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***Majorities within minorities:  
The experiences of non-suicidal  
self-injury in the LGBTQ communities.***

A thesis presented in partial fulfilment of the requirements for the degree of

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## **Abstract**

Non-suicidal self-injury (NSSI) is a maladaptive behaviour, defined as the purposeful destruction of one's own body tissue performed in absence of suicidal intent or social custom. Research suggests that NSSI is a risk factor for suicidal ideation and suicide attempts. Research also suggests that LGBTQ (lesbian, gay, bisexual, transgender, and queer) identifying individuals are at a higher risk for experiencing mental distress, NSSI and suicidality. Within Aotearoa/New Zealand, the Youth'12: Health and Wellbeing of Secondary School Students survey found that LGBTQ adolescents had significantly higher rates of NSSI and were five times more likely to attempt suicide than their heterosexual and/or cisgender counterparts. This thesis addresses these concerns through a qualitative approach, guided by the methodology of Interpretative Phenomenological Analysis.

This research examines how LGBTQ individuals who have previously engaged in NSSI make sense of their experience. The six individuals interviewed share their background histories, the process of coming out, and their experiences with NSSI. Participants further comment on the various ways in which existing ideologies within their social climates impacted their overall health and wellbeing.

There were numerous challenges faced by the participants. Some experienced discriminatory behaviours from family, friends, and health professionals. The process of coming out as LGBTQ was a difficult time for many. Participants experienced stigma and discrimination in association with both their identity, and the self-injurious behaviour. NSSI was seen largely as a coping mechanism, and participants displayed resilience in light of their circumstances.

Self-esteem and self-acceptance increased as participants acquired a stronger sense of belonging through meaningful connections. Building supportive friendships, and finding a

community contributed to positive health outcomes. However, despite a solidified identity, societal pressures remained.

The results of this thesis suggest that education and tailored support from health professionals is of utmost importance. The ongoing challenges experienced by the participants are reflected in research, and signify that educating families, health professionals, and the wider society is a crucial step in assisting this at-risk group. Implications for future directions are discussed.

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## Table of Contents

Abstract.....	ii
Acknowledgements.....	iv
Table of Contents.....	v
List of Tables.....	ix
List of Figures.....	ix
Introduction.....	1
Defining LGBTQ in this thesis.....	1
Chapter 1: Literature review.....	5
Overview.....	5
1. Non-Suicidal Self-Injury.....	5
Current definitions.....	7
The Aotearoa/New Zealand context.....	7
<i>The Dunedin Multidisciplinary Health and Development Study</i> .....	8
<i>Youth2000</i> .....	9
<i>The Youth Wellbeing Study</i> .....	9
Theoretical frameworks of NSSI.....	10
<i>Experiential Avoidance Model</i> .....	11
<i>Integrated Theoretical Model of Self-injury</i> .....	11
NSSI and suicidality.....	13
2. NSSI and LGBTQ communities.....	14
Definition considerations.....	16

Historical pathologisation .....	19
NSSI and suicidality in sex, sexuality, and gender minority individuals .....	22
<i>The Aotearoa/New Zealand Context</i> .....	28
<i>Minority Stress Model and the Decompensation Framework</i> .....	31
3. Current Research.....	35
Existing qualitative research .....	35
Relevance of this research .....	36
Aims and research questions.....	38
Chapter 2: Method .....	39
A Qualitative Approach .....	39
Interpretative Phenomenological Analysis .....	39
Reflexivity.....	40
Ethical Considerations .....	43
Design .....	45
Recruitment of participants.....	45
Data collection .....	48
Interviews.....	48
Data Analysis .....	51
Individual transcripts .....	51
Collation of transcripts.....	52
Chapter 3: Results .....	54

Theme 1. Support seeking: “I just wanted to be helped. I fell through the cracks”	56
1.1 The role of family .....	57
1.2 Social support.....	61
1.3 The support of health professionals .....	66
Theme summary.....	71
Theme 2. Hesitant sense of self: “You don't know that what you are is an option”	72
2.1 Pre coming out: Suppression of identity .....	72
2.2 Coming out: Isolation and invisibility .....	77
2.3 After coming out: Empowerment .....	82
Theme Summary .....	85
Theme 3. Survivorship: “When I came out I got a lot better really quickly and I no longer needed to self-harm so much”	86
3.1 NSSI: A necessity of its time .....	86
3.2 Shared experiences of survival .....	91
3.3 Preventing relapse .....	94
3.4 Perseverance .....	97
Theme Summary .....	99
Theme 4. Assimilation: “Sometimes it is just difficult”	100
4.1 Claiming space.....	100
4.2 Living with scars.....	106
4.3 Building a caring community.....	110
Theme Summary.....	116

Chapter 4: Discussion .....	117
What was the experience of LGBTQ individuals engaging in NSSI?.....	118
Early life experiences and backgrounds .....	118
Interaction between identity and NSSI .....	119
Participant’s self-reflection.....	120
Role of the LGBTQ communities and society at large.....	120
Application of theoretical frameworks of NSSI .....	122
Application of the Decompensation framework .....	123
Limitations of this study .....	124
Recommendations for future research and practice.....	127
Conclusion .....	128
References.....	129
Appendix A - Participant Information Sheet .....	151
Appendix B - Participant Consent Form.....	155
Appendix C - Interview Schedule.....	156
Appendix D – Glossary.....	157

### **List of Tables**

Table 1- Participants' identity information.....50

Table 2 - Superordinate themes and supporting subordinate themes.....56

### **List of Figures**

Figure 1- An integrated theoretical model of the development and maintenance of non-suicidal self-injury (Adapted).....13

## Introduction

### Defining LGBTQ in this thesis

The LGBTQ<sup>1</sup> (lesbian, gay, bisexual, transgender, queer/questioning; Clarke, Ellis, Peel & Riggs, 2010) umbrella refers to a specific set of self-identification, the four main ones being sex, sexuality, gender identity and gender expression (Jourian, 2015). It is beyond the scope of this thesis to address the multiple constructs and identities which exists in rainbow communities, so the focus herein is on the terms and concepts used within the cited literature, with the purpose of illustrating the identities of the participants of this study.

Sexual identities such as lesbian, bisexual and asexual are used to describe sexual attraction to others. Gender-identifying terms such as transgender, cisgender, and non-binary are used to describe individuals' self-perceptions of their own gender identity. While gender identity and sexual identity terms can be interrelated constructs of self-identity, they are distinct denotations of self-conceptualisation. For example, a person who is cisgender (someone whose gender identity matches their assigned sex at birth) can also identify as gay/lesbian (someone who is sexually or romantically attracted to the same sex). Another individual might identify as transgender (someone whose gender identity differs to their assigned sex at birth) and also identify as heterosexual (someone who is sexually or romantically attracted to the opposite gender) (RainbowYOUTH, 2017). The term non-binary denotes that an individual does not subscribe to the binary of female/male, and instead views gender as a spectrum (Richards et al., 2016). There are multiple gender identities and the definitions are largely individualistic, though it is custom to use non-binary and trans interchangeably.

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<sup>1</sup> For the purposes of this thesis 'LGBTQ', 'queer communities', 'queer and trans', 'rainbow communities', 'sexual and/or gender minorities' and 'sex, sexuality and gender diverse' are umbrella terms used interchangeably to identify individuals who are not heterosexual and/or cisgender. In cases of cited material which uses other terminology or looks only at certain identities under this umbrella, their usage is followed.

The identities which exist in the rainbow communities are multifaceted, complex constructs. There are no unified definitions, and for this reason language becomes salient as individuals engage with newfound vocabulary to describe their identities (Lee, Ylioja, & Lackey, 2016). Due to this, it is important and useful to differentiate identities. The describing term cisgender, is one of the ubiquitous terms widely acknowledged and used in the queer communities (Clarke et al., 2010; Jourian, 2015; RainbowYOUTH, 2017; Treharne & Beres, 2016). The utilisation of this term has been used primary for the purposes of not othering transgender individuals. It is less a label imposed upon individuals whose birth sex corresponds with their gender identity, and more of an effort to normalise transgender identities.

The notion that gender is a spectrum, and identity does not have to correlate with the sex at birth means there is no typical way to present as male or a female. However, sometimes it becomes important to draw the distinction between being cisgender and transgender. Whilst the term “cisgender” may not be widely acknowledged by people who are cisgender themselves, it is a necessary term in the LGBTQ communities. The use of cisgender is culturally and historically specific, as it makes a comment on the privileges associated with this identity (Jourian, 2015); people who are cisgender are not subject to transphobic discrimination in relation to their gender identity, as may be the case with transgendered and gender non-conforming individuals.

While LGBTQ is meant to represent inclusivity under its label, it is not an exhaustive definition and terminology is often contested within the queer communities. A plus sign (+) or an asterisk can follow after the abbreviation to represent this: i.e. LGBTQ+ or LGBTQ\*. The Q can play the same role and can mean queer (to represent multiple other identities) or questioning (those who are questioning their identity), although this can become complex, due to ‘queer’ being a separate identity as well as an umbrella term. The use of LGBTQ and

its synonymous labels establishes a community of individuals who are part of a minority group which is exclusive of those who identify as both heterosexual and cisgender. The umbrella term LGBTQ also include identities which are not otherwise explicit in the acronym, such as asexual (lack of sexual attraction to others), non-binary or gender-queer, as well as culturally-specific terms such as takatâpui (queer Maori identity), and fa'afafine (Samoan third-gender).

There is variation within rainbow terms, and definitions are subject to individualistic interpretation. Language has a significant impact on the lives of queer individuals, and can be used to validate identities or to exclude them. As such, a person's gender and/or sexuality identities can change and develop (Lee et al., 2016). For example, someone who thought they were attracted to the opposite sex in their teenage years might find attraction to same sex partners in their early adulthood, and later on identify as bisexual. This variation comes as an individual acquires a clear sense of identity and through that process finds new, more fitting vocabulary. During the formation period of self-identity, an individual may experiment with using different terminology. This contributes to the development of a stronger sense of self through identifying markers such as labels.

The LGBTQ terminology used within this thesis follows the academic material cited throughout, and the glossary featured on the website of RainbowYOUTH (2017)<sup>2</sup>. The terminology is consistent with a number of academic publications, however defining sexuality and gender diversity is a difficult task as there are interpersonal differences within the communities (Clarke et al., 2010; Lee et al., 2016; Treharne & Beres, 2016). For the LGBTQ communities, language is one of the shifting sites of identity. With the rise of the internet, the use of that language is globally exchanged and collectivised at rapid rates (Fox &

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<sup>2</sup> RainbowYOUTH is an organisation established in 1989, dedicated to helping young queer and gender diverse people in Aotearoa/New Zealand.

Ralston, 2016; McDermott & Roen, 2012; McDermott, Roen, & Piela, 2013). Linguistically, it is a quickly evolving area which often moves faster than academic publications (Jourian, 2015). The jargon used in online spaces may not necessarily be familiar to academics or even health professionals (Carabez, Pellegrini, Mankovitz, Eliason, & Scott, 2015). Furthermore, the rainbow communities have been historically defined and discriminated against by the very language they are reclaiming. One such example is the term “queer” –which previously was used as a homophobic slur, was reclaimed in the 1980s, and has subsequently become widely accepted by the communities (Barker, Richards, & Bowes-Catton, 2009). This has created tension between LGBTQ individuals who saw “queer” as a term relating to a specific identity, those who used it as an umbrella term (Rand, 2014; Treharne & Beres, 2016), those who used it as a politically charged statement, and those who wanted nothing to do with it.

Respecting the rights and autonomy of an individual by using the correct pronouns and identifying them by their chosen terminology is an essential component of interpersonal ethics (Ansara & Hegarty, 2014; Jourian, 2015). With this ethical consideration in mind, the most favourable resolution has been created for the purposes of this thesis. Specific terms and identity markers used by interviewees have been self-defined by those individuals. More pervasive terms, which are almost universally used and accepted by the LGBTQ communities, have been defined according to the academic literature and RainbowYOUTH (2017). For ease of reference throughout, a glossary of terms and concepts used in this thesis has been created (Appendix D), which the readers can refer to for clarification.

## **Chapter 1: Literature review**

### **Overview**

The emergence of research on non-suicidal self-injury (NSSI) has occurred relatively recently. Largely impacting adolescents, NSSI contributes to a number of negative health outcomes. Individuals who identify as sex, sexuality and gender diverse (or LGBTQ) have been consistently over-represented in NSSI statistics. This chapter provides an overview of literature pertaining to NSSI and its theoretical frameworks, and the impact NSSI has within the LGBTQ communities. This chapter also addresses implications for the research which is the focus of this thesis.

### **1. Non-Suicidal Self-Injury**

Non-suicidal self-injury (NSSI) is the purposeful destruction of one's own body tissue performed in absence of suicidal intent or social custom (International Society for the Study of Self-Injury, 2017; Klonsky, Victor, & Saffer, 2014; Nock, 2009). Occurring largely throughout adolescence, NSSI is considered to be a dysfunctional and harmful behaviour (Nock, 2009). In addition to this, self-injury often functions alongside pathologies such as disordered eating, depression, and anxiety (Garisch & Wilson, 2015). Perhaps most alarmingly, self-injury has been identified as a strong predictor to future suicidal thoughts and behaviours (Garisch & Wilson, 2015; Muehlenkamp & Gutierrez, 2007; Whitlock, Muehlenkamp, et al., 2013).

Reported lifetime prevalence rates for NSSI have been varied due to inconsistencies in definitions and varying assessment measures, however a widely accepted estimate falls around 18% (Muehlenkamp, Claes, Havertape, & Plener, 2012). Aotearoa/New Zealand shows higher numbers of prevalence of NSSI (48.7%; Garisch & Wilson, 2015).

Research into gender-specific NSSI has routinely reported mixed results. Some research suggests that female individuals engage in higher frequency rates of NSSI than males (Latimer, Meade, & Tennant, 2013; Whitlock et al., 2011). Further research suggests this inference may not be correct and that there are no statistically significant gender differences (Claes, Luyckx, & Bijttebier, 2014; Garisch & Wilson, 2015; Jacobson & Gould, 2007; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). The inconsistencies might be accounted for through the variable use of terminology and instruments used to measure rates of NSSI. Furthermore, the timeframe used to measure NSSI is variable, with some researchers assessing NSSI engagement only in the past 12 months, whilst others give lifetime prevalence rates. This could further affect the gender-specific reporting.

