_____ Research Report _____

A Qualitative Study of Self-Injurious Behaviour in Women Offenders

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A Qualitative Study of Self-Injurious Behaviour in Women Offenders

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Executive Summary

Key words: *non-suicidal self-injury; offender suicide attempts.*

Non-suicidal self-injury (NSSI) may be defined as the deliberate destruction of body tissue without suicidal intent and for purposes not socially sanctioned and may include behaviours such as cutting, ligature use, burning, hitting, swallowing sharp or indigestible objects, inserting and removing objects, and head banging. NSSI poses a serious threat to the safety and well-being of offenders and staff within the Correctional Service of Canada (CSC). To more effectively treat and prevent NSSI in offenders, a greater understanding of the origins and motivations of NSSI is required. The purpose of this study, therefore, is to analyse the motivations and emotions associated with engaging in NSSI as described by women offenders. Fifty-six federally sentenced women from seven institutions participated in semi-structured interviews that were designed to assess their history of non-suicidal self-injury.

Of the 56 women who participated in the study and had a history NSSI, 54 provided at least one reason for engaging in this behaviour. The most common reason provided by the women was to cope with their negative emotions. The second most common reason was to communicate with others about their problems and their need for care.

Fifty-two women provided information on the emotions they experience before and after self-injuring. The most common emotions reported prior to engaging in NSSI were anger, depression, and anxiety. After self-injuring, women most commonly reported feelings of relief, followed by feelings of regret.

Seventeen participants discussed the relationship between NSSI and substance abuse, despite the fact that substance abuse was not part of the original interview protocol. Ten of these 17 indicated that they were consuming drugs or alcohol while involved in an act of NSSI or that substance abuse increased the frequency of NSSI, while seven of these women reported that substance abuse actually decreased the frequency of NSSI or that they used drugs or alcohol as a substitute for NSSI.

The issue of coping strategies or alternatives to NSSI was spontaneously discussed by the participating women in many interviews and, over time, the interviewers began to specifically probe participants about this topic. Twenty-four participants reported that they had begun using coping strategies other than NSSI to help them deal with stress or negative emotions. The most commonly reported coping strategies were appropriate release of emotions, relaxation techniques and distraction techniques such as reading, exercising, and creating artwork.

The current study improves the current understanding of NSSI, particularly among federally sentenced women. Since the women most commonly reported engaging in NSSI as a method of coping, interventions could explore methods of teaching alternative copying strategies to a wider population of federally sentenced women.

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Introduction

Non-suicidal self-injury (NSSI) is defined as deliberate bodily harm or disfigurement without suicidal intent and for purposes not socially sanctioned (Klonsky & Muehlenkamp, 2007) and may include behaviours such as cutting, ligature use, burning, hitting, swallowing sharp or indigestible objects, inserting and removing objects from the body, and head banging. While all types of behaviours that individuals undertake to inflict harm upon themselves are difficult to comprehend, those involving NSSI may be the most perplexing. NSSI poses a serious threat to the safety and well-being of staff and offenders within the Correctional Service of Canada (CSC), and thus identifying methods of reducing and managing the behaviour is a priority for the Service.

In order to effectively treat and prevent NSSI in offenders, the field requires a greater understanding of the origins and motivations of the behaviour. While the literature in the area has speculated on the possible motivations for NSSI, few studies have empirically examined the motivations for NSSI; most focus on the correlates and risk factors of the behaviour to the exclusion of motivations (Nock & Prinstein, 2004). When empirical research is undertaken, conclusions are often ambiguous because of the use of inconsistent definitions (what is and is not NSSI) and the evidence that a single individual may engage in NSSI for a several reasons that may change over time (Kleindienst et al., 2008; Klonsky & Muehlenkamp, 2007). Despite these challenges, understanding the motivations for engaging in these behaviours is a critical initial component of treatment and prevention and research.

Many possible motivations have been proposed for NSSI, including obtaining attention from others, gaining external rewards, learning the behaviour from others, ending feelings of dissociation, and punishing oneself (Klonsky, 2007; Suyemoto, 1998). Among the motivations studied for individuals engaging in NSSI, coping is the most strongly established (Klonsky, 2007). Klonsky (2007) concluded the following based on a systematic review of 18 studies:

> Research indicates that: (a) acute negative affect precedes self-injury, (b) decreased negative affect and relief are present after self-injury, (c) self-injury is most often performed with intent to alleviate negative affect, and (d) negative affect and arousal are reduced by the performance of self-injury proxies in laboratory settings. (p. 235)

Offenders may use NSSI as a coping strategy in the absence of more adaptive strategies (Bonner & Rich, 1990; Liebling, 1992; Liebling & Krarup, 1993), although these studies inferred that maladaptive coping strategies were the source of the NSSI based on the presence of other factors (e.g., more problems with other offenders, reported higher level of stress, fewer social supports) and did not directly measure coping strategies. Since coping strategies were not directly assessed in these studies, differences in coping strategies used by those who self-injure and those who do not self-injure could not be determined. While there is no clear consensus on what constitutes an "effective coping strategy" and coping is considered to be a multidimensional process that differs in a variety of situations (Folkman & Lazerus, 1980), NSSI can unquestionably be considered a maladaptive method of coping with stressors.

The purpose of this study was to identify the motivations for engaging in NSSI and the emotions related to this behaviour among women offenders. Increased understanding of NSSI will contribute to the design of interventions and guide future management of the behaviour in CSC institutions. The present study examined the NSSI through semi-structured interviews with incarcerated women offenders in order to tap into the subjective experiences of the women.

Method

Procedure/Analytic Approach

Participants were recruited from Nova Institution for Women (Truro, Nova Scotia), Joliette Institution (Joliette, Quebec), Grand Valley Institution for Women (Kitchener-Waterloo, Ontario), Okimaw Ohci Healing Lodge (Maple Creek, Saskatchewan), Edmonton Institution for Women (Edmonton, Alberta), Fraser Valley Institution for Women (Abbotsford, British Colombia), and the Regional Psychiatric Centre (Saskatoon, Saskatchewan). This represents all the facilities for federally sentenced women within CSC. All offenders who were residing in these institutions during the study period were eligible to participate. Participants were recruited in several ways, including through meetings with offender committees (e.g., inmate committee, Native Sisterhood, pod representatives, house representatives), staff referral, posters, and directly approaching individuals.

A semi-structured interview, a portion of the Structured Clinical Interview for the Diagnostic and Statistics Manual, and a set of questionnaires were included in the protocol. Only the results from the semi-structured interview are discussed here.

Interviews were recorded when participants gave consent to do so. These interviews were recorded using a digital recorder and then transcribed verbatim by the research team. If the women preferred not to be recorded, notes were taken on their responses. Every effort was made to record the interviews exactly as they occurred, including pauses and overlaps.

Content analysis was used to analyze the interviews. The semi-structured interview schedule can be found in Appendix A. This interview schedule was used as a guide to structure the coding frame. An initial coding frame was developed by the primary author based on past research and theory on NSSI, which was also used to develop the semi-structured interview schedule. For example, since depression was known to be correlated with NSSI, a category was created for feelings of depression before engaging in NSSI. Several interviews were coded using this coding frame, and these interviews were examined to determine if some responses did not fit into the coding frame. Extra categories were created to account for these unanticipated themes (i.e., ideas or responses to specific questions that emerged throughout the interviews).

In determining what constituted a discrete theme, effort was taken to preserve the language used by the participants. Responses were categorized based on similarity of content.

As more themes were generated, categories were compared to each other to ensure that they were distinct, while maintaining similarity of content within each category as much as possible. This frame was then piloted by both researchers and revised accordingly based on a process of discussion ultimately resulting in agreement on how themes should be categorized (Silverman, 2006). The coding frame consisted of categories that could be used as: 1) qualitative themes, which are presented below with quotations to illustrate them; and 2) quantitative categories, which are presented as the frequency of respondents who endorsed the category. This methodology is based on the work of Creswell and Plano Clark (2007), and was used to form the basis of the coding frame.

All interviews were coded by two interviewers, with inter-rater reliability being established using 10% (n = 15) of the interviews. In the present study, inter-rater reliability was determined based on the agreement between the coders on the categories in which the interviews were coded. A variation on simple percentage agreement, known as "effective percentage agreement", was used to determine the agreement between the coders on the qualitative interview analysis. Effective percentage agreement restricts the definition of agreement to occurrences and not non-occurrences as measured by dichotomous ratings (Birkimer & Brown, 1979). The percentage agreement was 92.2%, which is regarded as an excellent rating (Lombard et al., 2002).

