure:
  - A. Place a check next to “Individual needs to obtain parental consent to participate in research project.” And sign and date form.
  - B. Explain to potential participant that parental permission is needed for them to participate in the project (including the screening).
  - C. Give them a copy of the CONSENT AND ASSENT FORM and show them the places where the parent must sign (2 places) and where they must sign (2 places).

- D. Encourage them to get parental permission and to schedule a time to participate in the project. If they return with parental permission, begin at STEP #10.
  - D. Thank them and GO TO STEP #18.
5. If under age and **ELIGIBLE** for Alternative Consent Procedure, provide (2) copies of consent/assent form (1 for them to complete and 1 for them to keep for their records). Answer any questions they have about the research project, making sure to point out that:
    - A. The study consists of (2) parts, the screening that will happen today and will last about 5 minutes; and, a qualitative interview that will last up to one hour, will be scheduled today, and will be conducted by a member of the research team.
    - B. Only certain participants will be selected for the qualitative follow-up interview.
    - C. The topic of the interviews and that the interviews may stir up feelings for them.
    - D. That the screening interview will not be audiotaped, but that the qualitative interview will be audiotaped if they are selected to participate in that part.
    - E. That participation is voluntary and that their participation or not will not have any bearing on the services they are eligible for at Rainbow Alley.
    - F. That they may withdraw from the project at any point during the process.
  6. Have them sign the Consent Form (where their parents normally would sign).
  7. Staple the Risk Assessment Form to the back of the Consent Form. Go to STEP #10.
  8. Provide (2) copies of consent/assent form (1 for them to complete and 1 for them to keep for their records). Answer any questions they have about the research project.
  9. Have them sign one copy of the consent/assent form.
  10. Read the INTRODUCTION from the LAMINATED SCREENING PROTOCOL.
  11. Read each question from the LAMINATED SCREENING PROTOCOL recording the participant's answers on a SCREENING PROTOCOL ANSWER sheet.
  12. If participant is not eligible for the qualitative interview (based on their responses to the screening protocol, go to STEP #15. If eligible, tell them that they have been chosen to participate in the qualitative interview.



13. Schedule them an appointment with an interviewer using the online scheduler.
14. Write out the appointment information on a REMINDER CARD.
15. Read the Conclusion to the SCREENING PROTOCOL.
16. Thank the participant and give them a \$5.00 gift card, having them initial that they received the gift card on the GIFT CARD RECEIPT FORM.
17. Give them a copy of each of the following:
  - A) NSSI REFFERAL LIST
  - B) SIB DISTRACTION
  - C) SIB MISCONCEPTIOSN
18. Dismiss the participant.
19. Attach the GIFT CARD RECEIPT to the CONSENT FORM.
20. File any unused forms.
21. File the SCREENING PROTOCOL ANSWER SHEET, the GIFT CARD RECEIPT FORM, and the CONSENT FORM (if completed).
22. Replace all project supplies
23. If project activities completed (no other interviews), then make sure file cabinet is locked, room is locked, and return keys

**UNDERSTANDING THE COMPLEXITY OF NSSI AMONG  
SEXUAL MINORITY YOUTH AND YOUNG ADULTS  
Screening Protocol**

**Introduction:**

Thank you for participating in this research study. We are conducting this study so that we can learn more about ways LGBTQ youth self harm, what purpose it provides in youth's lives, and how to provide help and support when needed. We know from previous research that a lot of young people at Rainbow Alley and their friends engage in self-harming behavior

(Give examples of self-harming behaviors if the participant doesn't understand or appears to not understand what is meant: Self-harming or self-injurious behaviors are behaviors that some people engage in – such as cutting or banging their head against something hard or other things like that – that are not meant as suicidal gestures.)

[FOR MINORS]

Before I ask you the screening questions, I want to make sure that you understand that if you indicate that you are currently being abused by someone who is an adult, that you are at risk for suicide, or that you are at risk for committing homicide that I am required by law to intervene to help keep you safe.

[FOR NON-MINORS]

Before I ask you the screening questions, I want to make sure that you understand that if you indicate that you are currently abusing someone who is a minor or if you tell me that you are at risk for suicide, or that you are at risk for committing homicide that I am required by law to intervene.

This is the brief screening interview and should last only for a few minutes since I only have a couple of questions to ask you.