While self-injury is not limited to individuals with a diagnosis, it continues to be pathologised. Those who engage in NSSI are subject to discrimination, as self-injury is viewed as a stigmatized behaviour. In their research, Presson and Rambo (2016) examined how those who engage in self-injury conceptualised their experience. The results showed that participants negotiated multiple identities in association with their self-injury, all of which were purposeful. Self-injury was meaningful to the participants. Presson and Rambo (2016) framed self-injury as a social construction, which required a dialogue between the health professional and the individual engaging in the self-injurious behaviour. Similarly, Adler and Adler (2007) found that those who engaged in self-injury were more complex than psychomedical literature previously suggested. To the participants, self-injury held significant value and was an active choice through which they could exercise their autonomy (Adler & Adler, 2007). Both of the studies mentioned, concluded that openness, understanding and acceptance was paramount to destigmatising self-injury, and those who engaged in the behaviour.

## **Current definitions**

The terminology used to discuss the topic of self-injury has varied considerably between studies, and has been used to describe a variety of behaviours. As a result, the definition for NSSI is inconsistent between researchers (Andover, Morris, Wren, & Bruzese, 2012; Latimer et al., 2013). Attempted suicide, parasuicide, self-mutilation, self-injurious behaviour, and deliberate self-harm (DSH) are terms that have all been linked in literature to both suicidal and non-suicidal behaviours. It has been proposed that the term DSH contains two facets which cover suicidal and non-suicidal behaviour (Skegg, 2005; Whitlock & Knox, 2007): self-harm with suicidal intent; and NSSI. However, studies are not always clear about which definition they follow, and literature in the area of self-injury is complex. Studies may use DSH to define a variety of harmful behaviours, NSSI, and self-injury with suicidal intent. This makes interpretation and comparison of results a challenging task.

As previous studies have been inconsistent with defining NSSI, this is also reflected in the results. Methods of engagement in self-injury vary, and some genders have higher instances of specific methods than others. For example, cutting is the most common method of NSSI (Nock, 2009), and is often reported in higher numbers in those who identify as female (Garisch & Wilson, 2015; Whitlock et al., 2011). However, males may engage in methods of NSSI which are masked by outward aggression, such as self-hitting (Latimer et al., 2013; Whitlock et al., 2011). Studies which do not account for different methods of self-injury, and instead choose to focus on one method (i.e. cutting) will render disparate results than those who are more inclusive in their measures.

## **The Aotearoa/New Zealand context**

To date, there have been three large-scale studies which have included items about self-injurious behaviours in Aotearoa/New Zealand adolescent and young adult populations.

These are: the Dunedin Multidisciplinary Health and Development Study, Youth2000 studies, and the Youth Wellbeing Study. Together, these form the basis of emerging NSSI literature across Aotearoa/New Zealand. The studies are further elaborated below.

### ***The Dunedin Multidisciplinary Health and Development Study***

The Dunedin Multidisciplinary Health and Development Study is a longitudinal study of a cohort of New Zealanders born between 1972 and 1973. The participants of this study were assessed biennially until the age of 15, and subsequently at ages 18, 21, 26, 32 and 38 (Poulton, Moffitt, & Silva, 2015). Mental health and psychosocial functioning were focused on alongside other health and wellbeing research themes. This study had a high participant retention rate, with 95% remaining in 2012 from the original cohort of 1037. As part of this study, research into DSH and NSSI was conducted.

At the age of 26, participants took part in a 20-minute semi-structured interview on self-injurious behaviours. Questions featured in context of mental and psychological pain, emotions, and general stress. Information on occurrence and frequency of self-injurious behaviours was collected. Two categories of self-injury were created. The first was consistent with the methods specified in the International Classification of Diseases (ICD) and labelled “ICD self-harm”. The second category was titled “other self-harmful behaviours” and addressed self-battery, denial of necessities such as food, excessive exercise, and self-biting and wounding (Nada-Raja, Skegg, Langley, Morrison, & Sowerby, 2004). While this paper addressed broadly the impacts of DSH and self-harmful behaviours, Coppersmith, Nada-Raja, and Beautrais (2017) focussed specifically on individuals whose behaviours could be defined as NSSI. Lifetime prevalence for NSSI at age 26 was 34%. Follow-up measures at age 32 addressed suicidal ideation, and Coppersmith et al. (2017) found that NSSI at age 26 was found to be a predictor for suicidal ideation at age 32.

## ***Youth2000***

The Youth2000 survey is a series of three national adolescent health and wellbeing surveys, administered in 2001, 2007 and 2012 (Clark et al., 2013). This project operates across a third of secondary schools in Aotearoa/New Zealand. Youth2000 is a comprehensive cross-sectional adolescent questionnaire, covering multiple facets of young people's lives, including psychological wellbeing. The aim of the project is to identify both risk and protective factors. This thesis will mainly focus on the findings from "Youth'12", the most recent survey.

Youth'12 surveyed 8,500 adolescents in high schools across low, medium and high deciles. Questions about self-injury were nested under emotional wellbeing, which included life satisfaction, depressive symptoms, DSH and suicidal ideation and attempts. The question that inquired about respondents' experiences of self-injury was phrased as "During the past 12 months, have you deliberately hurt yourself or done anything you knew might have harmed you (but not kill you)?" Lucassen, Clark, Moselen, Robinson, and The Adolescent Health Research Group (2014) reported that 23% of adolescents had engaged in NSSI in the past 12 months, with female students more likely to self-injure than male students (29% compared to 18%) (Clark et al., 2013).

## ***The Youth Wellbeing Study***

The Youth Wellbeing Study is a longitudinal research survey conducted by Wilson and colleagues, which commenced in 2012 and spanned four years (Wilson & Youth Wellbeing Study, 2015). The research centred on secondary schools in the Wellington region. The project aimed to address the prevalence, correlates, and prospective predictors of NSSI across a community sample of adolescents through a self-report questionnaire. The questionnaire was administered twice with mean ages of the participants being 16.4 and 16.5

respectively. Questions relating to emotional regulation, overall psychological wellbeing and sexuality were included in the measures.

A survey was used to collect data on NSSI. The research utilised an adapted version of the Deliberate Self-Harm Inventory (Lundh, Karim, & Quilisch, 2007), and this form was used to ascertain the frequency and type of self-injurious behaviour. Participants answered each question on a 5-item scale from “Never” to “Many times”. The questionnaire assessed multiple forms of NSSI (Garisch & Wilson, 2015).

The results from this project were consistent with international research, with the exception of the prevalence rate for lifetime history of NSSI, which was higher. A reported lifetime prevalence rate of NSSI in adolescents was 49%, with no gender differences found. This difference may be accounted for as Garisch and Wilson (2015) used comprehensive measures which took into account multiple presentations of NSSI, whereas previous research might have focused on a specific presentation, such as cutting. NSSI was positively correlated with the following risk factors: alexithymia, anxiety, depression, impulsivity, bullying, substance abuse, abuse history and sexuality concerns. NSSI was found to be negatively correlated with protective factors of self-esteem, resilience and mindfulness.

### **Theoretical frameworks of NSSI**

There are multiple models proposed for the aetiology and maintenance of NSSI. A substantial amount of support is for the theory that maladaptive emotional regulation leads to engagement in DSH, and more specifically, NSSI. This section covers two prominent theoretical frameworks, which will later be applied to the data collected during the current study.

### ***Experiential Avoidance Model***

The Experiential Avoidance Model (EAM) developed by Chapman, Gratz, and Brown (2006) is an evidence-based theoretical framework addressing the maintaining factors of DSH. This affect regulation theory proposes that DSH is a self-perpetual cycle, which operates as a negative reinforcement for the purposes of curbing undesired emotions. Specifically, when an individual experiences a stimulus which elicits an undesired emotional response, a sequence of events ensues. If the individual has difficulty with regulating emotions, or lacks the skills entirely, this exacerbates the arousal. Poor distress tolerance and high emotion intensity are factors that compound the experience. DSH offers temporary relief through reducing the intensity of the unwanted emotional arousal, or allowing the individual to escape the arousal entirely. The habituation creates a cycle, which over time becomes automatic. Chapman et al. (2006) point out that although self-reported reasons for DSH are varied, they are largely to do with emotional relief and eliminating unwanted internal experiences.

### ***Integrated Theoretical Model of Self-injury***

The Integrated Theoretical Model of Self-injury (ITMSI; see Figure 1) proposed by Nock (2009, 2010) describes a combination of distal risk factors and poor intrapersonal/interpersonal functioning affecting future stress responses, which alongside NSSI-specific vulnerability factors leads to NSSI as a way of regulating stressors. To elaborate on this premise, genetically predisposing factors (e.g. strong emotional reactivity), the presence of childhood trauma, and negative environmental events such as high levels of criticism from family members, impact the intrapersonal/interpersonal functioning of the individual. An individual experiences deficit in interpersonal skills (poor communication skills/ poor social problem-solving) and poor distress tolerance, alongside high levels of

emotional reactivity in intrapersonal skills. When a triggering event occurs, these vulnerability factors create a stress response in the form of either under- or over-arousal, or unmanageable social demands. The stress response is influenced by, and combined with any of the six NSSI-specific vulnerability factors. These are: social learning (behaviour modelled from others), self-punishment (feelings of self-hatred), implicit attitude/identification (the view that NSSI is more favourable to other behaviours), social signalling (communicating distress to others through NSSI), pain analgesia/opiate hypothesis (lower pain sensitivity threshold) and the pragmatic hypothesis (NSSI is a more accessible way of regulating emotions, particularly in adolescents). These processes can lead to NSSI.

Thus, NSSI is a means by which emotional regulation can be obtained quickly and efficiently in light of already existing vulnerabilities. The behaviour is maintained by multiple reinforcement processes. These are: intrapersonal negative reinforcement (NSSI diminishes unpleasant thoughts and feelings), intrapersonal positive reinforcement (NSSI increases desired stimulation), interpersonal negative reinforcement (NSSI provides an escape from unpleasant social stimuli) and interpersonal positive reinforcement (NSSI is a means of help-seeking). The functions of self-injury proposed by Nock (2009, 2010) are complex, and involve both internal cognition and external interaction with environments.

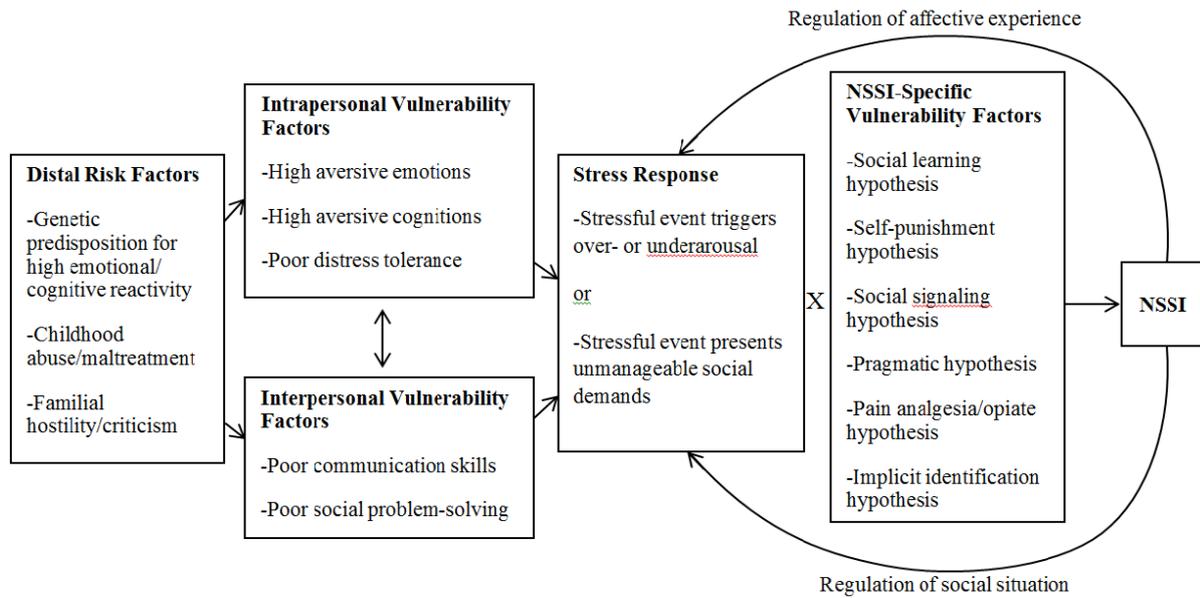


Figure 1. An integrated theoretical model of the development and maintenance of non-suicidal self-injury (Adapted from Nock, 2009, p. 79)

### NSSI and suicidality

Non-clinical samples have a lifetime NSSI rate of approximately one in five (Muehlenkamp et al., 2012). NSSI is clinically distinct from suicide, and not all individuals who engage in NSSI develop suicidal ideation or attempt suicide (Muehlenkamp, 2005; Muehlenkamp & Gutierrez, 2007). However, NSSI is a concerning behaviour as it is highly correlated with suicidality and suicide attempts, and some individuals who engage in NSSI do experience co-occurrence and future risk (Burke, Hamilton, Cohen, Stange, & Alloy, 2016; Klonsky, May, & Glenn, 2013; Nada-Raja et al., 2004; Nock et al., 2006; Reisner, Biello, Perry, Gamarel, & Mimiaga, 2014; Whitlock & Knox, 2007). Factors associated with NSSI and suicidal ideation/suicide attempts have been established. Trauma (Whitlock & Knox, 2007), childhood sexual abuse (Coppersmith et al., 2017), higher proportion of psychiatric disorders (Nock, 2009; Taliaferro & Muehlenkamp, 2015) and lesser levels of parental support (Whitlock, Muehlenkamp, et al., 2013), are all risk factors for both NSSI and suicide. A number of studies also connect LGBTQ identities to higher instances of NSSI and suicide

risk (King et al., 2008; Skerrett, Kølves, & De Leo, 2015; Stone et al., 2014; Wichstrøm, 2009).

One theory on the connection between NSSI and suicidal behaviours credits reduced inhibition through habituation (Whitlock, Muehlenkamp, et al., 2013). To clarify, the engagement in NSSI conditions the individual to perceive it as normal. When this self-injurious behaviour becomes a baseline, acceptance of more lethal behaviour grows. Furthermore, the physical act of deliberately destroying bodily tissue becomes increasingly tolerated over time. Normalisation of these behaviours subsequently serves as a link to suicidal patterns and behaviours.