Measures/Material

A semi-structured interview containing the following sections was designed for the study: (1) mental health history; (2) history of abuse; (3) sexual orientation; and (4) suicide attempts and NSSI. All sections contained questions that should be asked to all participants along with a set of possible prompts for each question.

Participants

Fifty-six women who had a history of NSSI participated in these interviews. In 54 of the 56 cases (96.4%), the participants consented to having their interview recorded. In two cases (3.6% of the interviews), the women preferred not to be recorded and notes were taken on their responses.

The average age of the participants was 33.4 $\pm$ 9.7. Other demographics on the sample

are presented in Table 1. These data were retrieved from the Offender Management System, which is a national database on federal offenders. The table illustrates that Aboriginal women are somewhat over-represented in the study group, compared to the population of federal women offenders. Minimum security women are under-represented comparatively. The relatively low representation of women from minimum security institutions may reflect the more complex needs of women who engage in NSSI associated with placement in higher security levels.

Table 1

Demographic Profile of Participants

Demographics	% (n) (N = 56)	CSC's Women Offenders Population[a] %
Ethnicity		
Non-Aboriginal	55.4 (31)	68.9
Aboriginal	44.6 (25)	31.1
Marital Status[1]		
Single, Separated or Divorced	71.4 (40)	--
Married or Common Law	26.8 (15)	--
Security Level		
Maximum	19.6 (11)	12.3
Medium	60.7 (34)	47.9
Minimum	19.6 (11)	39.8

[1] n=1 missing.

Results

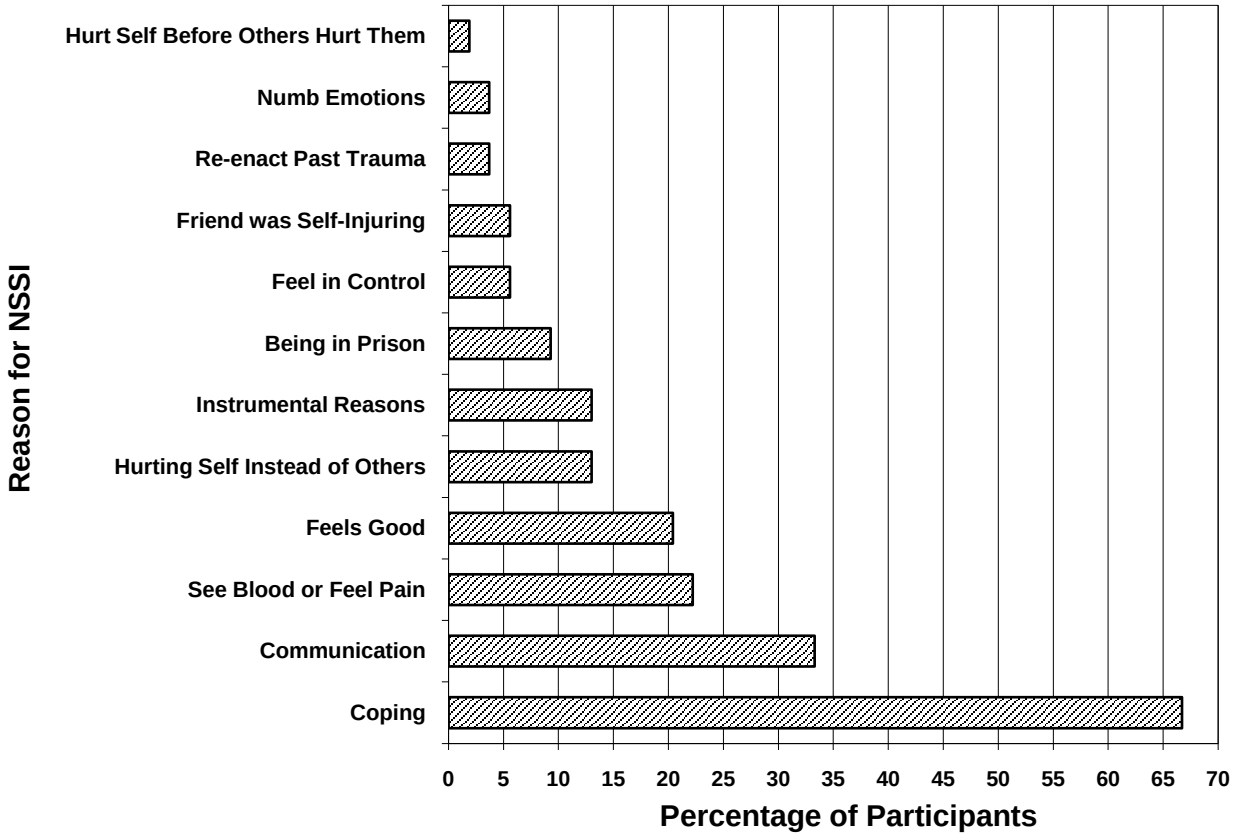
Themes that were identified from the interviews are described below. A description is provided for each theme, along with the number of women who endorsed each theme and quotations from the women to illustrate them.

Motivations for Engaging in NSSI

Participants were asked why they self-injured and what purpose they felt it served for them. Reasons for engaging in NSSI were provided by all but one participant. This one participant requested that her interview not be recorded, so it is possible that some information was lost in the manual recording of her responses. One other participant stated that she did not know why she self-injured. Therefore, the analysis of the reasons for engaging in NSSI will examine the 54 participants for whom data are available. Twenty-eight women (51.9%) gave more than one reason for their behaviour. Fourteen women gave two reasons, six women gave 3 reasons and eight women gave four reasons or more. The large proportion of women who gave more than one reason attests to the complex nature of NSSI.

Altogether, participants provided 12 different motivations for engaging in NSSI. The number of participants who endorsed each of the motivations is displayed in Figure 1.

Figure 1. Percentage of participants who endorsed each motivation for NSSI



Coping

The most common motivation given for engaging in NSSI was for coping. This reason was endorsed by two-thirds of the participants (n = 36). This was often described as either a reaction to negative emotions or as a way to release negative emotions. The emotions most frequently mentioned were frustration, anger, anxiety, and depression.

> P025: Yeah, it was after my brother raped me and I would have recurring dreams about it or whatever, or my mom's abuse. Her mental and emotional and physical abuse. I would cut to release pain from that too.

> P041: No, just basically, I grew up being told you couldn't get angry or you couldn't show your emotions. You had to push everything under the rug, so for me it was just an outlet. It was just a release of all the stuff I was keeping inside.

> P095: I cut myself because I wanted to release the pain that I had inside…because it felt better, it released it, what I was feeling inside.

Communication.

One-third of the women (*n* = 18) reported that they used NSSI as a form of communication. This generally took the form of communicating negative emotions that they could not verbally communicate to others. It was also often described as communicating a need for caring from others whom the women felt were not providing appropriate support to meet their emotional needs.

> P014: I mean when you start cutting your face, it's not about, "Oh, I need help, I'm going to kill myself". When you start cuttin' your face, it's like "Hello! I'm mad, I'm angry, there's somethin' goin' on, I don't like this."

> P037: Like, an example, me and my mom would get into a fight, and she wouldn't have remorse or sympathize with me, or just call me a drama queen and that would send me off. I would think of getting even, kind of thing, and make her want to, show her the kind of pain that she is causing me. It made sense in my head.

> P144: You know, like I told you before, it is probably just to get attention or to get security by someone. It is probably a cry for love too, cause I never was loved by my parents. So probably most likely that's what it was…Most likely I probably missed a lot of love and affection, so that is probably why I did it. … it was probably for someone to pay attention to me, you know, say, hey I love you. Even I never got I love by my boyfriends, or my proper husband. I was like I was always on my own.

To see blood or feel pain.

Twenty-two percent of the women (*n* = 12) described self-injuring because they wanted to see blood or feel pain. These women reported a need to inflict pain on themselves or to witness the blood that resulted from self-inflicted cutting.

> P050: Cause I just needed to feel pain.

> P061: I just, watching myself bleed, it made me feel better…was seeing the blood and the pain. It didn't even really hurt. Seeing the blood … made me feel better. It is hard to explain.

Feels good.