First, to help us connect your answers in this screening interview today to any future interview you might do for this project, we would like to assign you a coded number that consists of your first letter of your first name and the last letter of your last name, followed by the two-digit month of your birth and the two digit day of your birth.

[Assist participant with figuring out code].

1. The first question I have is: ***Have you ever thought about doing something on purpose to injure, hurt, or harm yourself or your body (but you weren't trying to kill yourself)?***

- a. And what was it that you thought about doing?

2. The second question, is: *Have you ever actually done anything on purpose to injure, hurt, or harm yourself or your body (but you weren't trying to kill yourself)?*

- a. And what was it that you actually did?

**Part VI: Conclusion**

Again, thank you very much for taking your time to do this screening. It has been very helpful. Here is a \$5.00 gift card to express appreciation for your time and participation.

**Appendix B**

**RISK ASSESSMENT FORM**

In order to participate in research projects, individuals under the age of 18 who are not legally emancipated minors must obtain parental permission. However, Federal regulations allow for alternatives under circumstances where there is risk to the youth should the youth attempt to obtain parental permission. Please answer the following three questions to allow the researchers to assess whether you need to obtain parental permission to participate in the project or whether an alternative assent/consent procedure is appropriate.

1. Do your parents/guardians know about your sexual orientation or gender identity?  
a. YES \_\_\_\_\_ b. NO \_\_\_\_\_
  
2. If your parents/guardians were to find out that you were gay, lesbian, bisexual and/or transgender, do you have any concerns that he/she/they might become upset enough that they might emotionally or physically harm you or kick you out of your home?  
a. YES \_\_\_\_\_ b. NO \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

---

\_\_\_\_\_ Individual needs to obtain parental consent to participate in research project.

\_\_\_\_\_ Individual is eligible for alternative consent/assent procedure

\_\_\_\_\_  
Signature of Youth Advocate

\_\_\_\_\_  
Date

## Appendix C

### UNDERSTANDING THE COMPLEXITY OF NSSI AMONG SEXUAL MINORITY YOUTH AND YOUNG ADULTS Semi-structured Interview Protocol

#### **Introduction:**

Again, we would like to thank you for participating in this research study. Our hope is that the information that you and other young people provide will help us better understand self-harm or what is often called self-injurious behavior so that we are able to provide support as it is needed. We're trying to learn more about this type of behavior because we know from previous research that a lot of young people at Rainbow Alley and their friends engage in self-injurious behavior as a way to cope.

[FOR MINORS]

First, I want to make sure that you understand that if you indicate that you are currently being abused by someone who is an adult or if you tell me that you are at imminent risk for suicide or that you are at imminent risk for committing homicide that I am required by law to intervene to help keep you safe.

[FOR NON-MINORS]

First, I want to make sure that you understand that if you indicate that you are currently abusing someone who is a minor or if you tell me that you are at imminent risk for suicide or that you are at imminent risk for committing homicide that I am required by law to intervene.

As we move through the interview, please let me know if something is making you too uncomfortable so that you feel like we need to stop or take a break.

Do you have any questions about the study before we begin that haven't already been answered?

#### **Part I: Identities**

I'd like to start by hearing from you about your sexual orientation and gender identity.

**1. There are lots of different ways in which people identify their sexual orientation. Some identify as gay, lesbian, bisexual, pansexual, queer, etc. When it comes to your sexual orientation, how do you identify?**

Follow-up questions:

- a) Tell me a little bit about what that means to you.
- b) How long have you identified as [LABEL]?

**2. Just like with sexual orientation, there are also lots of different ways in which people identify their gender identity. Some identify as male, female, transgender, transguy, MTF, etc. When it comes to your gender identity, what words or terms do you use to describe yourself?**

Follow-up questions:

- a) Tell me a little bit about what that means to you.
- b) How long have you identified as [LABEL]?

**The final question in this section regards how you feel about your sexual orientation/gender identity in various contexts-- things like how open you are, how people respond to you, if you feel supported or if you get hassled, those kinds of things.**

**3. So, to get started, how would you say things are for you at school?**

Follow-up questions:

- a) How about at home, with your family?
- b) And with your group of friends?
- c) [If works], and at work?
- d) And, finally how about other areas of your life – religious services or sports or other activities you are involved in?

## **Part II: NSSI**

Now that I have a better sense of who you are, I'd like us to switch topics and focus a bit more on self-injurious behavior. What we mean as self-injurious behaviors are a wide range of things that some people do that result in self-harm, but are not meant as suicidal gestures. As I mentioned before, a lot of young people at Rainbow Alley and their friends take part in such behavior.