The presence of both NSSI, and suicidal ideation and behaviours contributes to increased severity of symptomology (Andover et al., 2012). Even when an individual has ceased engaging in NSSI behaviour, the presence of self-inflicted scars continues to predict suicidal ideation and attempts (Burke et al., 2016). Early intervention and treatment for NSSI is paramount, as understanding the mechanisms behind why people self-injure can play a role at minimising future suicidal behaviours (Andover et al., 2012; Whitlock & Knox, 2007)

## **2. NSSI and LGBTQ communities**

Research with the LGBTQ communities has identified discrimination and stigma as specific risk factors which perpetuate poorer health outcomes for this minority group. Family, developmental, and social histories are cited as contributing factors to the presentation of pathologies in LGBTQ individuals, including an over-representation in NSSI statistics (Deliberto & Nock, 2008). Minority stress (Meyer, 2013), bullying (Lucassen et al., 2011), family rejection and homelessness (McDermott, Roen, & Scourfield, 2008), and difficulties in accessing health care services (due to fear of being outed or discriminated against by health professionals; Clark et al., 2014; Lucassen et al., 2014) are factors which also

exacerbate mental health problems for this group. Sex, sexuality and gender diverse individuals also experience more domestic abuse than their heterosexual siblings, have similar rates of intimate partner violence to heterosexual couples, and experience further trauma every day through homophobia, transphobia and microaggressions (Brown & Pantalone, 2011). Microaggressions, in particular, can come from both within the queer circles, and from outside of the LGBTQ communities (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016).

There is a general lack of demographic statistics on the prevalence of LGBTQ individuals in Aotearoa/New Zealand, or indeed overseas. While reasons for this are varied, it may be primarily attributed to the difficulties of measuring gender and sexuality. A report presented by Statistics New Zealand (2008) discussed including a sexual orientation question within the Census. The report cited inconsistency in defining terms, people's misunderstanding of said terms, and sampling difficulties due to uneven geographic distribution as reasons why they would not go ahead with the proposed changes. In 2015, Statistics New Zealand proposed a new gender identity standard for the upcoming Census of 2018, which would include the option of gender-diverse alongside male and female. While this would have provided useful data relating to non-cisgender individuals, it was vetoed, perhaps for similar reasons. The lack of clear terminology has been cited as a limitation in research with queer individuals previously (Greaves et al., 2017; Lee et al., 2016).

One of the studies which looked at the prevalence of non-heterosexual people of Aotearoa/New Zealand was the research of Greaves et al. (2017). The New Zealand Attitudes and Values Study (NZAVS) featured an open-ended measure, consisting of the question "How would you describe your sexual orientation?" While this question had a number of limitations, it put the non-heterosexual cohort at 5.8% (94.2% heterosexual, 2.6% gay or lesbian, 1.8% bisexual, 0.6% bicurious, 0.5% pansexual and 0.3% asexual). In line with this,

the research of Lucassen et al. (2015) evaluated sexual minority youth to represent 6% of the total sample of high-school students surveyed in Youth'12. The same survey reported 1.2% of young people who identified as transgender, 2.5% were unsure about their gender and 1.7% who did not understand the question (Clark et al., 2014). Using an open-ended measure for both gender and sexuality in a sample of 1234 university students, Treharne and Beres (2016) reported similar statistics in gender identity (1.1% identified as other than male or female). However this study had a much larger proportion of students who identified as other than heterosexual (28.8%).

It is possible that the inconsistencies in these figures are a result of the contextual and cultural implications of being an out LGBTQ individual. Specifically, the research of Treharne and Beres (2016) was amongst university students, a cohort which may be more liberated and open when it comes to exploring sexual attraction. The authors speculate that the passing of the Marriage (Definition of Marriage) Amendment Act in 2013 led to the increase of queer identity self-reporting. The act also passed a year prior to the NZAVS being conducted, and this has been shown to have contributed to larger response rates on questions of sexuality than previous research displayed (Greaves et al., 2017).

### **Definition considerations**

Similar to NSSI, research into sexual and gender minorities have been inconsistent in terminologies used. Sexuality and gender identity labels are personal, and some are used for political reasons (Jourian, 2015). Terminology used in research might not be reflective of how an individual chooses to identify, or they might not feel comfortable with sharing this information as they are still undergoing the process of identity forming (Skerrett et al., 2015; Stone et al., 2014). Furthermore, using research-prescribed measures rather than participant self-generated open box answers, means that prevalence rates of different sexual orientations

and gender identities are inconsistent. As the data collection formats are varied across studies, so too are the gender and sexuality statistics (Greaves et al., 2017).

There are three common dimensions through which an individual's sexual orientation is ascertained: sexual or romantic attraction; self-reported behaviour; and sexual identity (Greaves et al., 2017; Statistics New Zealand, 2008). The results reflect the measure chosen by the researcher, but can be incomplete and limiting. The terms under the umbrella of LGBTQ are further confined as they are predominantly of Western origin (Clarke et al., 2010). Due to this significant variability between terms, research constructed measures have not been able to adequately capture the prevalence of LGBTQ individuals in a general population sample, nor their future suicide risk (Stone et al., 2014).

Furthermore, researchers have experienced limitations, even when only looking at the subject of sexuality. Deliberto and Nock (2008) looked at the lesbian, gay and bisexual sexual identities. The options provided to participants were "heterosexual", "homosexual", "bisexual" and "other". However, the authors did not keep these groups as separate and rather, created a heterosexual group and merged the rest into a non-heterosexual group. This, as the authors themselves point out, was restrictive, as it did not permit analysis into the differences between the bisexual and homosexual subgroups and their respective NSSI trends. This research also failed to consider gender diversity, such as transgender individuals, and only looked at the sexuality of their participants, which further restricted the conclusions which could be drawn.

One of the proposed way for accurately representing queer and trans individuals in quantitative research is by using a single open-ended measure item (Fraser, under review). However, this method can become subject to prejudice through cisnormativity and heterosexism. To illustrate, a total of 13.1% of the participants in NZAVS answered the

open-ended question on sexuality with ‘standard’, ‘mainstream’, ‘normal for a man’, ‘god ordained- only my husband’ and other similar homophobic microaggressions (Greaves et al., 2017). Treharne and Beres (2016) had an identical experience with two participants, where normal was used instead of, or alongside, ‘straight’. This reflects the ongoing prejudices faced by the LGBTQ communities, where they are still seen as ‘abnormal’. It is possible that covert views like this contribute to a climate of internalised homophobia and further affect the rates of self-identification.

As there is no unified terminology for sexuality and gender identities (Lee et al., 2016), it can be challenging to understand the mechanisms underlying NSSI in these individuals. A binary understanding of gender (male/female) features heavily in NSSI research, however not only is it impossible to generalise these findings to individuals whose gender identity is outside the binary, but they are also extraneous. While some queer individuals may identify with the male/female markers, others might view their gender as existing on a spectrum (McPhail, 2004). The prevalence rates of NSSI in transgender individuals, when the research asks only male/female gender question are unreliable, as not all trans individuals identify with the gender binary (Ansara & Hegarty, 2014). If research is to target risk-factors and epidemiology of NSSI in rainbow individuals, it needs to take into consideration that providing only two gender options is restrictive, and that there are multiple gender identities.

In questionnaire or survey measures, having male and female as the only identifiers of sex or gender can further alienate those whose gender identity is non-linear (McPhail, 2004). People who identify as non-binary, intersex, gender neutral, gender-queer, questioning, or those who identify with indigenous gender identities such as takatāpui or fa'afafine, are erased through the Western heteronormative default of the gender binary. Treharne and Beres (2016) address the frustration faced by individuals who do not fit one or other of the gender

binary, and thus are not adequately represented in demographic measures. Treharne and Beres (2016) suggest that researchers need to be sensitive to non-normative gender identities and sexual orientations. In recent years, there has been an increase in research tailored to non-binary or gender nonconforming individuals. While this is a growing field, previous research that sets precedents in the field of NSSI does not take into account non-binary identities, with the consequence that the research renders these identities invisible.

### **Historical pathologisation**

In order to understand the impact and importance of LGBTQ research as it exists today, it is paramount to address the context from which it emerged. Historically, individuals who identify under the LGBTQ umbrella have been subject to pathologising, deficit-focused research (Snyder, 2011). Seen as a disease, those who engaged in homosexuality were viewed as sexually deviant and morally reprehensible from medical, political and socio-cultural standpoints. Queer and trans individuals have been subject to unethical treatments at various times and in various geographical locations. These range from conversion therapy in the USA, to chemical castration in the United Kingdom, to surgical lobotomies (Clarke et al., 2010).

The early 1970s saw the emergence of the gay liberation movement in the USA and other countries in the global north, beginning in 1969 with the Stonewall riots, an event central to modern LGBTQ rights (Duberman, 1994). The uprising at Stonewall served as a catalyst for gay activism, in particular in the field of mental health. In 1970 and 1971 the annual American Psychiatric Association (APA) meetings were disrupted by queer activists in a bid to challenge the pathologisation of homosexuality (Drescher, 2015). These protests were successful and led to gay activists hosting panels with the APA, educating them on the

stigma caused by the systemic pathologising of homosexuality in the psychiatric community (Clarke et al., 2010; Drescher, 2015).

The pathologising of homosexuality, in the second (“Sexual orientation disturbance”) and third (“Ego-dystonic homosexuality”) editions of the Diagnostic and Statistical Manual (DSM; APA, 1968; 1980) had real-life implications for LGBTQ individuals. Largely, it was used as a precedent for the social condemnation of homosexual individuals on the basis of immorality (Clarke et al., 2010), and normalised stigma and discrimination (Drescher, 2015). The complete removal of homosexuality from the DSM came in 1987, with the revision of the third edition (APA, 1987). With it came a major reform in attitudes on sexuality, which was echoed in legislation around the globe (Clarke et al., 2010; Drescher, 2015; Duberman, 1994). The non-cisgender population, however, was not a part of this shift.

Advances towards acceptance of transgender and non-binary individuals have been gradual. The diagnosis “Gender identity disorder”(GID) first appeared in DSM-III under the chapter of psychosexual disorders (APA, 1980). As with homosexuality, the designation of non-cisgender conformity as a mental illness resulted in discrimination and oppression. The DSM simultaneously demonstrated how transgender individuals were viewed by the medical community, reinforced the belief that non-cisgender identities were seen as a mental illness, and gave permission to members of society to oppress non-cisgender individuals on that basis (Amber & Stephanie, 2009).

With the publication of DSM-5, GID was renamed “Gender dysphoria” (GD) to better reflect and validate the existence of transgender individuals (APA, 2013). While the previous diagnosis of GID focused on pathologising the individual, GD defines the clinical problem as the dysphoria caused by the incongruence between an individual’s sex assigned at birth and their gender identity. Gender dysphoria is now separated from sexual dysfunction and

paraphilias in the DSM-5. There are numerous articles which commend the change of criteria and attribute the new diagnosis to the progress of wider acceptance in understanding transgender individuals and identities (DeFeo, 2015; Heffernan, 2012; Moran, 2013; Winters, 2012). However, while this definition shift is a move toward acceptance, the fact that GD remains in the DSM-5 indicates it is still seen as psychologically abnormal.

Despite the overall progress, stigma and discrimination still permeate the rainbow communities. The diagnoses of the DSM have been exploited by anti-LGBTQ groups to propel the arguments that queer individuals are deviant, despicable and dysfunctional (Amber & Stephanie, 2009; Clarke et al., 2010; Drescher, 2015). These discriminatory ideas are still present in societies, and are reflected in a number of ways. For example, beginning in September 2017 Australia held a plebiscite asking participants whether the law should be changed in favour of marriage equality. The Australian Marriage Law Postal Survey drew strong divisive campaigns on both sides. Those in opposition have targeted LGBTQ individuals with vitriolic force, further prejudicing this already marginalised group (The Equality Campaign, 2017). Despite the challenges faced by the opposition, the majority of voters (60.6%) advocated in favour of marriage equality. As a result of the postal survey, the Australian senate presented the marriage equality bill before its members, and Australia became the 25<sup>th</sup> country to legally recognise same-sex marriage (Marriage Act, 1961).

Non-cisgender identities continue to be pathologised in the DSM. Conversion therapy, though now considered unethical and obsolete, is still being practiced by psychologists today (Dart, 2017; National Center for Lesbian Rights, 2017). In many countries homosexuality is criminalised, and in some it is punishable by imprisonment or death (Stonewall, 2017). The current shifts in research to understand rather than fix queer individuals should not be underestimated. These shifts are inherently political in their nature, changing the fabric of society and saving lives. It is impossible to write a thesis on the LGBTQ communities

without that process becoming in itself an act of activism. The changes in the DSM represent a movement away from a previously stigmatizing climate to a more receptive one (Clarke et al., 2010; Drescher, 2015). The exposure gained from this spotlight focuses attention on existing conversations and works to destigmatise the minority groups that have, throughout history, been targets of hate-speech, discrimination, and brutality.

Over the last few decades, Aotearoa/New Zealand has made great strides towards acceptance of LGBTQ individuals. The Homosexual Law Reform Act passed in 1986, and legalised consensual sexual relations between males over the age of 16. The Human Rights Act (1993) outlawed discrimination on the grounds of sexual orientation. The Civil Union Act (2004) formally acknowledged the legality of homosexual relationships in the same capacity as heterosexual relationships. In 2013, the government of Aotearoa/New Zealand amended legislation to formally recognise same-sex marriage (Marriage (Definition of Marriage) Amendment Act, 2013). While these shifts have been considerable, results from recent research still indicate significant disparities between the lives of young LGBTQ people of Aotearoa/New Zealand and their cisgender, heterosexual peers (Clark et al., 2014; Lucassen et al., 2014).

### **NSSI and suicidality in sex, sexuality, and gender minority individuals**

As has already been stated in this thesis, there is an established link between NSSI, suicidal injury and increased levels of suicidality (Andover et al., 2012; Muehlenkamp & Gutierrez, 2007; Skegg, 2005; Whitlock & Knox, 2007; Whitlock, Muehlenkamp, et al., 2013). Identifying as LGBTQ has been correlated as a strong predictor for both NSSI (Garisch & Wilson, 2015; Power et al., 2015), and DSH and suicidality (Björkenstam et al., 2016; King et al., 2008). As people within queer and trans communities are already considered to be at-risk groups for these behaviours, those who engage in NSSI are even

more susceptible to negative health outcomes (House, Van Horn, Coppeans, & Stepleman, 2011; Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003). Results within Aotearoa/New Zealand highlight the importance of researching these populations. Minority stress is a vulnerability factor for LGBTQ youths. Therefore, it is of paramount importance to address these groups and their unique experiences within research, to understand how health professionals and families can provide compassionate, tailored support.