Twenty percent of the participants (*n* = 11) reported that NSSI felt good. This reason was different than simple relief from emotions; the NSSI actual felt good physically and/or emotionally.

P007: We used to try to like, come up with like, a reason to why we probably do it. And there is no reason except that we both agreed that it makes you feel good.

P026: For me, yeah. But it's not acceptable in society, I know. Not supposed to do that. I understand. But it feels good… I'm talking about a neck ligature. If you tie it around really tight, and you keep it there or whatever, the slower you breathe the higher you get. It's like a high. So I've done it a couple of times to get high, but, it can kill you.

Hurting self instead of others.

Fifteen percent of participants (n = 7) recounted turning their desire to hurt other people inwards onto themselves. In this way, the women used NSSI as a substitute for hurting other people.

P011: Somebody was fighting with me, and they, I really wanted to hit them. Really, really bad. And I couldn't do it. So I'd freak out, and I'd start beating my head off the wall…Cause I didn't want to hurt her. So I banged my head, and I banged my head, and I'd scream…. I do it because I don't want to hurt somebody else and I have to get rid of it.

P014: Um, I used to like cut myself before I used blades or knives because I was a very aggressive and violent person. Instead of acting out and hurting someone and dealing with what comes after that, I would take it out on myself and cut myself which made me feel good…It made me feel better. It would calm me down when I cut myself. Instead of attacking people I turned it inward.

Instrumental reasons.

Fifteen percent of women (n = 7) disclosed that they used NSSI for instrumental reasons (i.e., to obtain external rewards). In the institution, this often meant getting a change of location or attention from staff.

P026: I have cut my arm to be brought back to the back [segregation], cause I don't like it in the front.

P137: No, well, at the end I thought maybe they would send someone to assess me properly, you know what I mean. Like just to let me go back in the pod and relax and be in my room, and da-da-da-da. I was like, well, that don't make sense.

Being in prison.

Nine percent of participants (n = 5) reported that being in the institution was a reason they self-injured. They described feelings of anxiety about coming into the institution or depression and isolation when they were placed in segregation.

> P061: Yeah, it's more the sadness, depression thing. I guess part of the head thing was a bit of sadness, depression thing, because I was in segregation and I was really depressed. They wanted me to … we have to stand for count, and I refused to do that, cause I was just so depressed and everything like that. And I was just like, fine you want me to stand up, I'll stand up. And I just smashed my head. And then I went unconscious and everything like that. I had to be taken out in an ambulance and stuff like that.

> P116: You get taken away from friends, family, it is just, you are so segregated. You know what I mean? There is one good guard and then there is four [bad] guards to the one. It's just, you get depressed in here. Big time. Especially when, you know, you work so hard to get something. And they are like, oh well, just wait if off a little longer. When it comes to family stuff in here, they say that it is the number one thing, you know. Family contact. But I've been waiting 60 days almost now to get a PFV with four of my kids. That I have full custody of, no Children's Aid involvement, nothing. You know? And it has taken a long time. So, stuff like that, it hurts the heart. And then, so now I understand why some people do it. This place, prison, it is hard on women.

To feel in control.

Six percent of women (n = 3) reported using NSSI as a way to feel in control or empowered in situations where feelings of control were missing.

> P006: I just wanted my parents to stop fighting. I thought, um, by slicing my wrist it would kind of put a different attention to the situation. And it did in a little tiny way. I mean my parents ignored it but, um, there was less fighting for a little while, yeah.. I would even say a tad of like, um, empowering feeling.

> P007: It was like my personal use, kind of deal. It's for me and me only. Because I had control, and nobody knew about it.

Friend was self-injuring.

Six percent of participants (n = 3) of women reported that they self-injured because friends were self-injuring. Either seeing someone else gave the woman the idea to self-injure, or the woman self-injured to be like someone else they admired.

> P069: Yeah, she was cutting. And she said that she only did it for the pain. And the pain takes away the thoughts of what's going on, because now you are not thinking about that

> emotional pain, you are thinking about the physical pain. So that's what I did. But I couldn't… I did it whenever she did it, and I couldn't get into right, I didn't understand how that was taking anything away. So I stopped. I didn't really do good to me.
>
> P143: At first when I was a teenager, I did it to be like my friend[1].

Re-enact past trauma.

Four percent of woman (n = 2) reported self-injuring as a way to re-enact past trauma. Past trauma in these cases included either childhood abuse or abuse continuing into adulthood, and could have been sexual, physical or emotional in nature.

> P011: And when are you are kind of used to abuse, it just makes more sense…Like when you are used to seeing other people get hurt. And for me, when I'm banging my head and stuff, it just seems like hurting yourself is the right thing to do. At the time. Cause some people might hurt somebody else. Because, maybe that's what they are used to.
>
> P110: When I was 17, I used to burn myself with cigarettes. I think the reason I did that was because when my mom was alive she used to burn me with cigarettes to punish me. When she killed herself, I did it a couple of times after. I don't know why, but I just did.

To numb emotions

Four percent of participants (n = 2) explained that they used NSSI as a way to numb their emotions. In these cases, physical injury was a method of dulling the emotional pain they were experiencing.

> P039: [I] think it is pretty typical though. For people to not want to feel, I know people that have been come up the way that I've come up. That, I know from myself, numbing out my emotions is something I don't like… until recently I haven't liked feeling them. So I will do whatever I can to avoid them. So as soon as that comes out I don't self-harm anymore, but back then I didn't know what else to do, I did that. I didn't know what coping strategies were, I didn't know what any of that stuff was. I think all in all people just do it because they don't want to feel emotional pain. And even, you know for myself, you want to get that, it didn't hurt me when I did it. It just something to take my mind off of feeling the way I was feeling. Right? And then when I was done doing it, the whole situation was just done and over with, right?
>
> P077: I was really, really sad. When I cut myself, it didn't hurt. It just kind of numbed that pain I was feeling.

[1] Translated from French.

Hurt self before others could hurt them.

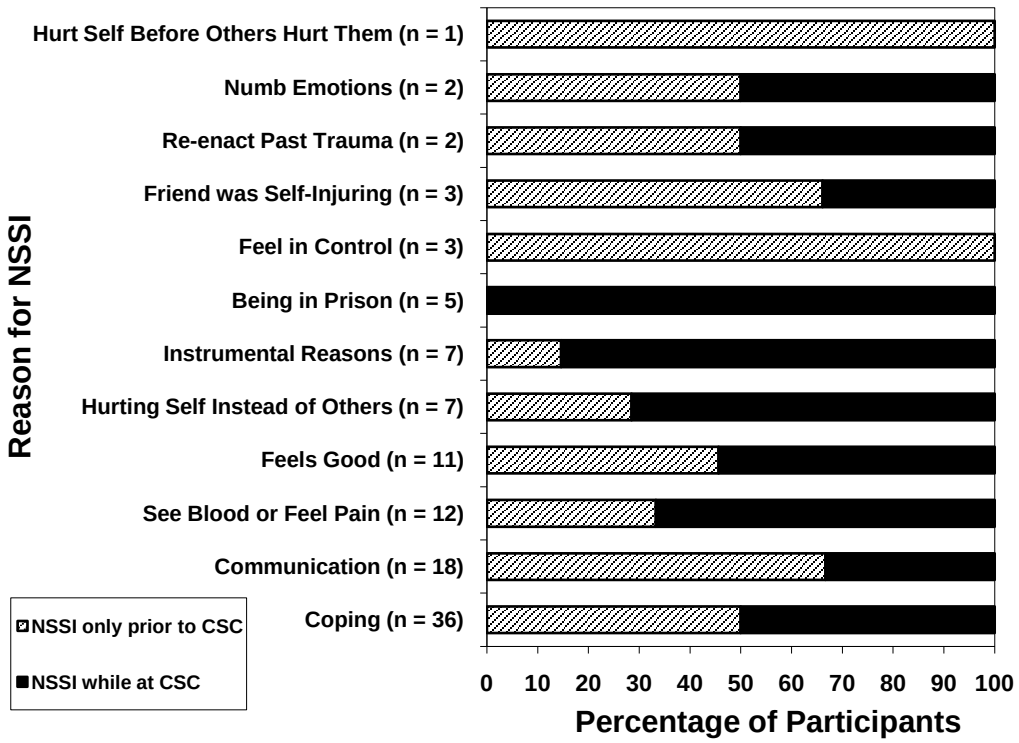
Two percent of woman (n = 1) described injuring herself before another person could injure her.