**1. How common is self-injurious behavior among you friends? (Social network)**

- a) Are these friends from school, from Rainbow Alley, from somewhere else?
- b) How did you first come to know that some of your friends do this?
- c) Do your friends talk about self-injurious behavior?

- a. A lot? A little?
  - b. How openly do they talk about it? With a small group of friends? With a lot of people?
- d) What kinds of behaviors do your friends engage in?
- e) What is the most common?
- f) Do your friends talk about what motivates them to self-injure?  
If yes, can you describe some of the reasons?
- g) In general, would you say that your friends engage in these types of behaviors when they are alone or when they are with other people, or both?
- 2. Tell me a little bit about how you first learned of self-injurious behavior? (Onset)**
- a) How old were you?
  - b) Was this before or after you started coming to Rainbow Alley?
  - c) When you first heard about it, what was your reaction?
  - d) How long after you first heard about it did you try it?
    - a. Was it by yourself or with someone else?
    - b. What did you first try?
    - c. What was it like for you the first time you did it?
    - d. Do you remember why you first tried it?
  - e) How long after that did you find yourself doing it again?
- 3. How did it develop from there? (Trajectory)**
- a) What kind of time period was this over?
  - b) Did you find you stayed with one type of self-injury or did you try different types?
- 4. When was the last time that you engaged in [self-injury]? (Recency)**
- a) What did you do?
  - b) [If within last 12 months]: And how often do you [behavior]?
    - a. Is that the only type of self-injury you are currently doing?

- b. [If no]: In general, how often would you say you engage in any type of self-injurious behavior?
  - c) [If more than 12 months ago]: Given that it has been a while since you [behavior], is it something you feel like you are done with? Or do you think it might be something that you do again in the future?
    - a. [If something done with]: What has helped you no longer [behavior]?
    - b. [If something might do again in the future]: What would determine if you [behavior] again?
- 5. Where is it that you most often [behavior]? (Context)**
- a) What is it about that place that you think makes it the place where you normally [behavior]?
  - b) Are there other places that you have [behavior]?
- 6. And is it something you normally do alone or with someone else? (Context)**
- a) [With someone else]: And who do you normally do it with?
  - b) [With someone else]: Is there something about that (or those) friendship/relationship that you think makes it something that you do together?
- 7. A lot of folks who engage in [behavior] can identify certain things – places, people, experiences – that trigger their self-injurious behavior. What do you think are triggers for you? (Triggers)**
- a) And how often do those triggers happen for you?
- 8. Some people have thoughts about self-harm that they may or may not act on. Can you tell me a little bit about how often you think about hurting yourself, but not intending suicide? (Ideation)**
- a. What happens when you usually think about it? Do you follow through? Do you struggle with whether or not to do it?
  - b. [If not] what kinds of things keep you from acting on your thoughts?
- 9. What does [behavior] do for you? (Function)**
- a) Are there other things it does for you?



**10. Some people who [behavior] report that it is like an addiction – something that they don't feel like they have much control over. Do you feel like you have control over [behavior]?**

a) [If yes]: What indicates to you that you do have control over it?

### **Part III: The Future**

I'd like to shift gears now and talk a bit about what you see in the future for yourself.

**11. If you think about yourself 2 or 3 years from now, do you see yourself engaging in [behavior]?**

a) [If no and if they are currently still engaged in behavior]: What do you think is going to change between now and then that will help you stop?

**12. [If currently still engaged in behavior]: Is [behavior] something that you want to stop doing?**

a) [If yes]: What kinds of things do you think would help you stop?

b) [If yes]: What kinds of things have gotten in the way of you being able to stop?

### **Part IV: Meaning**

**13. So my final question, is what does [behavior] mean to you?**

### **Part V: Other Thoughts**

Is there anything else you'd like to share about [behavior] that we haven't covered?

### **Part VI: Conclusion**

Again, thank you very much for taking your time to have this conversation with me. It has been very helpful and will add so much to the findings of our study.

I'd like to give you a couple of resources about self-injurious behavior.

The first is a handout on the top 15 misconceptions of self-injury. The second is about various distraction techniques and alternative coping strategies. And then finally, the last is a sheet with information about different places you can contact if you need various types of services.

Finally, I would just like to check in with you to see if – now that we have completed the interview – if you feel like you are currently in any imminent danger of harming yourself.