When organised as subgroups by sexual identity, bisexual females were more likely to report poor mental health (Kerr, Santurri, & Peters, 2013), suicidal ideation and suicide attempts (Blosnich, Nasuti, Mays, & Cochran, 2016; Shearer et al., 2016) compared to other LGBTQ subgroups, and bisexual females also had higher NSSI rates than both lesbian and heterosexual women (Sornberger, Smith, Toste, & Heath, 2013; Swannell, Martin, & Page, 2016). A meta-analytic review into sexual orientation and NSSI conducted by Batejan, Jarvi, and Swenson (2015), found that, on average, people who identified as sexual minorities were three times more likely to engage in NSSI than heterosexual participants, with bisexual individuals being at highest risk. Those who identify as bisexual may experience additional stressors, such as instances of biphobia from both heterosexual and homosexual social groups. Similarly, in an integrative review Jackman, Honig, and Bockting (2016) found differences between subgroups, and reported that bisexual and questioning individuals were found to be at an increased risk for NSSI, as were transgender and non-binary individuals.

Identifying as sex, sexuality, and gender diverse has been associated with higher instances of NSSI and suicidal behaviours (Clark et al., 2014; Lucassen et al., 2011; Reisner et al., 2014; Skegg et al., 2003; Swannell et al., 2016; Tsypes, Lane, Paul, & Whitlock, 2016; Whitlock et al., 2011). Deliberto and Nock (2008) found a significant increase in self-harming behaviours in individuals who experienced same-sex attraction (32.6% versus 11.1% in the control group). Reisner et al. (2014) used a representative sample in their study, of

which 7% identified as LGBQ (lesbian, gay, bisexual, and questioning). This small proportion of the sample accounted for 67% of NSSI cases and 80% of total youth suicide attempts. Using an online LGBT (lesbian, gay, bisexual, and transgender) sample, Bryan and Mayock (2017) reported an 18% lifetime prevalence rate of suicide attempts amongst this group. In another online research, which focused on transgender adults, Dickey, Reisner, and Juntunen (2015) reported that 41.9% of the sample had a lifetime history of NSSI. In a sample of adults “diagnosed with transsexualism” (p.485), Davey, Arcelus, Meyer, and Bouman (2016) found that 19% of the participants who were in the medical system waiting for gender confirmation surgery, were also currently engaging in NSSI. The experience of NSSI in transgender individuals is particularly complex, as it involves an added stress of having to acquire the pathologising GD diagnosis before a person is able to medically transition. This can mean that NSSI becomes interwoven into the gender identity as a way in which to signify dysphoria-related distress (Roen, 2015).

Clinical samples report a higher rate of self-injury than non-clinical samples (Garisch & Wilson, 2015; Stewart, Baiden, & Theall-Honey, 2014; Wilson & Youth Wellbeing Study, 2015). Nock et al. (2006) reported that a staggering 70% of adolescents who engaged in NSSI had also made at least one suicide attempt. Queer and transgender individuals have a high rate of psychiatric disorders (Chakraborty, McManus, Brugha, Bebbington, & King, 2011; King et al., 2008; Rimes, Goodship, Ussher, Baker, & West, 2017), and therefore may be overrepresented in both clinical and non-clinical cohorts. Furthermore, lesbian and bisexual women who engage in intentional self-injury present for medical care at rates higher than heterosexual women, and at an earlier age (Björkenstam et al., 2016). Thus, providing tailored, competent treatment, and focusing on effective prevention strategies are both required.

There are specific risk factors associated with NSSI engagement in sexual and gender minority individuals. Challenges with identity formation and overall identity confusion can

contribute to higher rates of NSSI (Claes et al., 2014). Previous trauma (Brown & Pantalone, 2011), gender dysphoria (Peterson, Matthews, Copps-Smith, & Conard, 2016), loneliness, hopelessness and internalised homophobia (Nickels, Walls, Laser, & Wisneski, 2012) have also been proposed as risk factors which aggravate instances of NSSI for queer individuals. House et al. (2011) conducted an internet survey with LGBT (lesbian, gay, bisexual, and transgender) participants. The results demonstrated that interpersonal trauma and sexual discrimination were both predictors of increased risk for NSSI behaviours.

While LGBTQ individuals wish to seek support, findings have shown that this can often be a challenging task. The research of McDermott (2015) highlights that queer youth find it difficult to ask for support, struggle to articulate their distress, and find the process shameful. The heteronormative and cisnormative social climate plays a role in this. When seeking access to health care, LGBTQ individuals report experiencing gender- and sexuality-based discrimination. The research of McNair and Bush (2016) suggests that same-sex attracted women have sought support from health professionals at rates higher than heterosexual women, however the quality of this experience was much lower. James et al. (2016) report that one-third of transgender participants in their survey have had negative experiences with health professionals in the past year. These experiences included verbal abuse from health professionals, and refusals to provide treatment on the basis of their gender identity. Almost one-quarter of participants did not seek medical treatment out of fear of mistreatment by medical staff. In an internet survey, which examined help-seeking for NSSI in sexual minority adolescents, Zaki, Gross, and Pachankis (2017) reported that bisexual youths were reluctant to seek professional help. Consistent with this finding, Clark et al. (2014) reported that the rate of New Zealand trans-identifying adolescents who were unable to access health care was double the rate of non-trans participants. For LGB (lesbian, gay, bisexual) adolescents this rate was 35% (Lucassen et al., 2014). These figures are concerning,

as the Unhealthy Attitudes report by Stonewall (Somerville, 2015) details that one in ten health and social care practitioners do not feel confident in responding to the needs of lesbian, gay and bisexual patients, while a quarter do not feel confident in providing responsive services and support to those who are transgender.

Furthermore, the research of Somerville (2015) reports that one in six health and social care practitioners do not see sexual orientation as an important consideration for treatment. This poses a further problem. While disregarding sexuality may be seen as a way of normalising of lesbian, gay and bisexual identities, it fails to take into the account the specific stressors sexual minority individuals may experience (Muehlenkamp, Hilt, Ehlinger, & McMillan, 2015). Being responsive to the needs of sex, sexuality and gender individuals requires acknowledgement of their identities and the environments that shape them (Fisher, Poirier, & Blau, 2012). Alongside this, health professionals also need to provide inclusive care for transgender and non-binary individuals (dickey, 2017; Frohard-Dourlent, Dobson, Clark, Doull, & Saewyc, 2017).

There is a dearth of research into prevalence of NSSI in non-cisgender individuals. In a systematic analysis, Marshall, Claes, Bouman, Witcomb, and Arcelus (2016) identified only five studies which addressed this relationship. This vulnerable group needs more attention, as transgender participants were found to engage in higher rates of NSSI and suicidality than cisgender participants. In a sample of transgender individuals, a lifetime prevalence of 37% for NSSI was found (Claes et al., 2015). Specifically, NSSI was found to be significantly higher in transmen (57.7%) than transwomen (26.2%). Arcelus, Claes, Witcomb, Marshall, and Bouman (2016) reported a lifetime rate of NSSI at 46.3% in trans individuals receiving care at a gender clinic. Those who engaged in self-injury experienced more interpersonal problems and transphobia, and had higher general psychopathology compared to trans individuals who did not engage in NSSI. The participants of the U.S. Transgender Survey

(James et al., 2016) reported a lifetime attempted suicide rate of 40%, nearly nine times the national average.

Scarcer still is research into individuals who identify with indigenous genders and sexualities, who engage in NSSI. Studies that have looked at LGBTQ individuals by race and ethnicity have found inconsistent results. While some research showed no race/ethnic differences between NSSI behaviours in rainbow sub-groups (Walls, Laser, Nickels, & Wisneski, 2010), other research compared the NSSI rates between homosexual and heterosexual groups. For example, Lytle, De Luca, and Blosnich (2014) examined the prevalence of self-injury in LGB (lesbian, gay and bisexual) individuals by racial and ethnic differences. All racial and ethnic LGB groups had significantly higher instances of depression, self-injury, suicidal ideation and suicide attempts when compared to heterosexual individuals. Multiracial and 'other race' identifying participants had the highest risk. This is consistent with research which routinely compares LGBTQ individuals to heterosexual groups, however comparison between subgroups would have rendered more compelling results. Similar findings were also reflected in the research of Bostwick et al. (2014), who found that sexual minority participants (who were also racially and ethnically diverse) reported higher rates of self-injury, suicidal ideation, and suicidal attempts when compared to non-LGB individuals. The authors further found that within sexual minorities, Latino and American Native/Pacific Islander youths had significantly higher suicide attempt rates, and that Asian and Black youths were less likely to engage in self-injury, and had fewer instances of suicidal ideation and attempts when compared to White sexual minority youths and thus had more protective factors (Bostwick et al., 2014).

One main resilience factor for LGBTQ youth engaging in NSSI has been the support of family (Bryan & Mayock, 2017). In particular, family support served as a protective factor in both NSSI and suicidality (Reisner et al., 2014). Family connectedness has been shown to

reduce the likelihood of suicidality and suicidal ideation in youth in general (Taliaferro & Muehlenkamp, 2014). The research of Benau, Jenkins, and Conner (2016), which explored the impacts of parental monitoring, suggested that having supportive and understanding family environment decreased NSSI engagement in both heterosexual and homosexual youths. However, participants who did not identify with either homosexual/heterosexual identities, but rather had a mixed sexual orientation, were most likely to engage in NSSI regardless of the levels of parental monitoring. In general, having a trusted non-judgemental adult present, served as a protective factor against self-injury (Nickels et al., 2012; Walls et al., 2010).

In interviews with their LGBT (lesbian, gay, bisexual and transgender) participants Scourfield, Roen, and McDermott (2008), factors contributing to resilience were: the ownership of the queer identity through resisting pathologisation; fighting back against stigma and discrimination when bullied, which developed a stronger sense of identity; and finding safe spaces with trusted people. The research of (Wichstrøm, 2009) also highlights both family harmony and social support as protective factors against NSSI and suicide attempts. The research of Denny et al. (2016) found that supportive school environments contributed positively to the wellbeing and self-esteem of male sexual minority youths. Whitaker, Shapiro, and Shields (2016) found that school connectedness served as a protective factor against suicidal ideation for LGB (lesbian, gay and bisexual) youth. Together, these findings demonstrate the important role of family, healthy self-esteem, and community where an individual feels that they are able to express their identity without fear.

### ***The Aotearoa/New Zealand Context***

Results from Youth'12 survey reported that around half of the queer and trans youth surveyed have been hit or harmed by another person (50% of trans, 43% of same/both sex

attracted youths versus 33% non-trans) (Clark et al., 2013). Compared to 23% of heterosexual, cisgender participants who engaged in self-injury, queer youths were overrepresented in these statistics. Same and both-sex attracted participants reported being over twice as likely to engage in DSH as their heterosexual peers (59.4%), and nearly half (46%) of the transgender participants reported engagement in DSH (Clark et al., 2014; Lucassen et al., 2014). Same/both sex attracted youth were four times more likely to report having attempted suicide than their heterosexual counterparts. Transgender youth were five times more likely to have attempted suicide in the past year than cisgender youth.

Youth'12 also surveyed for risk factors, some of which were found to be consistent across both transgender and same/both-sex attracted youth. About one in five LGBTQ youths drank alcohol at least weekly in the past month, and a large number (41%) of both sexuality and gender diverse adolescents reported experiencing significant depressive symptoms (Clark et al., 2013, 2014; Lucassen et al., 2014). Indeed, Lucassen et al. (2015) found that there was an increase in reporting depressive symptomatology by sexual minority youths in 2012, when compared to the results of the same study in the year 2001. This increase was not apparent amongst sexual majority (heterosexual) youth. This finding was consistent with the systematic review and meta-analysis performed by Lucassen, Stasiak, Samra, Frampton, and Merry (2017), which found robust evidence for higher rates of depressive disorder and symptoms amongst the non-heterosexual group.

Skegg et al. (2003) examined gender differences and rates of deliberate self-harm in homosexual participants. Like previous work of this kind, the authors emphasised the difficulty with defining terms in both the homosexual and self-injury domain. There were two relevant questions which focused solely on sexual attraction. Self-injury was defined as 'deliberate self-harm regardless of intent'. Skegg et al. (2003) found a significant increase in self-harming behaviours in individuals who experienced same-sex attraction.

Utilising the data from Youth Wellbeing Study, Fraser et al. (2017) looked at prevalence of NSSI in sexual minorities. The sexuality question was measured using a five-point scale (100% heterosexual, mostly heterosexual, bisexual, mostly homosexual and 100% homosexual). While overall, LGB people were found to engage in NSSI at a rate five times higher than heterosexual participants and had a lifetime NSSI rate of 20.6%, Fraser et al. (2017) found that, contrary to previous research, those who identified as wholly gay/lesbian did not have a statistical difference in NSSI rates compared to heterosexual adolescents. Those who self-reported as 'mostly homosexual' and 'bisexual' were most at risk for NSSI engagement. This supports previous research that has found that bisexual individuals are at higher risk for self-injury.

The finding that individuals who identified as 100% gay or lesbian did not self-injure at higher rates compared to heterosexual participants can be interpreted in a number of ways. As queer identity formation is a gradual process, those who identify fully with gay or lesbian identities may have integrated themselves better and thus have more protective factors, such as support from friends and family. The gay and lesbian participants may also have been less likely to experience emotional confusion and distress if they were clearer about their identity and sexuality. Furthermore, the validation of marriage equality (2013) may have eliminated previous stigma attached to being gay or lesbian, while biphobia still remained in both heterosexual and queer communities. Small sample size (11) may have also contributed to insignificant results and as the authors point out, some individuals may simply not yet have come out. This is the most current research presented on NSSI in sexual minorities in Aotearoa/New Zealand, and caution in regards to the results must be exercised. If future research shows no significant difference between gay and lesbian participants then it is a small victory. However, these are just the first two letters of an acronym that encapsulates

multiple sex, sexuality and gender diverse identities, many of which are still subject to everyday stressors and negative life outcomes.

### ***Minority Stress Model and the Decompensation Framework***

Minority stress has been proposed as one of the main mechanisms in connecting LGBTQ individuals to high instances of pathology, NSSI and suicide. The Minority Stress Model (MSM; Meyer, 2013) suggests that minorities such as queer individuals are disproportionately stigmatized when compared to the heterosexual majority, and as a result of their minority status experience a multitude of stressors in their social environment which contribute to negative health outcomes. MSM frames NSSI as a risk-factor resulting from the compounding effects of discrimination and victimisation (Liu & Mustanski, 2012). Previous research has applied MSM and has shown results consistent with the model (Brennan et al., 2017; House et al., 2011; Muehlenkamp et al., 2015). Adaptations of the MSM have also addressed transgender and gender nonconforming individuals (Hendricks & Testa, 2012).

The primary focus of MSM is on external stressors which are by-products of the environment. Effects such as interpersonal prejudice, bullying and other compounding factors, such as low socio-economic status affect the individual who identifies as a minority. General life stressors are accentuated through specific minority stressors. For example, workplace stress is intensified when an individual experiences workplace discrimination. This leads to internalisation of negative schemas such as expectation of rejection, concealment of queer identity, and internalised homophobia. Combined with low levels of social support, these events and cognitions can lead to unfavourable mental health outcomes for gender and sexual minorities.