P021: Sometimes it is so others don't hurt me. I hurt myself before they have a chance to.

Motivations based on presence of NSSI in CSC's institutions.

The motivations for engaging in NSSI based on whether the women did or did not engage in NSSI while in a CSC institution were compared. The proportion who endorsed each reason is depicted in Figure 2. Statistical analyses were not feasible due to small numbers, but some trends can be identified. A larger proportion of women who had self-injured in a CSC institution endorsed using NSSI for instrumental reasons, as a method of hurting themselves instead of others, and to see blood or feel pain.

Figure 2. Proportion of women who did and did not engage in NSSI while in a CSC institution who endorsed each motivation for NSSI



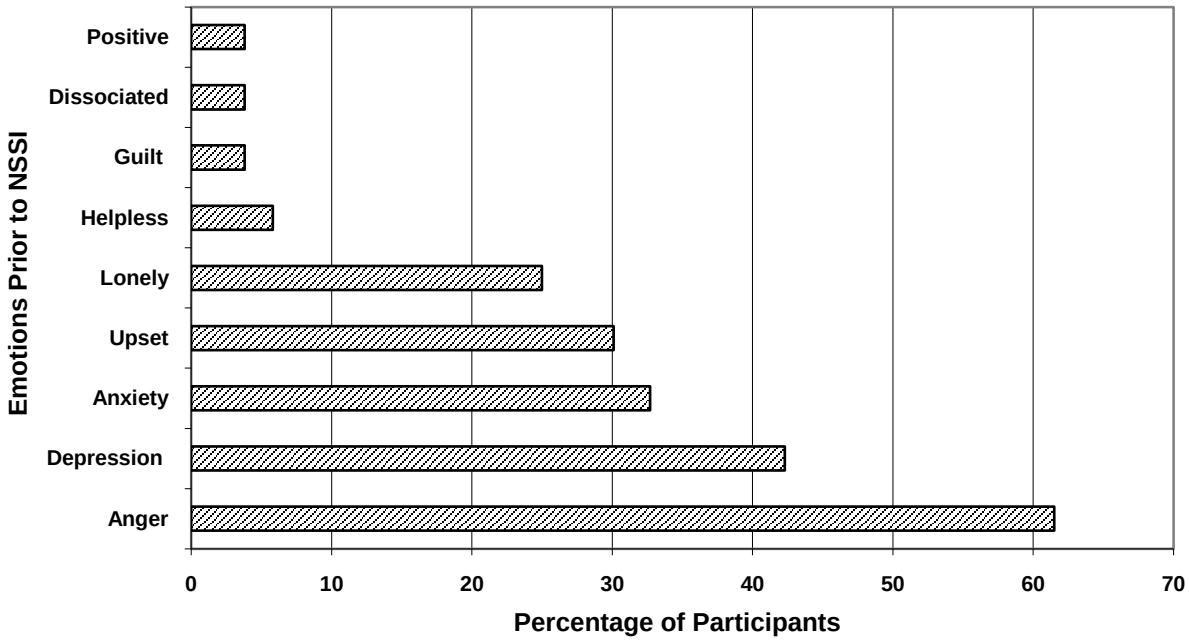
Emotions Experienced Prior to NSSI

Participants were asked to recall one or more specific incidents of NSSI and describe how they felt prior to engaging in the behaviour. Fifty-two women described the emotions they experienced before they self-injured and four women did not identify any specific emotions. Similar to the reasons for engaging in NSSI, many women described experiencing more than one emotion prior to engaging in NSSI. Thirty-five women (67.3%) listed two or more different emotions they had experienced immediately prior to engaging in NSSI. The variety of reasons the women supplied for engaging in NSSI and the large proportion of women who described feeling more than one emotion prior to self-injuring speaks to the complexity of this behaviour.

Participants described nine different emotions experienced immediately prior to engaging in NSSI. As much as possible, emotions were grouped together to preserve the language used by the women. The themes emerging in this section reflect the choice of language supplied by the participants. The vast majority of the emotions described were negative in nature. Two women described feeling a positive emotion prior to NSSI. The number of participants who endorsed

each of the emotions prior to NSSI is displayed in Figure 3.

Figure 3. Percentage of participants who endorsed each emotion experienced prior to NSSI



Anger

The most common emotion that the women reported experiencing prior to NSSI were those related to anger. Sixty-two percent of participants (n = 32) described experiencing feelings of anger, rage or intense frustration immediately prior to self-injuring.

> P014: It was always when I was mad, in a rage, you know… always, always enraging. Just anger.

> P043: Pissed off. I was so mad at my boyfriend and the shit I was going through. I thought, well, I'll just take it out on myself.

> P118: It is just to get rid of my anger. I get so angry that instead of hitting somebody else and taking it out on another person, I'll just take it out on something that won't get hurt. The first time I ever punched a wall was a brick wall, and I broke my knuckles.

Depression

Forty-two percent of participants (n = 22) reported feelings of depression, sadness, hopelessness, and worthless prior to NSSI.

P007: I'd be sad, depressed. I'd feel everything but good emotions.

P061: When I cut the tops of my legs once, when I was really depressed, when I was on the outside. I was using drugs and I was tired of disappointing my family…And I was really depressed so I cut the tops of my legs… I didn't want to feel the pain anymore of being sad.

P095: [I felt] really down, crying. I remember crying, really, really, really down. I felt sorry for myself. I had no hope. I just gave up.

Anxiety and fear

One-third of the women (n = 17) reported feelings of anxiety or fearfulness prior to self-injuring. Participants either described being in a fearful situation or feeling highly anxious or stressed immediately before engaging in NSSI.

P024: I need to do it in order not to feel danger. I don't know, something about danger there. …Everything's in danger unless I did it.

P095: I was scared coming [in]. I mean I am a first time federal sentence woman. It is not something, I don't have a big, long criminal history. It is not something I wouldn't do the rest of my life, it is just something terrible happened, a tragedy in my life, and I am here dealing with it. And the chances of me reoffending are next to nil.

P096: I think just being scared to know that somebody is going to hit me or do something to me. Sometimes when my husband was beating me, oh my god. … Cause I just knew that he was looking for me, you know, to come and hurt me.

Upset

Sixteen (30.8%) women reported feeling upset prior to engaging in NSSI. Participants who endorsed this emotion described feelings of being hurt and upset, usually accompanied by high arousal. The intense emotional experience associated with being upset distinguished it from feelings of depression and sadness described in the previous paragraph.

P021: Probably frantic. Probably, you know, really upset or something is going on with my life.

P028: I remember just being so upset … and it seemed like nothing would work. And I remember first I was screaming into my pillow and the tears were flowing…then it was like I saw the wall then it was just instant. Head connect to wall.

Loneliness

One-quarter of the participants (n = 13) reported feelings of loneliness prior to engaging in NSSI. Women who endorsed this emotion described feelings of abandonment and having a lack of people to turn to for emotional support.

> P028: Somebody was like "you are a hooker and you are going to die a lonely, lonely woman". And it hit me, like oh my goodness, what if they're right? So like, thoughts of loneliness would probably send me overboard.

> P030: Um, I think I was thinking about why did he do that? And I guess he doesn't really want me around, so I didn't really have anyone else to turn to. [I was] …alone, I dunno, I think I was more scared to be alone than anything.

Other emotions

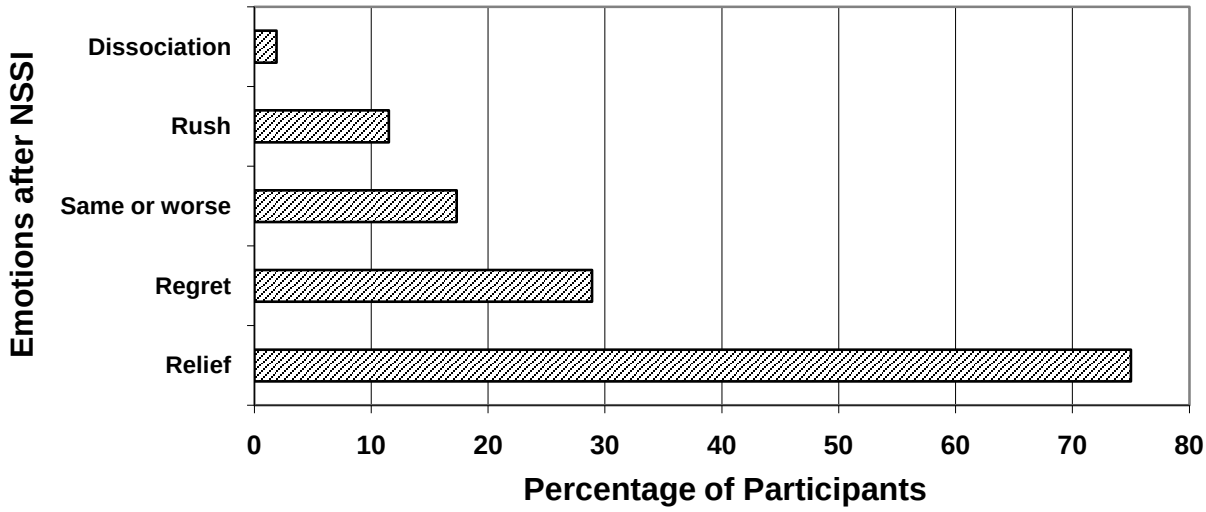
The following emotions were endorsed by 4% to 6% of the women (two to three women): helplessness, guilt, dissociation, and positive. These emotions are valid but less frequently experienced prior to engaging in NSSI.

Emotions Experienced After NSSI

Participants were also asked to describe how they felt immediately after engaging in NSSI. Fifty-two women described the emotions they experienced after they self-injured. Four women did not identify any specific emotions experienced after NSSI. The majority of participants reported feeling one type of emotion after engaging in NSSI, although a number indicated that they felt two or more different emotions. Thirty-eight women (73.1%) endorsed only one emotion after self-injuring, while 14 (26.9%) endorsed two or more.

Participants described five different emotions that were experienced immediately after engaging in NSSI. The majority of participants indicated that they felt some form of relief or another positive emotion after self-injuring, while a number of women indicated that they felt worse or experienced regret after engaging in NSSI. The number of participants who endorsed each of the emotions after NSSI is displayed in Figure 4.

Figure 4. Emotions experienced immediately after engaging in NSSI.



Relief

A large proportion of the participants indicated they experienced a form of relief immediately after engaging in NSSI, or that they felt better after self-injuring. Three-quarters of the participants (n = 39) endorsed this feeling. Many women described self-injury as a way of reducing negative feelings and releasing unpleasant emotions.

> P031: I feel calm, because at the time my chest is tightening and I feel like someone is stepping on my chest and I can't breath. And then when I do it I just feel like, aahhh, okay. I'm okay, now I'm safe.

> P086: It actually relieved some of it. It's funny, but it relieves some of the stress, like some of the anger that was there.

> P144: I would feel better. To be honest, I would feel way better. You know, it is like my fit would be gone. Poof, you know. …yeah, it does feel good after.

Regret

Twenty-nine percent of the women (n = 15) reported feelings of regret, embarrassment, or shame after engaging in NSSI. A common theme with these participants was the feeling of having done something wrong or shameful.

P031: But then immediately I start feeling guilty. Like, oh my god, I shouldn't have. Like, at the time I didn't… but now I know that it's not a normal coping mechanism, right? So now I feel guilty when I do it.

P078: Sad. Sad that I did that to myself. I was really disgusted with myself that I'd done that…I was embarrassed about it.

P112: I don't know. I don't know how to explain it. Not sure. I guess I would have to say that I felt stupid. Because now I would have to go back to the hospital and get more stitches.

Same or worse

Seventeen percent of participants (n = 9) indicated that after engaging in NSSI, they did not feel better. These women described feeling worse after self-injuring, or that their emotions stayed the same afterwards, even if they injured themselves because they thought it would make them feel better.

P036: I never really feel anything. I mean, I thought maybe that when I did hurt myself that it would take away the pain in my heart. And the pain was still there.

P069: I thought maybe if I do this it will distract me and stuff like that. But once again, it didn't. It's never [given] me the satisfaction … it only works for a second with me. It would work for a second and that was it.

Rush

Twelve percent of the participants (n = 6) indicated that engaging in NSSI gave them a feeling of a rush, a high, or a sense of empowerment. Some women compared the experience to the feeling they got from substance abuse. Others indicated that NSSI gave them a sense of power.

P006: But maybe even just a little tad of power…I would even say a tad of like, um, empowering feeling.

P026: There are times that doing it gives you a rush. It gives you a rush, like almost like doing cocaine. It gives you a heavy rush to your head. It feels good, it soothes you, it gives you that energy or that feeling you need.

P077: It was kind of like an adrenaline rush, after doing it.

Dissociation

Two percent of participants (n = 1) indicated that she felt surreal after engaging in NSSI.

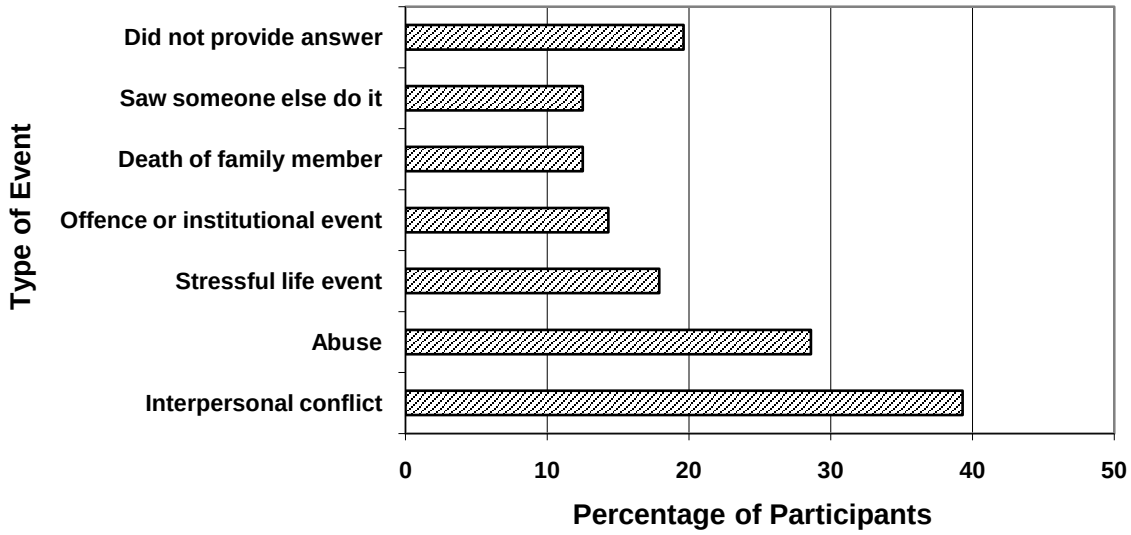
P026: No, I feel surreal after I've done it. Like it's not real.

Precipitating Events

The women were asked to describe any events that may have preceded an incident of NSSI. Precipitating events occurring prior to an incident of NSSI were discussed by 80.4% (n = 45) participants. Twenty percent of participants (n = 11) either did not mention a specific event prior to engaging in NSSI or could not remember a precipitating event. Of the participants who discussed precipitating events, the majority indicated that one type of event preceded their incidents of NSSI. However, 44.4% (n = 20) indicated that more than one different type of event had triggered an incident of NSSI.

Participants described six different types of events that typically precipitated their NSSI. With the exception of witnessing another person self-injure, all the events described as precipitating NSSI were of a negative or extremely unpleasant nature. Almost half of the women indicated that some form of interpersonal conflict had precipitated an incident of NSSI. Being the victim of abuse was also endorsed by a large proportion of the respondents. The number of participants who endorsed each of the precipitating events to NSSI is displayed in Figure 5.

Figure 5. Types of precipitating events prior to NSSI.



Interpersonal conflict

Almost half of the women (*n* =22) indicated that interpersonal conflict had precipitated an incident of NSSI. Sources of conflict were typically described as family members such as caregivers, friends, or relationship partners. Participants often expressed having difficulty managing interpersonal conflict, and that NSSI was their way of coping with it.

> P011: Like when I used to fight with my mom and dad, or my mom, and I was getting in trouble for something…and I felt like I didn't do anything wrong. I'd lose it. I didn't like the fact that I was in trouble and I'd self-harm myself.

> P025: But it was, but if I was involved in a relationship with someone and that relationship was getting crazy, I would cut to release pain that way.