While MSM is a comprehensive framework, it neglects the fact that stress is a natural reaction to negative external events. When a stress response is the result of social norms, a

queer individual experiencing that stress does not have a choice in changing their situation or response. MSM does not take into account the internal stressors of the individual and instead views them as fixed results of the external environment. Additionally, in order for MSM to be applicable an individual must be out, at least to some degree, to experience the environmental stressors related to their out status. This does not account for the stress experienced by individuals who are questioning their sexuality, or those who have not yet come out. In the case of the participants of this thesis, all of whom engaged in NSSI before coming out, this model lacks substantiate evidence. The framework does not take into account factors for measuring minority stress-related negative outcomes for closeted populations. Furthermore, the model does not take into account resiliency factors, which are an important consideration for queer identities, since research is divided on which specific sub-groups experience most challenges.

The Decompensation Framework (TDF) proposed by Riggs and Treharne (2017) addresses these concerns. The authors challenge the definition of minority stress described by MSM, and argue that stress, by its very definition is produced in context of power dynamics. The focus of MSM is problematic, as it positions the gender and sexuality diverse individuals as the ‘stressed minority’ and stress as a social position. Thus, the MSM implies that the minority individual is liable for the discrimination they receive. Contrary to this belief, the fact that LGBTQ minorities experience minority-related stress is the result and function of the social climate in which the individual exists. Put simply, it is not the responsibility of the minority to not be distressed, as their stress is a natural response. The stress-related negative health outcomes are the culpability of the system within which the minority individuals exist, and individuals who put stress on minority groups through discrimination are further responsible. Riggs and Treharne (2017) go on to explain that the internalisation proposed by MSM means that the initial social stress becomes subjective and “reduced to individuals,

largely devoid of an account of the role of social norms in shaping how particular individuals may be rendered legitimate targets of negative regard” (p.595). Thus, the MSM framework holds the view that minority individuals are responsible for managing and dealing with stress which comes their way, and does not take into account the prejudiced environments in which the minority individuals exist as victims of circumstance.

TDF stipulates three key components which construct a framework. The first is ideology, the focus of which are institutionalised social norms. The ideologies to which a person is exposed, shape what it means to be an intelligible human being, and are conducive to stress. They are a basis through which stigmatisation becomes possible and contribute to the exclusion of the stressed, marginalised individual. Riggs and Treharne (2017) define the specific ideologies of the TDF as “ideologies of race, sex, gender, sexuality, class, and ability to enshrine particular bodies or identities as the norm, against which all others are compared” (p.596). Here ideological systems such as homophobia, transphobia and cisgenderism work to delegitimise the experiences of the LGBTQ group.

The second component for the TDF framework comes in the form of intersectionality. First introduced by Crenshaw (1991), intersectionality is based on the principle that each individual has multiple identity categories and these are all intrinsically linked, and affected by various ideologies simultaneously. Human identity is comprised of multiple facets, and needs to be considered in this context of multiple relationships at play. For example, aspects such as race, gender, sexuality and class overlap and are not mutually exclusive, and conceptualising stress from only one perspective (i.e. a racist ideology) is not sufficient, as multiple factors of ideology are interlinked. The MSM does not account for intersectionality as it solely addresses stress from a sexuality perspective. This is perhaps why results of LGBTQ research presented above have been so vastly varied; there is no uniform experience

in queerness. Instead, an intersectional approach considers the compounding effects on dominant ideological discourses.

The last component for stress, as conceptualised by the TDF, is the notion of privilege. As a theory, privilege is the antithesis of social inequity and oppression, and represents individuals who are positioned favourably in regards to dominant power systems (Riggs & Treharne, 2017). It comments on the automatic benefits gained by certain types of status, which typically arise from birth. Those who are a part of dominant, majority groups automatically gain privileges, which minority individuals are not privy to. Privilege relates to stress as social norms are established by the majority. Riggs and Treharne (2017) further elaborate on the idea that privilege can also mitigate marginalisation and therefore stress, as it is a factor for ascertaining resiliency. For example, homosexual individuals who are cisgender, white, and middle-class, automatically have more privilege and thus more protective factors than someone who is a lower-class, bisexual, trans individual of colour. Briefly put, ideologies privilege some individuals over others, and this becomes important in the context of intersectionality.

TDF highlights that decompensation is a product of failure to provide protection, support and inclusion to marginalised individuals, as a result of social norms guided by multiple ideologies. As aptly described by the authors: “To decompensate, then, is to cease being able to compensate, to cease being able to make up for the daily discrimination, to cease being able to prop oneself up in the face of ideologies that render one’s existence unintelligible” (Riggs & Treharne, 2017, p. 600). When an individual is not provided with the resources needed to counteract the effects of societal discrimination, repeated cumulative stress results in negative health outcomes. Therefore, to apply TDF to NSSI is to phenomenologically seek understanding into this behaviour.

### **3. Current Research**

There is robust quantitative evidence to support the notion that LGBTQ individuals engage in NSSI at disproportionately greater rates than heterosexual, cisgender individuals. However, these studies have been largely population based samples, which establish an association, but do not seek to understand the experiences of individuals who make up this group. The current research aims to explain connections already established through quantitative studies, by providing an opportunity to listen to personal stories and understand first-hand the way LGBTQ individuals of this study conceptualise their NSSI experiences.

#### **Existing qualitative research**

There is a paucity of qualitative research into experiences of NSSI from the perspective of sexually and gender minorities. The five studies presented here give an overview of themes which are prevalent in the existing research.

Participants in an online qualitative research questionnaire conducted by (McDermott, Roen, & Piela, 2015), conceptualised self-injury in three ways: engagement in self-injury as a result of homophobia and transphobia; self-deprecating feelings of hatred, fear, and shame; and as a separate behaviour not directly linked to gender or sexuality. The final theme also featured in another study. In their mixed methods research, Bryan and Mayock (2017), interviewed participants who spoke of their self-injurious behaviour as unrelated to their queer identity, or as part of a complex set of experiences.

Alexander and Clare (2004) conducted a qualitative study examining the subjective experiences of lesbian and bisexual women who engage in self-injury identified six themes. These covered: negative external experiences as precursors for NSSI, feelings of invisibility and invalidation, the fact that participants felt different to their peers, strong negative

emotions associated with these differences as one of the reasons for NSSI, and using self-injury as a coping mechanism (Alexander & Clare, 2004). The final theme addressed moving on from self-injury. Similarly, participants in the research by McDermott et al. (2008) conceptualised the reason for their self-injury as a way to cope with feelings of anger and shame.

The fifth qualitative study involved Japanese sexual minority participants, and explored suicidality and self-injury. The definition of “self-harm” was consistent with NSSI, and DiStefano (2008) reported that while suicidality was a serious issue, NSSI had a similar grave impact. Cutting was the most common method. Participants conceptualised self-injury as being in contrast to the intolerant culture of which they were a part; NSSI provided safety and psychological pain which they could control, versus the psychological pain brought on by ideologies which they had no control over. While the study reported a number of cultural differences, it highlighted that living in a prejudicial environment ruled by strict ideologies, contributed to negative health outcomes in the lives of Japanese LGBT individuals.

### **Relevance of this research**

The current research builds on previous literature to explore in depth what stressors influenced participants’ engagement in NSSI, the contributing risk and resiliency factors, the progression of the participants’ queer identities, and why they stopped self-injuring. It provides a unique opportunity to explore the full timeline of NSSI and its relationship to queer identities.

Tsypes et al. (2016) emphasises that frequency, versatility (the number of NSSI methods used) and functionality (reasons why individuals engaged in NSSI) are all crucial points to consider in sexual minority suicide prevention. Furthermore, more research is needed to address the onset and offset (cessation) of NSSI Deliberto and Nock (2008).

Factors contributing to successful NSSI cessation have been reported to include social and therapeutic support, and changes in how NSSI is perceived by the individual engaging in the behaviour (Kiekens et al., 2017; Whitlock, Prussien, & Pietrusza, 2015). The current research addresses factors relating to functionality, and understanding the mechanisms behind cessation of NSSI in the participants.

Qualitative research is pertinent to the field of NSSI and suicidology. Previous research into NSSI amongst the rainbow communities has largely focussed on explaining phenomenon applied through quantitative methodology. Whilst this has been hugely beneficial in establishing correlations, the research produced has not provided understanding into why LGBTQ individuals engaged in NSSI at disproportionate rates when compared to cisgender, heterosexual participants. The utilisation of qualitative methodology draws on the established quantitative literature, and provides robust discussion to help understand the nature of the subjective experience. Hjelmeland and Knizek (2010) support this view and state that while causal explanations are beneficial and provide the first step necessary to address the issue, they can be repetitive. The authors favour qualitative methodology as it allows the researchers to explore relationships between factors through hermeneutic inquiry.

In this bottom-up approach, subjective accounts provide the context in which researchers might understand certain phenomena. Because of this, qualitative research is needed to examine the perspectives of LGBTQ individuals first-hand (McDermott et al., 2013). The premise of the current research is based on this notion. Furthermore, through this work, the researcher aspires to understand the common themes of what matters to LGBTQ individuals who have engaged in NSSI and ascertain the needs to be addressed by health professionals in roles of support for future cases.

## **Aims and research questions**

As IPA follows an inductive approach (Reid, Flowers, & Larkin, 2005), the aim of the current study is to explore how LGBTQ people who have previously engaged in NSSI make sense of their experience. This research hopes to address some of the following queries:

1. Exploration into the participants' backgrounds and contexts which have shaped them.
  - a. Family, friends and social support
  - b. Experiences with stigma, discrimination and/or acceptance
2. The nature of the interaction between the participants' sexual/gender identity and NSSI, in particular during:
  - a. The onset and offset of their self-injury
  - b. The process of their coming out
  - c. Whether the participant's identity was influenced by NSSI and vice versa
3. The role NSSI played in participant's lives as shown by self-reflection.
  - a. How they were helped or hindered in their recovery
  - b. What observations did they come to on their journey
4. How the theoretical frameworks of NSSI and TDF reflect the experience of the participants.

## **Chapter 2: Method**

The central concern of this thesis is how LGBTQ individuals make sense of their past self-injury, and whether there is a relationship between the self-injury and their queer identity. These research questions shaped the nature of the data collection and a qualitative approach was followed. Participants were recruited via social media. Six semi-structured face-to-face interviews were conducted. Interviews were audio-recorded and transcribed. The finalised transcripts were analysed by the application of Interpretative Phenomenological Analysis (IPA). This research was approved by Massey University's Human Ethics Committee: Southern A.

### **A Qualitative Approach**

The methodology behind this research is grounded in qualitative epistemology. The basis of this methodology is that human experiences are inherently subjective, as the way individuals perceive the world is in the context of their environment (Smith & Osborn, 2004). Interpretative Phenomenological Analysis was employed, as it is a theoretical position which builds on idiographic perspective and the theoretical foundations of phenomenology and hermeneutics (Shinebourne, 2011). IPA was selected as the most suitable methodology for exploration of NSSI due to its grounding in health psychology, as self-injury is not a condition but rather a set of behaviours. It allows for multiple levels of interpretation, making the analysis a rich, creative process (Smith, 2004). Reflexivity, which is embedded in this approach, allows the researcher to have an interactive relationship with the data.

### **Interpretative Phenomenological Analysis**

The validity of qualitative research relies on shaping rich descriptive and personal accounts of human experience. It is this construction and interpretation of "the constituent properties of an entity" (Smith, 2007, p. 1) that propels first-person perspectives. The

qualitative researcher seeks to understand the world each participant is positioned within, utilising theories such as hermeneutics, phenomenology, and social constructionism (Smith & Eatough, 2007). In order to explore a different and complementary perspective to the largely quantitative focus within the existing literature, the current study focuses on examining subjective experiences through the use of data collection and analysis processes underpinned by the framework of IPA (Smith, Larkin, & Flowers, 2009).

IPA is a framework that works through the assumption that people are self-interpreting beings, and IPA engages both the researcher and research participants at an idiographic level (Pietkiewicz & Smith, 2014; Reid et al., 2005). IPA acknowledges that both researcher and participant have a part to play within the research, and thus the process, by default, is double-hermeneutic; the researcher is interpreting the researched, while the researched is interpreting their conceptualisations (Smith, 2011).

The IPA approach concerns itself with interpreting lived experience, usually obtaining data through one-on-one semi-structured interviews (Pietkiewicz & Smith, 2014; Smith et al., 2009). The focus of the interviews is meaning making, or more specifically, what matters to the participants and what does it mean in the context of their experience (Reid et al., 2005; Smith, 2007). This 'lived experience' paradigm has been challenged for its apparent simplicity (Chamberlain, 2011), however Larkin, Watts, and Clifton (2006) argue that when the theoretical underpinnings of IPA are honoured, the analysis produces conceptual, interpretative accounts that go beyond a simple description.

### **Reflexivity**

As the participants of this study make their own meaning and understanding, so too does the researcher. Awareness of the interplay between personal views, preconceived ideas, academic theories and frameworks, and being receptive to the participants meaning making is

crucial. Qualitative psychology, including IPA, provides room for reflexivity within the research. It positions both the researcher and the researched as living, experiencing beings and surmises that the two have a symbiotic relationship which affects the outcome of the research (Shaw, 2010). Meaning-making is contextual and involves a level of subjectivity (Shaw, 2010; Smith et al., 2009). The desire to seek understanding into the topic of LGBTQ individuals who engaged in NSSI was formulated through researchers' experiences.

Volunteering as a Youthline phone counsellor and peer support worker through the organisation Kites, meant that the researcher has had prior experience in communicating with people in distress, and was able to utilise strategies learned through training, such as strategies for building rapport, when interviewing her research participants. The researcher was guided by principles of empathetic active listening during the interviews. However the same experience that positively impacted on the interviews had to be consciously set aside during the analysis process, so as not to make assumptions and introduce bias.

The queer identity of the researcher provided an additional layer of knowledge when it came to writing this thesis; the vocabulary used by participants was accessible and commonplace to the researcher. This also meant that more unconventional terminology, as well as the use of gender-neutral pronouns, was anticipated and treated with respect. Additionally, on two occasions the disclosure of the researcher's identity allowed for rapport building with two participants who were otherwise reluctant to speak about their experience with somebody who was outside of LGBTQ circles.