> P075: Because a lot of gossip, a lot of stuff that people talk about, I can't handle it. I can't handle when people talk about me. I can't handle when people make crap about me. And then I just feel so…and then I get a whole bunch of people hating me for a whole bunch of lies. And it just makes me feel, you know, not good.

Abuse

Twenty-nine percent of participants (*n* = 16) indicated that being the victim of abuse had previously triggered an incident of NSSI. Women described abuse occurring in childhood or adulthood or both, and included physical, sexual and emotional types of abuse.

P005: Because when I was sexually abused nobody seemed to notice. It's like "Hello! It's right in the house and you can't see and can't tell?" And then nobody is listening to me, and so I just started cutting.

P030: Very first time, I think it was when I [was] hurt by my boyfriend and I dunno I just slashed my wrists.

P111: No, it was many, many years ago. I was young, and I guess through all the abuse I've experienced, and you know, my mom was always working and she was never home, she was out partying.

Stressful life event

Eighteen percent of participants (n = 10) described a stressful life event or a marked increase in stress prior to an incident of NSSI. These events were typically non-specific in nature and often described as a generalized increase in stress resulting from problems in the home during childhood or some form of perceived failure.

P006: I would say it was always in response to something, yeah…ah, response to failure, failure in school, not getting a good mark. Studying really hard but not getting it, like.

P069: I was like 15 or something. And I just had a really upsetting moment in my life, and I just thought, I don't know, I wanted to try it again. Because I was willing to try anything, right?

Offence or institutional event

Fourteen percent of women (n = 8) indicated that an incident of NSSI had been precipitating by the commission of their offence, being arrested, or another event related to being in a correctional institution. Participants described NSSI as a response to anxiety related to entering the institution or events experienced once inside.

P067: I didn't do it again until after 13, probably four years later. And I was just having way too much emotional stress from being involved in the offence I was involved in.

P100: The last time I banged my head was when I got my first prison sentence.

P116: Yeah, I lived in pod 3 in the max unit. And a girlfriend of mine lives on pod 2. And we can see each other, so one guard was kind of rude and closed the blinds on us. And I was like, well, what's that? And it was early in the morning. And then she opened hers,

and kept mine closed, and came back and switched back and forth…so I got annoyed with it and I got pissed off. So when one of the officers came to let another inmate in on the pod, I threw open the door and came out at everyone. And I had nail clippers in my hands from cutting my fingernails. And I was so mad and irritated with them that I cut my arm in front of them.

Death of family member

Thirteen percent of women (*n* = 7) described a recent death of a family member as precipitating NSSI.

P074: After my dad died. I was 13.

P095: Yeah, I did it because I wanted to be with my daughter, the one who, you know, the daughter who passed away.

Saw someone else do it

Thirteen percent of participants (*n* = 7) explained that they had engaged in NSSI after having witnessed another person self-injure. The person they had seen was typically a friend or a peer. Interestingly, all of the women who endorsed this precipitating event indicated that it occurred prior to their first incident of NSSI only. None of the participants indicated that witnessing another person self-injure precipitated any subsequent NSSI. This suggests that seeing another person engage in NSSI may initiate the behaviour, but does not maintain it.

P049: Like, I seen someone else do it and then I did it…one of my brother's friends.

P069: I started hanging out with a person, and the girl she was doing that. And she said it helped her, right.

Effect of Substance Abuse on NSSI

Despite the fact that questions about substance abuse were not specifically asked during the interviews, thirty percent of participants (*n* = 17) mentioned that substance abuse had some form of influence on their NSSI. Of those 17 women, a large proportion indicated that consumption of drugs or alcohol was involved in an act of NSSI or that it increased the frequency of NSSI. Conversely, six participants reported that substance abuse actually decreased the frequency of NSSI or that they used drugs or alcohol as a substitute for NSSI. These women

reported that they were intoxicated or high at the time of engaging in NSSI. Since questions regarding substance abuse were not asked directly, these numbers are likely an underestimation of the number of women who believe that substance abuse has a direct relationship with their NSSI.

Table 2

Influence of Substance Abuse on NSSI

	% (n)
Substance abuse implicated in NSSI (N =56)	
Yes	30.36 (17)
No	69.6 (39)
Impact of substance abuse on NSSI (N=17)	
Increased NSSI	58.8 (10)
Decreased NSSI	41.2 (7)

Substance abuse increased NSSI

Fifty-nine percent of participants who discussed substance abuse (n = 10) indicated they had engaged in NSSI during periods of substance abuse or that the use of drugs or alcohol increased the frequency of their NSSI.

> P011: I did it a lot when I was young. But when I was a teenager, I'd only do it a couple times a year. But it's been more, the last couple years. When I've been doing drugs, it's been more.

> P121: It was always when I drank. So you mix the depression with drinking, and you get nothing but bad.

Substance abuse decreased NSSI

Forty-one percent of participants who discussed substance abuse (n = 7) reported that substance abuse reduced the frequency of their NSSI behaviour or that they used drugs or alcohol as a substitute for NSSI.

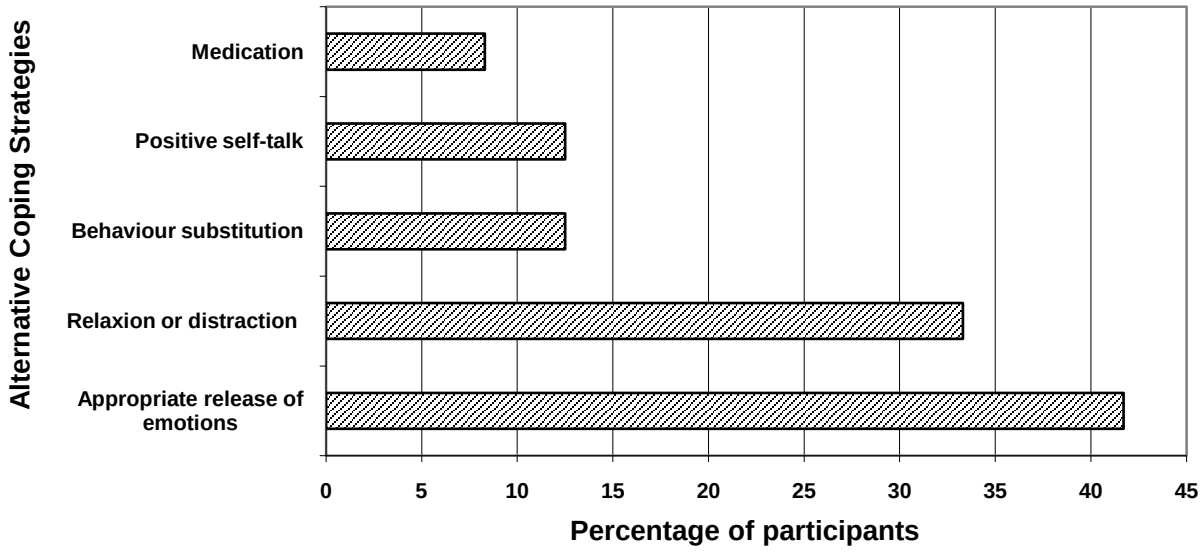
> P037: No. I haven't done it since I was 16…I think I started using drugs and alcohol and doing that kind of things instead of hurting myself physically.

Methods of Coping: Alternatives to NSSI

Questions addressing coping strategies were not part of the semi-structured interview protocol. However, the issue of coping strategies or alternatives to NSSI was spontaneously discussed by the women in many interviews and, over time, the interviewers began to probe participants about this topic. Thus, these results should not be considered a reflection of the number of women who use alternatives strategies, but rather an exploration of some of the strategies used by women to decreased or prevent their NSSI.

Forty-three percent of participants (*n* = 24*)* reported that they have begun using coping strategies other than NSSI to help them deal with stress or negative emotions. These women reported that participating in institutional programming and/or speaking to a counsellor or psychologist had been helpful in reducing or eliminating NSSI. Programs such as Dialectical Behaviour Therapy (DBT) and the Women's Substance Abuse Program (WOSAP) were mentioned as providing skills and tools to help develop appropriate coping mechanisms. Of these 24 women who commented on using alternative coping skills, 83.3% (*n* = 20) mentioned one or more specific coping methods they learned in programming or therapy. Commonly reported coping strategies include: appropriate release of emotions, relaxation and distraction techniques, substitution techniques, positive self-talk, and taking medication. Figure 6 outlines examples of the specific strategies reported and the number of participants who endorsed each strategy. Note that participants often endorsed more than one strategy.

Figure 6. Coping strategies reported by percentage of participants.



Appropriate release of emotions

Of the 24 women who reported on using coping strategies as an alterative to self-injurious behaviour, 41.7% (*n* =10) reported that they attempted to release emotions in an appropriate way. For example, these women indicated that they would seek emotional support from someone or ask for help when they felt the urge to engage in NSSI. Other examples of releasing emotions included crying and talking to someone about their feelings.

> P021: I utilize my skills. Like when things are going on with my kid and it really upsets me, I'll pick up the phone and talk to my PW, or I'll go and talk to the facilitator from the Violence Prevention. Or I will go down and say I need to talk to psychology. Like when I started to have really bad nightmares about the rape when I was five, I knew that was a trigger for me for self-harm. So I would go and reach out to psychology and say, look this is what is going on.

> P061: Well, now since I've gone to Pinel and back, I've been trying to tell people when I want to self-harm so then they put [me] in the baby-doll and I go into seg so that I don't harm myself. So that's what we're working on now. So, we are replacing, you know, so I don't self-harm.[2]

[2] The "babydoll" refers to a gown that cannot be torn which is used for women who are at risk of injuring themselves. "Seg" refers to segregation.

Relaxation or distraction techniques

One-third of the women (n = 8) also reported that they use relaxation and positive distraction techniques as an alternative to engaging in NSSI. Participants indicated that they used positive outlets such as writing, reading, creating artwork, listening to music, exercising or watching TV. Other strategies included in this category include turning to religion and spending time alone in their room.

> P039: I just think I learned different coping strategies, I learned what coping strategies were, and I learned different ways if I am feeling something to do that positive thing instead of doing the other stuff…[I] read a lot of self-help books, and I watch a lot of shows.

> P77: I'll go work out, I'll go beading. I just find other things to do if I am mad or angry.

Positive self-talk

Thirteen percent of the women (n = 3) indicated that they used positive self-talk as a strategy for coping.

> P075: I take a deep breath and I focus. I say, "it's not my problem, it's their problem". Cause I'm a good person.

Behaviour substitution

Thirteen percent of the women (n = 3) reported that they use some form of behaviour substitution. Participants cited snapping elastic bands and holding ice cubes as a substitution for NSSI. Replacing negative aspects of life with positive ones was also mentioned.

> P005: You know how some people have these elastic bands? I had that a lot. I'd sit there and hit it for the release instead of cutting.

> P031: If I hold an ice cube it helps the sensation of it…I learned it through my program, DBT…Just holding it because [of] the sting of it.

> P110: Well, I just did other things, you know. I had a little sister, I took care of her. I did other things with her. When I was 22 I had my little girl. So, I just replaced stuff with, all

the bad stuff with good stuff.

Medication

Eight percent of the women (n = 2) reported that they are able to better control their NSSI behaviours due to taking prescribed medications such as antidepressants.

> P096: I don't do it in here. Because it is different in here. And because I'm on my medication. Before when I was out I wasn't taking my meds.

Speaking to a psychologist or attending programs

Seventeen percent of these participants (n = 4) mentioned that simply speaking to a psychologist or counsellor or attending programs was helpful in reducing NSSI. These women did not mention what specific coping strategy they learned, only that participating in programming or psychology was helpful.

> P039: I think just coming here. I'm learning stuff…So I just think I learned different coping strategies, I learned what coping strategies were, and I learned different ways if I am feeling something to do that positive thing instead of doing the other stuff.

> P096: No, it is because of the tools. Because we have DBT here and they teach you to have more self-esteem and things like that.

> P150: This institution is really helpful. They take the time to sit and talk with you, and the psychologist here is the best.[3]

[3] Translated from French.

Discussion

The purpose of this study was to obtain a better understanding of the motivations for engaging in NSSI and the emotions related to this behaviour among women offenders. Secondarily, the study uncovered strategies used by the women to replace the self-injuring behaviour. Common themes emerged from the qualitative analysis of the interviews that helped shed light on the subjective experience of these women.

Motivations for Engaging in NSSI

The vast majority of women who have engaged in NSSI were able to articulate a reason for doing so. This finding supports the idea that NSSI is an intentional behaviour, serving a purpose in the lives of those who engage in the behaviour. Most women had an internal logic for their behaviour that, while maladaptive, explained the function of NSSI in their lives.

Multiple reasons for engaging in NSSI were cited by participants in this study. Over half of the women endorsed two or more different reasons for why they engage in the behaviour. Similarly, a number of different precipitating events were reported by the participants. These findings support a growing body of research indicating that NSSI is a complex behaviour serving multiple functions simultaneously (Suyemoto, 1998). It is therefore important not to over-simplify or generalize regarding individuals' reasons for engaging in NSSI.

The empirical evidence is strongest for the use of NSSI as a means of coping with negative emotions (Klonsky, 2007). Evidence for this reason has been found in a variety of samples, including across different age groups and psychological profiles and for both genders (e.g., Briere & Gil, 1998; Brown, Comtois, & Linehan, 2002; Herpertz, 1995; Nock & Prinstein, 2004). Among the participants of this study, coping was by far the most common motivation for engaging in NSSI

NSSI as a form of communication was also frequently endorsed by the women in this study. About one-third of the participants reported using NSSI as a means of communicating negative emotions that they were unable to express verbally. Many women felt that their NSSI was a "cry for help" and that they used it as a way of communicating their need for attention and caring. The literature suggests that this function of NSSI may develop in situations where other

strategies for communicating emotions and the need for support have been unsuccessful (Allen, 1995).

Several other reasons for engaging in NSSI were identified in this study, but support for them was not as strong as for coping. Nevertheless they represent valid, though less common, reasons for NSSI. One of these was the effect of witnessing other people self-injure, known as the contagion effect (Walsh & Rosen, 1985). While this effect has been proposed often in the literature (Cookson, 1977; Matthews, 1968; Menninger, 1935; Offer & Barglow, 1960; Rosen & Walsh, 1989; Walsh & Rosen, 1985), particularly for institutionalized populations, there was weak support for it in this study. Similarly, while the effect of institutionalisation on NSSI has been widely discussed in the literature (e.g., Fillmore & Dell, 2000; Franklin, 1988; Kilty, 2006; Thomas, Leaf, Kazmierczak, & Stone, 2006), we found little evidence to suggest that institutionalisation played a principal role in triggering NSSI for federally sentenced women. In fact, most women discussed self-injuring outside of the institutions rather than inside. For a more detailed discussion on the location and initiation of NSSI in federally sentenced women, please see Power and Usher (in press).

Additional analyses were conducted to determine whether women who engaged in NSSI while in a CSC institution did so for reasons that differed from those who only self-injured prior to being admitted to CSC. The data suggest that a larger proportion of women who had self-injured in a CSC institution endorsed using NSSI for instrumental reasons, as a method of hurting themselves instead of others, and to see blood or feel pain. It is possible that women who had previously used NSSI for instrumental reasons continued this behaviour once in a CSC institution given that external rewards would be even more extensive in an institution (e.g., removal from cell, attention from staff). Several of the women who described using NSSI as a substitute for hurting someone else did so in reference to institutional staff (i.e., they were in situations where they were angry and wished to hurt staff, but stopped themselves from doing so and instead hurt themselves because they realized the consequences of assaulting a staff member). These types of situations are unique to an institutional environment and therefore women who self-injure for this reason may be more likely to continue this pattern of behaviour in the institution. More research is required to determine if these trends are true in a larger population.

Emotions Related to NSSI

A common theme that emerged from the interviews was the women's experience of feeling negative emotions prior to NSSI. Anger, depression, and anxiety were all frequently mentioned as emotions that precipitated NSSI. This finding is consistent with existing literature that supports a correlation between depression, anxiety, anger and NSSI (Andover et al., 2005; Klonsky et al., 2003; Roe-Sepowitz, 2007; Ross & Heath, 2002; Simeon et al. 1992).