There are multiple benefits to insider research. As suggested by Le Gallais (2008), if the researcher is known to the participants, rapport is much more efficiently established, and the time saved can be used in more meaningful ways during the interview. Holding an insider status allows the researcher to establish a level of trust which can make the participant

respond to questions with a higher level of insight, and contribute to more in-depth data. Furthermore, if the researcher is viewed as a peer, the relationships with participants are more empathetic, and the interpretation of data can provide a rich analysis. However this same familiarity can lead to researcher bias and for this reason reflexivity was utilised as a valuable tool and assisted in staying close to the research aims.

The insider status has a number of implications for reflexive practices. Having personal investment in one's research means there is a danger of losing the voices of participants as they get pushed aside in favour of the researcher's world view. These potential biases of the researcher mean that a conscious effort needs to be made to minimise assumptions. Two reflexive journals were utilised in the data collection and analysis for this study. The first reflexive journal was used to write down the researcher's thoughts, personal feelings of the process, and the challenges which came with hearing sincere, and at times tragic stories. The second journal was specifically for writing down the experiences of participants; making connections and establishing themes. The second journal was used in the writing of the results section.

Although due care was taken to separate the experiences of the researcher and the researched, the purposeful process of reflexivity allows the researchers to be positioned within their own research (Smith et al., 2009). As subjectivity can never truly be escaped (Shaw, 2010), the work that follows is likely to be coloured to some degree by the experiences of the researcher. One positive implication for the researcher is that it is easier to 'step into the shoes' of the participants (Pietkiewicz & Smith, 2014), having been guided by prior knowledge and personal experience. This reflexivity is a careful balance between not silencing participants in favour of the researcher's voice, while allowing the researcher to utilise the experience to aid in the interpretative process. As such, it is a consideration which was monitored throughout this research.

## **Ethical Considerations**

A number of ethical considerations were made for the purposes of this study. The focus was to get a cross-section of voices from within the queer communities. As the advertisement was open to all identities that fit the parameters, there was a possibility that cultural consultation might be required if a potential participant was Māori. A cultural consultant was consulted prior to the advertisement going live, to ensure the researcher's interactions were respectful of cultural differences.

In recruiting participants the main consideration was to do with rapport building. It was important not to alienate the potential participants and to allow them time to consider the implications of the study. For this reason, initial email communication was used to address questions and concerns. For example, one participant initially expressed distrust of researchers who, they felt, reduced the participants' identities to mere pathological conditions. The aims of the study were communicated to this participant, placing emphasis on the desire to hear about each subjective experience and not to generalise the LGBTQ communities. Another participant was concerned about the researcher's position as they did not want to be a part of a study if the researcher was heterosexual. The IPA methodology, which views the researcher as positioned within their research (Smith et al., 2009), allowed for personal disclosure of the researcher's position within the LGBTQ communities. This built rapport on a personal level, and the participant communicated that they felt comfortable proceeding with the interview.

In recruiting research participants in Wellington, Aotearoa/New Zealand, there was the potential that the researcher might know the participants personally. As the potential participants approached the researcher first, it was at their discretion whether or not they wanted to participate. In one instance, a person known to the researcher in general life

emailed expressing interest. The researcher stressed this real-life connection, its implications and assured confidentiality regardless of whether the individual chose to participate or not. This potential future conflict also extended to those whom the researcher did not know, but might meet in a different context in future. The Participant Information Sheet had a section emphasising this. If the potential participant did not feel comfortable with this, then the interview would not go ahead. It was made clear by the researcher that the participation within the study was confidential and that the participants had the right to withdraw at any time before the interview and seven days after, placing the decision with the potential participant.

Participants for this study were recruited due to past self-injurious behaviour, and the sensitive nature of personal experiences of NSSI was an ethical consideration, so that the interview process did not trigger new episodes of self-injury. Research in this area suggests that talking about suicidal behaviour and ideation does not increase distress or suicidality, rather, it can be beneficial to the participant (Gould et al., 2005). It was possible that the same might not apply to NSSI (Whitlock, Pietrusza, & Purington, 2013). The research implemented strategies for dealing with this by providing a list of local support services to all participants irrespective of whether they reported any distress during the interview. Distress was monitored throughout the interview and participants were encouraged to contact the researcher or research supervisor directly if they wished to discuss concerns.

A final consideration was the researcher's own position; being directly a part of the LGBTQ communities meant that this had to be addressed and managed. There was a personal bias in regards to the selection of the thesis topic, but it was of utmost importance not to let the personal investment interrupt the research process. During the interview process the author utilised tools such as active listening and minimal encouragers learned through prior counselling workshops. This meant that the experience of the participants was not

stifled by the researcher speaking. During the data analysis, the researcher was able to manage bias using techniques specified by Smith et al. (2009), such as immersing oneself in the world of the participant and making inferences from their perspective. Despite this, some subjectivity is inevitable. One of the reasons why IPA was chosen was to allow a space for reflexivity, through which the researcher's position was illustrated. Adopting this methodology meant that both the researcher and the research participants were able to provide input and retain their voices.

## **Design**

### **Recruitment of participants**

It has been suggested that small samples are best utilised in qualitative research in order to focus the analysis on depth rather than breadth, and a sample between six and eight participants is generally considered sufficient (Hefferon & Gil-Rodriguez, 2011; Pietkiewicz & Smith, 2014; Smith et al., 2009). The sample for this study comprised of six young adults between the ages of 18 and 26 living in Wellington, Aotearoa/New Zealand.

For LGBTQ individuals, social media is able to provide opportunities for informal teaching and learning, and the making of meaningful connections through online channels to people in remote locations, helping them feel less isolated in their queer identity (Fox & Ralston, 2016). The sampling of sexuality and gender minorities via the internet can provide effective response rates to address research concerns as it can be difficult to identify and reach potential participants in person (McDermott et al., 2013; Miner, Bockting, Romine, & Raman, 2012). The project design involved recruiting participants through individual and group pages on Facebook. An advertisement was posted on the private page of the researcher. A number of the researcher's social media contacts shared it on their private Facebook pages.

The researcher also approached and gained approval from administrators to post the advert on the following community pages:

- Gay Wellington – A Facebook group of the Wellington Gay Welfare Group, set up to help disseminate news and discussions for the sex, sexuality and gender diverse communities.
- Genderbridge NZ - A Facebook group for the organisation Genderbridge which provides peer support to transgender and gender diverse people, their whanau and friends.
- Gender Minorities Aotearoa- A Facebook group for the peer led, cross cultural organisation which provides information and resources and advocates for the rights, health, and well-being of all transgender, transsexual, takataapui, intersex, and other sex and gender minorities in Aotearoa (Gender Minorities Aotearoa, 2017).
- Rainbow Connections Wellington – A page set up to connect the Wellington rainbow communities and share news, events and resources.
- Rainbow Wellington- A Facebook group of the non-profit association which educates communities at large on lesbian, gay, bisexual, transgender and intersex issues. A place to share information.
- Transgender and Intersex NZ - A group which provides a supportive social environment for sex and gender minority people and their whanau.
- UniQ Victoria- A Victoria University student run queer representative group.

The reasons for this social media recruitment approach in partnership with LGBTQ organisations were twofold; to reach beyond the researcher's personal networks with the help

of others “sharing” the advertisement, and to foster credence in the research by having respected and established Wellington LGBTQ spaces publicise the project.

The advertisement, outlining what the study brief and that data was being collected via interviews, included inclusion criteria for potential participants. These were age (18-30 years), identifying as LGBTQ (or sex, sexuality and gender diverse), a history of self-injury, abstinence of self-injury for at least the past three months, and the willingness to speak about personal experience. The participants also had to be able to give informed consent and undertake the interview in English. Discretion and confidentiality were emphasised on the advertisement. Those who were interested in finding out more about the project, or participating in the project after viewing the posting on Facebook, were invited to email the researcher directly.

The age range for participation was capped as the focus of this study was on young adults, who had ceased engaging in NSSI. The terms ‘sex, sexuality and gender diverse’, ‘queer’ and LGBTQ were included in the advertisement to reflect the transitory nature of terminology, and to provide options to those who did not identify as lesbian, bisexual, gay, transgender or queer/questioning. This broad definition was intentional as one focus was to address a lack of LGBTQ research in this area and to identify individual voices within this group who might not have qualified under narrow terminology. The goal was to reflect the diversity within non-heterosexual and gender non-conforming communities.

The use of the definition of “self-injury” rather than NSSI was a purposeful decision. The researcher consulted with administrators of the pages prior to posting the advert and found that the use of the prefix “non-suicidal” could have been triggering to some members of the selected groups. The term NSSI and its definition was used in the Participant Information Sheet (Appendix A), and clarified with those who emailed the researcher.

## **Data collection**

When a potential participant made initial contact with the researcher a response was sent addressing the questions they might have had, as well as the Participant Information Sheet and consent form (Appendix B). They were asked to read through the forms to see if they met the inclusion criteria, and if they were still interested to let the researcher know of suitable times to meet. The next stage of the communication process was arranging the interview. Two options for the suitable location were provided: a private room within the library of one of the two Wellington universities. It was clarified that the interview would last approximately an hour and would be one-on-one, although if the participant desired they were able to bring in a support person with them. Location, time and date was set up and was confirmed by the researcher as a reply to the participant and then as a separate email reminder the day before the meeting. Six individuals took part in the research.

## **Interviews**

Data was collected via a semi-structured interview schedule (Appendix C) to keep the interview on track and make sure each of the study aims were addressed. Hard copies of the consent form and the Participant Information Sheet were provided to the participants. A list of local support services was provided to the participants to utilise if they wanted. One \$20 supermarket voucher was given in recognition of the participant's travel and time. At the start of the meeting each participant was asked to read through all the forms alongside the researcher, and to sign the consent form. The participants were encouraged to ask any questions they might have before and during the interview, and to clarify anything they were unsure about. Participants were informed of the option to decline to answer any question which they were uncomfortable with, the ability to stop the interview at any point, and the option to withdraw or amend their interview data from the study at any time up to seven days

after the interview. They were also given the option to receive a summary of research findings. The option to receive a summary of the research findings was taken by all participants. None of the participants withdrew their data. Interviews commenced after the participant signed the consent form. All interviews were audio recorded and semi-structured as guided by the processes of IPA (Smith et al., 2009).

To alleviate the initial nervousness of the participants which is often associated with being recorded (Smith, 2007; Smith et al., 2009) the first few questions were general. Each participant was asked demographic and identity questions relating to the study. It is custom when speaking to individuals within the queer communities to clarify their preferred pronouns to avoid misgendering through one's own assumptions. The descriptors in Table 1 were to be used to establish how the participants self-identified, and provided a respectful way to begin inquiry into their experience. Two of the participants used gender-neutral pronouns (them/they) and the four remaining used the female pronouns (she/her). Questions surrounding gender identity and sexuality were also asked at the beginning, to provide a clear understanding of the context through which they spoke of their world-view.

Some participants, Sam for example, demonstrated that they used multiple terms interchangeably: *"I identify as queer as well, previously it was more bisexual but now it's more focused on queer people as a broad spectrum"*. Others, like Ruth, spoke of the progression of their identities: *"If people ask me I'll probably say lesbian because I'm in a committed female relationship, but in the past I would have identified as bisexual"*.

Table 1

*Participants' identity information*

<u>Pseudonym</u>	<u>Age</u>	<u>Preferred pronouns</u>	<u>Gender Identity</u>	<u>Sexuality</u>	<u>Other Identities</u>
Lisa	18	She/her	Transgender female	Heterosexual	
Ruth	19	She/her	Cisgender female	Lesbian	Bisexual/Queer
Hilary	22	She/her	Cisgender female	Lesbian	
Abby	26	She/her	Queer	Queer	Lesbian
Charlie	26	They/them	Non-binary	Asexual	Aromantic
Sam	24	They/them	Gender neutral	Queer	Bisexual

Questions about NSSI were structured according to a historical timeline of events; when NSSI first started, how it progressed and when it ceased. Questions about queer identity were similarly addressed, with inquiry into interpersonal relations past and present, and how the participants saw their identity at the time of the interview. Open-ended questions allowed participants to answer in-depth, with prompts inquiring deeper into the nature of the response (Pietkiewicz & Smith, 2014).

The interview followed the structure on an arc, where the more personal and sensitive questions were asked in the middle of the interview so the participants had the chance to process any heightened emotions that may have occurred as a result of inquiry and reassert to

their usual demeanour (Pietkiewicz & Smith, 2014; Smith et al., 2009). A week after each interview was completed (to allow participants the option to withdraw or amend their data) the interview was transcribed. Pseudonyms were created and identifying personal details were removed from the transcripts.

## **Data Analysis**

### **Individual transcripts**

The analysis of the interviews followed the general guidelines outlined by Smith et al. (2009) and followed the IPA approach. Within this study, the focus was on presenting an account from LGBTQ communities and exploring the phenomena of NSSI within this group. Initial reading of completed transcripts was done alongside the interview recordings. This allowed the researcher to remember the environment in the interview room. Notes were made on perceived emotions in the voice and intonation of participants. This allowed the researcher to check the transcripts for accuracy and to take note of specific verbal and auditory emotional cues that the transcripts would not be able to display on their own. There was an aspect of reflexivity within the readings of the transcripts, associated with personal characteristics of the researcher, as discussed earlier. Epistemological reflexivity was also applied; phrasing of the questions posed by the interviewer was considered during the readings, and notes made on how the specific questions were articulated and whether this may have played a role in the participant's responses (Pietkiewicz & Smith, 2014; Smith et al., 2009).

The transcripts were then analysed individually, separate of the recording with specific questions in mind. Those questions were:

1. How did LGBTQ individuals make sense of their self-injury?

2. What evidence was presented by the participants about the impact of the experience of self-injury?
3. What was the interaction between the participants' identity and their self-injuring history?

The focus was placed on exploring the meaning of each subjective experience. Each transcript was read through multiple times with notations being made in form of *exploratory comments* at first. *Exploratory comments* focused on the content of linguistic choices, descriptive context of stories, and conceptual elements which prompted further question were highlighted (Pietkiewicz & Smith, 2014; Smith et al., 2009). As the analysis of the scripts progressed through numerous close readings, *exploratory comments* alongside the transcripts metamorphosed and were collated into *emergent themes*. The researcher's main aim through this time was to act as an interpreter for the participants, utilising a level of critical abstraction (Pietkiewicz & Smith, 2014). Careful focus was placed on honouring IPA's theoretical orientation at this stage so as not to shift the participant's meaning making into something that it wasn't (Pietkiewicz & Smith, 2014; Smith et al., 2009). The finalised accounts given by participants, with themes extrapolated through psychological conceptualisation were what formed the basis of these *emergent themes*. The researcher collated these to create *objects of concern*. *Objects of concern* are defined as "anything that matters to the participants" and are used to form the basis of the themes (Larkin & Thompson, 2012). The process was repeated for each transcript.