The majority of participants indicated that NSSI was successful in relieving those negative emotions, at least in the short term. This suggests that NSSI plays a role in affect regulation for a large proportion of the women in this study. The affect regulation functional model of NSSI is supported in the literature. According to this model, individuals who suffer from emotional instability and who have difficulty managing affect are prone to using NSSI as a strategy for alleviating negative emotions (Klonsky, 2007). The relief of anger, anxiety, loneliness, and emotional pain is frequently cited in the clinical literature as support for the affect regulation function of NSSI (Gratz, 2003). The present study's finding that NSSI serves a function of coping with negative emotions is consistent with the literature. For a large number of women in this study, NSSI appears to be successful in regulating emotions which may, ultimately, serve to reinforce the behaviour.

The considerable proportion of women (29%) who did not experience an alleviation of negative emotions after NSSI, even when NSSI was undertaken with this explicit intent, is not consistent with the literature. The logical progression when NSSI is used as a means of coping with negative emotions is that relief from negative emotions immediately follows the incident. There is a great deal of support for this model in the literature (Klonsky, 2007). The women who did not experience relief may have undertaken NSSI to cope with negative emotions because they were told by another person that it would work or witnessed another person doing it for this reason, but found it did not work for them. Alternatively, the negative emotions that many women reported afterwards, such as shame and embarrassment, may have been stronger than any positive emotions creating an overall feeling that was negative rather than positive after engaging in NSSI.

Precipitating Events

It is not surprising that coping with abuse was frequently provided by the women as a

reason for initiating NSSI, given that numerous studies have found that childhood abuse is correlated with NSSI (e.g., Borrill, Snow, Medlicott & Paton, 2003; Favazza & Conterio, 1989; Fillmore & Dell, 2000, 2005; Gladstone et al., 2004; Gratz, Conrad & Roemer, 2002; Himber, 1994; Langbehn & Pfohl, 1993). The mechanism by which abuse may lead to NSSI is poorly understood. To date, there have been no studies that examined how the two are linked in adults, although two studies have examined the process in younger populations (Prinstein et al., 2008; Weierich & Nock, 2008). It is unclear whether individuals use NSSI as a method of coping with negative emotions associated with abuse, as a means of recreating the trauma that has become "normal" for them, or if the NSSI is the result of another factor or factors associated with the abuse experience.

Substance Abuse and NSSI

The relationship of substance abuse to NSSI that was reported spontaneously by a number of the women in the study is an important finding, consistent with existing literature (Klonsky & Muehlenkamp, 2007; Young, Justice, & Erdberg, 2006). The significant proportion of women who indicated that substance abuse increased their NSSI behaviours or that they engaged in NSSI during a period of increased substance abuse supports these findings. In contrast, a number of participants reported that substance abuse actually decreased their NSSI behaviours. These women indicated that drug and alcohol consumption became a substitute for NSSI, or that they chose to engage in NSSI when drugs or alcohol where not readily available. This finding may be consistent with the theory that NSSI is primarily used as a coping mechanism. It is possible that, for a number of women, substance abuse and NSSI become interchangeable coping strategies for dealing with negative emotions or past trauma such that when substance abuse is not an option, NSSI is substituted. This is a novel finding since a negative correlation between substance abuse and NSSI has not been reported in other studies.

Alternatives to NSSI

Alternatives to NSSI were not discussed by all participants and as such the coping strategies that emerged from in the interviews should not be considered to be representative of all study participants. The information provided, however, gives important insight into the use of alternative strategies as a substitute for NSSI.

More importantly, most of the strategies mentioned can be learned by other women who

self-injure. The key is to provide options so that each woman can find the strategy that is best suited to her needs. Also, the finding that many women spontaneously cited skills they had learned in programs or therapy as alternatives to engaging in self-injurious behaviour lends support for the methods currently being employed in CSC's interventions. Dialectical Behaviour Therapy (DBT), for example, trains participants on the use of some of these strategies to help women decrease or stop their NSSI (Linehan, 1993). DBT targets the needs of women with Borderline Personality Disorder. The teaching of alternative coping strategies is a major component of other correctional programs as well, although they are not necessarily targeting reductions in self-injurious behaviour.

Conclusions

There are some limitations to the current study. The women who participated in the study were not a random sample. However, the women were drawn from all federal women's correctional institutions increasing the chances that the study is representative of the population.

The potential for social desirable responding always exists in research and this issue may be of particular importance in face-to-face, semi-structured interviews. The depth and breadth of information provided, however, suggests that the interviewers established good rapport with the participants and that most women shared their experiences openly.

The study improves the current understanding of NSSI, particularly among federally sentenced women while supporting many of the conclusions drawn from the literature. The strongest support for the reason the women used NSSI was as a method of coping. Alternative strategies for coping have been learned by many women, often through institutional programming such as DBT, and other therapies. Correctional planning may be well served by offering offenders training in coping strategies as an alternative to NSSI in a wider range of programs, and not limiting access to these intervention strategies to women with Borderline Personality Disorders who qualify for the DBT program.

Substance abuse was found to be implicated in NSSI, although the relationship is a complicated one. Further research is required to understand this relationship in more detail. Given the high levels of substance abuse in incarcerated women, the link between substance abuse and NSSI may be particularly important for this population.

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Appendices

Appendix A : Semi-Structured Interview Schedule

I'd like to ask you some questions about your history before you entered the institution and about things that have happened since you came here. At the end of the interview I will ask questions about self-injury and attempted suicide.

Section A: Mental Health

I'm going to ask you some questions about your mental health.

Have you ever talked to a psychologist, counsellor, or doctor about psychological problems you were having?

When?

Why did this happen? (Possible prompts → you wanted to go, someone else made you go, something bad happened that you wanted to talk about)

How often did you speak with this person?

Have you ever spent a night in a psychiatric hospital?

Have you ever been diagnosed with a psychological disorder?

Section B: Sexual Orientation & Behaviour

Next, I'd like to ask you some questions about your sexual orientation and behaviour. Some people may find this embarrassing to talk about, but please feel comfortable to be as honest as you'd like.

How would you identify your sexual orientation (are you heterosexual, homosexual, or bisexual)?

Since you have entered the institution, have you had sex with a male? Female? (Possible prompts → any kissing or touching that you would think of as sex)

Before you entered the institution, did you ever have sex with a male? Female? (Possible prompts → any kissing or touching that you would think of as sex)

Section C: History of Abuse

Now, I'd like to ask you some questions about your history and if you have ever experienced abuse.

Did you experience abuse as a child?

(Possible prompts → did anyone hit you, humiliate you, call you stupid, seriously threaten you, touch you in an inappropriate manner, sexually abuse you)

What kind of abuse?

Who was your abuser? (Mom, Dad, Brother, Sister, teacher)

Have you experienced abuse as an adult?

(Possible prompts → did anyone hit you, humiliate you, call you stupid, seriously threaten you, touch you in an inappropriate manner, sexually abuse you)

What kind of abuse?

Who was your abuser? (Possible prompts → Could be from a partner, boss, etc)

Section D: Suicide Attempts & Self-Injurious Behaviour

Finally, I'd like you to answer some questions about any suicide attempts or self-injury that you may have done. This may be a difficult topic, however, you should talk about things in a way that you are comfortable with.

Have you ever hurt yourself on purpose? (Possible prompts → cutting, slashing, using a ligature/strangulation, inserting something under your skin, head banging)

What types of self-injury have you done?

What type do you do most often?

Tell me about the first time you harmed yourself.

When did it happen?

How did you do it (type of self-injury)?

Why did you do it? Did something happen to trigger the event?
How did you feel immediately before you did it?
How did you feel immediately after you did it?
What happened immediately after you did it?
Did anyone find you while you were doing it? Was it likely that someone would find you?
Did you seek help after you did it? Did you tell anyone about it?
Did other people know you self-injured? How did other people react to the event?

What about when you have injured yourself since the first time?
How did you do it (type of self-injury)?
Why did you do it? Did something happen to trigger the event?
How did you feel immediately before you did it?
How did you feel immediately after you did it?
Do you seek help after you did it?
Did you tell anyone about it? If so, how do people react?

Do you self-injure sometimes more than other times?
(Possible prompts → living at home, in the institution, money problems, drinking alcohol, feeling stressed, having relationship problems)
When do you do it more?
When do you do it less?

How often do you self-injure?
(Possible prompts → how much in the last week/month/year)
Did you self-injure more or less before you were incarcerated?

Do the other offenders know you harm yourself? Do they talk to you about it?

When you injured yourself before you came into the institution, why did you do it?
What about since you came into the institution? Are the reasons different? Is the type of harm different? Do you do it more or less?

What part of the body do you usually injure?

Have you ever attempted suicide?