### **Collation of transcripts**

The final stage of the analysis involved creating clusters of themes and seeing whether any relationships emerged within (and later between) the transcripts. The evidential basis for these was provided by the transcripts themselves; the relationship between the

themes and the accounts was cross-checked regularly. A list of *superordinate* themes emerged, each with *subtheme* clusters, dedicated to relating back to the main themes.

It is generally acknowledged that within IPA the researcher brings an individual meaning making to the task and thus personalising techniques of analysis is encouraged (Pietkiewicz & Smith, 2014; Smith et al., 2009; Smith & Osborn, 2004). The guidelines are flexible and encourage creative interpretation to suit individual research aims, provided the researcher has been familiarised with the theoretical underpinnings of IPA (Pietkiewicz & Smith, 2014). The whole analysis followed a more kinaesthetic traditional approach, that is, the pen and paper method was used with colour coding. The transcripts were printed out twice – a master copy with notes and emergent themes, and a second copy used to cut up the transcripts and place the quotation extracts within their subthemes.

### Chapter 3: Results

Four superordinate themes, each of which had three subordinate themes, emerged through interpretation of the data. These are as follows:

1. Support seeking: *“I just wanted to be helped. I fell through the cracks”*
2. Hesitant sense of self: *“You don't know that what you are is an option”*
3. Survivorship: *“When I came out I got a lot better really quickly and I no longer needed to self-harm so much”*
4. Assimilation: *“Sometimes it is just difficult”*

These themes were interpreted and selected as part of the IPA process, and relate to the experience of being an LGBTQ individual who has previously engaged in NSSI. The aim of this chapter is to explore the superordinate themes, expanded on by subordinate themes to provide an analysis for the participant's experience. Table 2 (below) provides a quick reference for readers, addressing the themes to be discussed.

The result section draws on the bioecological theories of Bronfenbrenner (2005). In particular, the systems model has previously been utilised on a practical level for the purposes of intervention in LGBTQ youth (Luke & Goodrich, 2015; Morrison & L'Heureux, 2001). Individuals are embedded in their context and relationships exist across systemic levels. Bronfenbrenner (2005) identifies these as the micro, meso, exo and macro systems. In order to understand the participants phenomenologically, the interactive nature of these systems requires acknowledgement. The structure of the results in this thesis is guided by these systems. In other words, the immediate environments (microsystems), the relationships between those environments and settings in which the person is embedded (mesosystems), the interaction between that world of the individual and how they are influenced by wider environments such as the LGBTQ communities (exosystem), and the underlying implications

of cultural ideologies concerning heterosexism and cisnormativity (macrosystem), are all explored in this section.

Due care has been taken in preserving the participants' accounts faithfully as they appeared in the context of transcripts. The proposed themes and the corresponding extracts were selected on the basis of their relation to the central thesis questions. These superordinate and subordinate themes were chosen on the basis of shared experience; however each participant had individual variation. For example, the particulars of gender identity and sexuality, as well as more general characteristics (such as childhood experiences) differed with each account. The focus therefore lies in addressing the overarching experiences which are, to some degree, shared by all participants.

All extracts presented are verbatim; however repetitions, and filler words have been edited out for readability. Parts of the extracts which require clarification or feature identifying information have been overwritten by the researcher, and this is indicated by the use of square brackets.

Table 2

*Superordinate themes and supporting subordinate themes*

<u>Superordinate themes</u>	<u>Subordinate themes</u>
Support seeking: <i>“I just wanted to be helped. I fell through the cracks”</i>	<ol style="list-style-type: none"> <li>1. The role of family</li> <li>2. Social support</li> <li>3. The support of health professionals</li> </ol>
Hesitant sense of self: <i>“You don't know that what you are is an option”</i>	<ol style="list-style-type: none"> <li>1. Pre coming out: Suppression of identity</li> <li>2. Coming out: Isolation and invisibility</li> <li>3. After coming out: Empowerment</li> </ol>
Survivorship: <i>“When I came out I got a lot better really quickly and I no longer needed to self-harm so much”</i>	<ol style="list-style-type: none"> <li>1. NSSI: A necessity of its time</li> <li>2. Shared experience of survival</li> <li>3. Preventing relapse</li> <li>4. Perseverance</li> </ol>
Assimilation: <i>“Sometimes it is just difficult”</i>	<ol style="list-style-type: none"> <li>1. Claiming space</li> <li>2. Living with scars</li> <li>3. Building a caring community</li> </ol>

**Theme 1. Support seeking: “I just wanted to be helped. I fell through the cracks”**

The first theme addresses the experiences of coming out as LGBTQ and revelations surrounding NSSI. It captures the complexity of the participants’ experiences of seeking support. Members within the participant’s interpersonal communities, such as friends and family, are addressed first. This is followed by the experiences of participants seeking support in healthcare settings.

## 1.1 The role of family

For adolescents, living at home with their families has a number of implications. Teenagers who are financially supported by their parents do not usually have the freedoms associated with adulthood and are not able to be self-reliant. The struggle with self-identity can be a challenging one to navigate within an environment which can restrict self-expression. Generally, parents have some control over how their children present in appearance, who they establish friendships with, and how they spend their free time. Extreme deviation from this can result in disciplinary techniques such as grounding, a practice in which privileges are removed from the adolescent for a set period of time, which can cause tension between parent and child. Confusion surrounding gender and sexuality or self-injury - in particular, if the adolescent feels they are unable to discuss this with their parents - coupled with the limited ability to express their true self, can place strain on relationships, leading to overwhelming emotions for the child. As adolescence is a time during which emotional management is learned (Wilson & Youth Wellbeing Study, 2015), and as NSSI is commonly used to emotionally regulate (Chapman et al., 2006; Nock, 2009), this behavior can be logical to some. All participants engaged in some degree of avoidance techniques with family members. When NSSI was addressed, many found it to be a degrading experience.

*Abby: I tried to hide [NSSI] when I was younger, but I didn't do a very good job. So [my parents] found out after about 6 months that I've been self-harming. Then I was kind of checked every now and then to make sure that I hadn't been cutting. So people knew.*

*Interviewer: Yeah and how did you find that experience?*

*Abby: It was awful, it was humiliating. Yeah. I didn't like it because it felt like I was being punished for it instead of being helped, I feel like they could have*

*dealt with it a lot better.*

For Abby, the first six months of engagement in NSSI was a private experience. This can be construed as her behaving in ways so that her self-injury was not noticed. However, the phrase “I didn’t do a very good job” in the interview is punctuated by a laugh from Abby herself. This, taken at its face value can be self-explanatory; she did not hide her NSSI as well as she thought. However, the laugh displaces this interpretation. Abby is seeing humour in this, as if to say that she didn’t want to do a good job of hiding it, because she wanted for this behaviour to be exposed. The punchline is in the irony of her statement versus her action.

When Abby’s parents found out about her NSSI, she experienced distress due to the infringement of her bodily autonomy. Puberty is a particularly confronting time for adolescents, irrespective of self-injury. While Abby’s parents were likely to be approaching the topic of NSSI from a place of concern, having her body checked for signs of self-injury was demeaning to Abby and did nothing to assist her in addressing underlying causes and concerns. Furthermore, Abby viewed this behaviour as punishment, which would have been ineffective at curbing future self-injury and perpetuated the idea that self-injury was a shameful, demonised behaviour. In this way, NSSI can place strain on the family structures (Kelada, Whitlock, Hasking, & Melvin, 2016). While Abby does not specify how she articulated seeking support from her family, it is likely that this “humiliating” experience would have rendered any future possibility of support from her family inaccessible, due to this misunderstanding.

In a similar way, the experience of Sam and Holly can be viewed as counterproductive. Both participants and their families engaged in high levels of avoidance when the topic of self-injury was addressed.

*When I was 13 my mum found out. We had a talk about it, but at the time (and*

*she believed this until quite recently), I said “I'm just doing it because a lot of other people are doing it”, so that must have just been a frightened response. We kind of talked about it and then we didn't talk about it for a long time. It was just not- we just ignored it.*

(Sam)

*We didn't really talk about [the self-injury], [my mother] just said that I need to go to a therapist; she made it about me not going to school but then she would hide anything with blades and anything that I could use to hurt myself, like knives and everything.*

(Holly)

Sam (a non-binary participant) utilised normalisation as a technique to avoid further questioning, as they did not want to elaborate on their experience of being a self-injurer. The admission that it was a “frightened response” suggests that Sam themselves knew this was not the norm. However, the justification that everybody else was engaging in self-injury served as a trade-off to both parties and permitted avoidance. If it was not seen to be a big deal, then Sam could continue the behaviour without their family’s judgement while receiving support for everything but the self-injury. As NSSI is often misunderstood by parents, experiences of help-seeking are largely negative for the child and the parent (Kelada et al., 2016). Thus, avoidance served as a way of preventing further conflict. The use of “we” in this account reflects that the unspoken agreement to avoid the topic of NSSI was implemented by both Sam and their mother. Sam did not know how to ask for support, and their mother did not know how to provide support. As neither party had the knowledge to recognise that NSSI needed to be addressed, they instead adopted a behavioural and emotional tactic of avoidance.

Holly's mother did not directly acknowledge the self-injurious behaviour when it transpired. Instead, a course of action which addressed the side-effect of Holly not attending school was suggested. However, running parallel to the discovery of NSSI, Holly was struggling with homophobia surrounding her queerness. The reason why Holly abstained from attending school was because her newfound sexuality did not mesh with the Catholic values her single sex school represented. In the interview Holly said "*I couldn't be myself at school so I stopped going*". During this time Holly had not yet communicated her lesbian identity to her mother. The hiding of sharp objects signified to Holly that while her mother was concerned about her, she was either unwilling or unable to discuss it. Family support is one of the major protective factors for NSSI and suicidality (Bryan & Mayock, 2017). The fact that her mother did not acknowledge the root cause of her self-injury or indeed the self-injury itself, meant that Holly felt that she was left without family support on this matter.

The parents of some participants engaged in total avoidance:

*I think [my parents] knew that I was very depressed and was self-harming but they never said anything.*

(Ruth)

Ruth does not display specific feelings in this extract and it is presented, rather, as objective fact. What is unclear is whether Ruth herself reached out to her parents or not. The avoidance displayed by her parents could be representative of the helplessness they felt about the situation, rather than neglect. This is consistent with research into parents' experiences, whereby parents report feelings of stress, anxiety and helplessness when it comes to dealing with their child's NSSI (Kelada et al., 2016). It is possible that although her parents did not speak to Ruth directly about her NSSI and depression, they may have engaged in conversations with other people, or with each other. What is evident from this extract is the

divide between Ruth and her parents, regardless of the reason why. This is also exemplified in all participants' accounts: a divide between the child and the family grows as the discovery of NSSI takes center stage.

## **1.2 Social support**

The desire to fit in speaks to the teenage experience, as it emphasises the need for community outside of the family. Indeed, strong supportive friendships serve as protective factors against NSSI (Scourfield et al., 2008). With family discord being prevalent in the lives of those interviewed, it is understandable that the participants also sought support outside of the family circle. However this tactic came with its own set of challenges. Participants exhibited a general desire to keep their NSSI private, particularly in the school environment. Despite this, self-injury was made public and participants were subjected to unfavourable reactions.

*In high school people said "oh you're such an emo, you're doing this for attention" which I wasn't. I hid them. But even if I was, those comments were unnecessary, and they kept staring and it was really uncomfortable.*

(Abby)

*While I was [overseas] the school I was attending said that they wanted to hold me back for a year because some kids told the teachers I was self-harming and I thought well "Hell no! I don't think it's gonna help. I'm not going to have my life held back".*

(Lisa)

The school environment was a source of added stress to participants, an experience consistent with literature on this topic (Clark et al., 2014; Fox & Ralston, 2016; Lucassen et

al., 2014). Abby's cohort of classmates imposed the label "emo" upon her. The 'Emo' alternative teenage subculture that is recognisable via particular fashion, music and behavioural choices, is also known for normalising self-injury (Young, Sproeber, Groschwitz, Preiss, & Plener, 2014). Whilst at school Abby did not align herself to any particular subculture. She emphasises the realness of her experience regardless of her reasoning for NSSI: at first Abby rejects the notion that her self-injury was attention seeking, and then she promptly adjusts her language to include that attention seeking behaviour. Perhaps she engaged in NSSI in private and hid her wounds (as she did not want others in her peer group to perceive her differently), while also wanting to gain attention (as an unspoken way of asking for support) at the same time. Regardless, the behaviour displayed by her classmates was unsolicited and amounted more to bullying than consolation.

Lisa spoke about her self-injury as a private affair which should not have concerned anyone. The threat of being held back in her year at school made her irate as she did not perceive her self-injury to be a barrier to her future success. Like Abby, Lisa has a largely unfavourable experience with her peers finding out about her NSSI. This experience addressed the right to know – who is given permission to know about the NSSI and who doesn't. The teachers, as guided by Lisa's classmates were a potential threat to her autonomy. For all participants in this study, self-injury was synonymous with coping. For Lisa, the need to defend herself at school exacerbated the feeling of being misunderstood.

While the wider school environment was prejudiced, participants shared in close friendships. Some attempted to reach out to their friend groups for support surrounding NSSI. Friends are generally the first to hear about their friend's queer identity and NSSI (Luke & Goodrich, 2015). When friends were not accommodating in providing emotional support, participants experienced internal conflict about how much to disclose as they did not want to

be stigmatized by their friends. In Holly's case, this resulted in her questioning the quality of the friendships.

*I thought it was really cool to carve writing and pictures- it sounds really weird now. I do remember one of my friends, she noticed. But none of them said anything. I felt quite embarrassed. The type of friend group that I had was very innocent. None of my friends kissed boys and we would have fun by climbing trees...so they weren't really prepared for that level of intensity; they knew about my sexuality and then there was this new thing [self-injury]. I didn't feel as though I could talk to them about it because they didn't understand at all.*

(Holly)

Holly reflects on attempting to disclose her self-injurious behaviour to her friends, but emphasises a belief that they would not be able to relate to her. She discloses that she matured quicker than her friends. Prior to this, Holly states that she was the first in her friend group to explore a romantic relationship, which featured physical intimacy. Her newly found queer identity was accepted by her friends, despite them initially finding it shocking. Due to this initial reaction, Holly describes the compounding effect of her sexuality, combined with her NSSI as something too intense for her friends to understand. Not wanting to further isolate herself, she makes the active choice to abstain from disclosing any further details about her self-injurious behaviour, thereby maintaining the friend group who provide a level of support to her.

The embarrassment Holly feels stems from her "writing and pictures" being seen, as she may have had concerns about not fitting in with the "innocent" stereotype depending on what she carved. She simplifies the complexity of her teenage friendships, likening these to a

childlike abandon, with activities such as climbing trees. Describing her friend group as innocent, however, implies an assumption on Holly's part. She does not feel comfortable letting her friends in as she does not want to be seen as too "intense", thereby implying that she perceives her friends to be naïve. Having experienced kissing (albeit with a girl) by this stage of her life, she assumes her heterosexual friends cannot relate to her experiences.

The isolated experience of being a self-injurer was presented in a number of accounts. Despite the support of close friends, some participants still felt like they were not truly understood.

*A couple of my friends knew. I still felt a bit of an outcast because you know, they had this stuff but I'd been in the psych wards for 6 months, I'd been really unwell and so I still felt apart.*

(Abby)

While research demonstrates that many LGBTQ individuals who engage in self-injury are reluctant to seek clinical help (Zaki et al., 2017), many also experience psychiatric disorders and poor mental health (King et al., 2008). Disordered eating is a risk factor for NSSI in both non-queer and queer populations (Colledge, Hickson, Reid, & Weatherburn, 2015; Connolly, Zervos, Barone, Johnson, & Joseph, 2016; Skegg, 2005). Abby suffers from PTSD and an eating disorder, pathologies which, alongside her NSSI, led to hospitalisation. The use of the word "outcast" symbolises a distance from her friendships, and is related to her "psych ward" admission. It denotes a physical isolation from Abby's relationships as well as symbolic distance. Demonstrated here, there is also an underlying but perpetual stigma associated with hospitalisation; Abby felt "apart" because her "unwell"-ness in no way resembled the experiences of her friends. It is an experience she has not shared with her

peers, and with the lack of common ground she was unable to find the support she was looking for from her friends.

Ruth's queer identity caused considerable disharmony within her social circles. She attributes her self-injury to the hardship of not being accepted.

*I definitely think that a lot of the reason why I was self-harming was because of the way my mum ended up treating me. And I do think that if I didn't identify as queer I don't think I would have had issues with my friendships, with my family, with all of those. I think it was when I began to actually actively take on my queer identity and the more I started trying to fit into it, and when I started having partners who were queer, that's when people started saying "don't do that, we don't want you to fit this mould, fit this one instead" and that's when I started self-harming more and more.*

(Ruth)

The dilemma between coming out or staying closeted has been explored in research before (DiStefano, 2008). Both have pros and cons, as we can see in Ruth's case. Prior to this statement of narrative, she had spoken about making attempts to hide her queerness and that as a result, her self-identity suffered. Here we see Ruth reclaim her identity and communicate it at an interpersonal level. This act poses new challenges, as it propels her into a territory where her support networks begin disintegrating. While her self-injury began due to internal distress, the prejudice she experienced resulted in instances of higher rates of NSSI.

Over time, the conflict between Ruth and her mother intensified. In the interview, Ruth gives the examples of microaggressions her mother (and rest of her family) took part in, from making negative comments about Ruth's clothing choices, and negative commentary on

gay characters in the media and in real life, to more overt homophobia, such as preventing Ruth from seeing her girlfriend. There is a lack of emotion in her voice as Ruth communicates that if she did not identify as queer she would not have to put up with the negative responses of her friends and family. This may be a form of desensitization to distance her from emotion, as Ruth almost seems apathetic explaining this information. She has clear insight into what led her to rely on NSSI, which is the desire of everyone around her to conform. Her refusal only aggravates the circumstances and she uses self-injurious behaviours to simultaneously express her anger, frustration and rebellion.

### **1.3 The support of health professionals**

Although self-injury is often a private and secretive behaviour, most participants in this study sought support from health professionals. Those participants who did not identify as cisgender spoke about the difficulties in accessing medical care, as the focus on their gender identities overshadowed the treatment.

*When it comes to transgender people, it has less to do with overt discrimination or their hatred and more to do with an incompetent medical system.*

(Lisa)

Lisa felt trapped within a medical world in which she struggled to find support. As a transgender woman on hormone replacement therapy, she has no choice but to attend appointments with doctors, psychologists and receive further therapy in association with her gender dysphoria. A part of this involved addressing and treating her self-injury, which Lisa thinks has been incompetent. The incompetency comes in two forms: health professionals blaming the fact that she self-injures on her being transgender, and thus pathologising her

identity further; and when seeking help specifically for NSSI, the health professionals are distracted by Lisa's gender identity due to lack of knowledge and understanding, and thus do not provide the necessary support for the self-injury. This professional myopia makes Lisa disheartened, and her underlying frustration is an expression of this feeling.

Other participants spoke directly about the unfavourable experiences they've had with health professionals:

*I had some issues with the mental health nurse who does not understand queer stuff. Like, she'd ask "has it affected your sex life" and I was basically like "I don't want a sex life". Apparently I'm such a curiosity that it ended up all over my notes. And then there was me asking her repeatedly to use gender-neutral pronouns.*

(Charlie)

*So the counsellors had no understanding of trying to be non-monogamous, or queer, and it would be met with comments like "girls are just more promiscuous at this age" - just a real lack of understanding. So now I stay away... One of the biggest issues with that was also when you have a history of self-harm, you've got a history of unhealthy relationships and then you come in to those situations, they make you feel like it's your fault and sometimes it's been made quite explicit to you, that it is your fault, so I didn't deal with that very well. As far as doctors go it's just misgendering all the time. And I've had to be okay with it, but going in and hearing a lot of stuff about smear tests and stuff - just not being comfortable in that environment.*

(Sam)

A constant source of frustration shared by non-cisgender participants related to being misgendered. The majority of health professionals have accepted that sexualities such as gay and lesbian exist as the norm, and do not put an emphasis on homosexuality as a topic which needs discussing. However, falling outside the sexual and gender binary norms meant that participants who identified as non-binary or transgender felt that they were not competently treated. This is salient from perspectives of both the patient and the health professional: a quarter of healthcare staff in the UK do not feel confident treating trans patients and 72% do not receive training on LGBTQ health issues (Somerville, 2015).

Indeed, both Sam and Charlie battled to have their gender-neutral pronouns recognised and respected, eventually giving up their identities for the duration of the appointments so their medical concerns were addressed. Being in a context where health professionals are not well-versed in queer-specific issues is a frustrating experience for both these participants. However, they have found that if they are to seek help and receive competent medical treatment, they need to have some resilience against being misgendered and misunderstood by health professionals.

Both participants express that these experiences have detrimental effects on not only their mental health, but also their sense of self. As a result, both subsequently experienced long periods of avoiding mental health help as they wanted to avoid stigmatisation. This is consistent with the findings by Zaki et al. (2017).

Self-injury, in itself, was sometimes not taken seriously in healthcare settings:

*There is the perception that it's quite a childish thing to do, which I've heard from health professionals, which hasn't been helpful because it's obvious that if you were in a better state of mind you would do another thing instead.*

(Sam)

There is deep-seated frustration in the accounts of participants, a longing to be recognised and respected. Sam states that if they were coping, they would not be self-harming. The reach for help is met with patronising remarks and the situation can remain unresolved.

By contrast, other participants were able to navigate the healthcare system with greater ease, and as a result find it a more fulfilling experience.

*I didn't feel as though I had a parent figure to look up to because I wasn't very close to my mom. So then I developed that with [therapist] and it helped me a lot.*

(Holly)

*[Therapist] knows me very well which is helpful because I trust her completely. She's really supportive and thinks that I'm doing the right thing and believes in me, all of that. It's just helpful to have someone to talk about [self-injury], because you know you still get the self-harm urges, I feel like that's always a thing. You know, like any kind of addiction. It's really good to have someone to talk that stuff through with.*

(Abby)

These two accounts reflect how supported the participants have felt within the therapeutic environment, with Holly going as far as to identify her therapist as a parental figure. The client-therapist relationship is sacrosanct here, both Abby and Holly trusting in their health professionals completely. While the family and friends may not have provided adequate support, this role has been filled by the therapist. These extracts represent hope

through engagement in therapy. Self-injury is easier to manage when one is able to navigate it through support from others.

With the help of a therapist, Ruth was able to address ideas surrounding her sexuality, while Abby reflected on her first experience of professional support with a school counsellor.

*One time I was talking about my self-harm and my counsellor, who is also queer said "do you think you have any internalized homophobia" and I was like "nah, no no nah" I denied it and then after a few months we explored it a bit more and I realized that I did actually have quite a lot of internalized homophobia from the people around me and learning to let that go helped quite a lot.*

(Ruth)

*I just wanted to be helped. I fell through the cracks. [Health professionals] checked me for self-harm, but they didn't really try to treat the causes. They were just trying to minimize the symptoms which didn't work. Also, I really wish that my counsellor had persisted when she said "I think you're going through issues with your sexuality", because I think if I had been able to discuss that, even though I've been resistant to it, that would have helped a lot.*

(Abby)

Ruth grew up in a homophobic environment which conditioned her to interpret her sexual identity as unnatural, contributing to a state of unrest. Abby's first counsellor asked her whether she might be a lesbian; however she vehemently denied this, prolonging her search for her true identity. Abby's extract locates her initial resistance and denial of her queerness as a relationship between her and her counsellor. There is complexity in this, as it

reflects on the dynamic dual nature of the client-therapist relationship. Though the therapist needs to build rapport, the client must be willing to be receptive in order to change. The onus is on both parties to meet each other half way. With the support of the right counsellors and openness to take responsibility, both were able to mitigate negative feelings surrounding self-identity.

### **Theme summary**

For participants, support seeking was a multidimensional experience which included the impact of friends, family and health professionals. The intrapersonal process is complex, and the way participants interacted with their social networks was often built on presumption. Communication between all parties suffered when there wasn't support, or when trust had been broken through negative comments. Family members did not recognise the struggles faced by their children, leaving distance in place of love and understanding. However, participants did not provide their parents with the opportunity to engage with them and were avoidant and at times secretive. Social networks within the school environment stigmatised the participants through discrimination. These experiences lead participants to engage in NSSI further, by adding to an already vulnerable identity. The participants felt distant from their close friend groups when their friends were not able to respond to the participants' wants and needs. Health professionals played an important part in the lives of the participants of this study, in both positive and negative ways. While some had unfavourable encounters which led them to isolate themselves further, others were able to discuss psychological experiences which were not addressed with family and social circles. Adolescence was a turbulent time for participants, and one of figuring out their true identity. The fact that NSSI and sex, sexuality and gender were often integrated into one in narratives is a reflection of that confusion. Avoidance about both subjects was common, and this

behavior was displayed by all parties. While the first superordinate theme touched upon external factors of support, the following theme addresses the internal resilience and the strength it takes to preserve self-identity.

## **Theme 2. Hesitant sense of self: “You don't know that what you are is an option”**

The second theme can be likened to a timeline, in that the data tracks the emergence of the participants' identities. Previous research suggests that emerging adulthood is an especially challenging time for sexual and gender minorities, as it is a period in which NSSI becomes most prevalent (Power et al., 2015). It is apparent in the raw data that many of the participants internalised negative emotions about their self-identity. These negative emotions were in response to external influences and environments. The data strongly suggests that these circumstances contributed to the participants' engagement in NSSI. Social stigmatisation was one of the main root causes that contributed to negative self-identity. Participants used aversiveness as a way of managing unfavourable environments, spoke of isolation associated with their coming out, and subsequently navigated discriminatory social climates in order to find self-acceptance.

### **2.1 Pre coming out: Suppression of identity**

Heteronormative standards perceived by participants as the ideal social state, perpetuated a feeling of inadequacy in participants who were questioning their sexuality and gender identity. Socialised in an environment where they were expected to conform, positive self-image about their emerging queer identities were inhibited.

*I thought it was something really wrong with me, that I wasn't attracted to anybody, but the idea of being queer was unacceptable because that would be*

*worse than if there was something wrong with me for some reason.*

(Abby)

*Going through a big period of thinking that homosexuality particularly was completely and utterly wrong, and was really bad, up until I was 12. That was just how it was. And then my body and head wanting particular things that I just thought were so not okay.*

(Sam)

Participants spoke of being worried about their identities, and felt extremely uncomfortable at the possibility that they might be queer and/or transgender. Many participants spoke of the heteronormative world in which they lived and the lack of out queer role models while they were growing up. Abby and Sam were unable to acknowledge their self-identities as queer due to the constraints placed upon them by family, friends and societal pressures from existing ideologies. As a result, they suppressed their queer identities. However, the thoughts and attractions participants experienced were in direct opposition to their outwardly presented identities. While they fought to conform to appear as they thought were heterosexual and/or cisgender, their internal identities were manifesting through attraction and desire. Navigating sexual desires – a natural part of adolescence - had to be balanced with conformity, and this caused internal anguish. For both Abby and Sam, this translated into attempts at rejecting their queer identities until they either could not deny it any longer, or had a safe environment in which to come out.

When Abby addresses her anxiety about the possibility of being a lesbian, she states that she perceived her queerness as something “unacceptable”, and would rather have “something wrong” with her instead of accepting her sexuality. This apparent internalised

homophobia contributed to instability in her identity, and caused further stress. Similarly, Sam communicates that they had to withhold their identity. The idea of being queer was impossible to entertain as Sam and Abby did not want to receive criticism for their actions. Paradoxically, addressing the topic of self-identity in this way led to a path of most resistance. Considering the complexity of relationships within family and the wider community, one way of coping effectively would include maintaining a strong sense of identity through this difficult and confusing time. However, participants added complexity to an already uncomfortable experience by fusing the external influences with their own perception.

The advantage to staying closeted is that one is not subject to as much stigmatisation as openly queer individuals receive. However, the struggle of existing in an environment prejudiced against queer identities does affect individuals who are coming to terms with their gender and sexuality, and this has been shown to lead to NSSI as a way of coping (DiStefano, 2008).

*I couldn't be 100% who I wanted to be and I think that contributed a lot to the depression and self-harming, not being able to be myself.*

(Holly)

LGBTQ individuals experiencing homophobia are more likely to engage in more frequent self-destructive behaviour (McDermott et al., 2008). Perhaps the mechanisms utilised by the participants here guarded them against more overt homophobic behaviours, thereby making it more manageable to exist within a homophobic society where out people were targets of harassment.

Participants who experienced prejudice sheltered their identity from others and from

themselves through mechanisms of denial. Negative connotations to do with identifying under the LGBTQ umbrella were learned through prior exposure.

*Because I went to an all-girls Christian school no one was out. Except there was one girl from the year above. She came out as a lesbian after she left school and everyone was like "it's disgusting". We actually had a teacher who was a lesbian as well and people would be getting changed in the changing rooms and say " Oh she's watching us, that's disgusting" so that was the only experience that I had from people talking about lesbians. So I was like I don't want to be that! I don't want people to think that I'm perving on them. It wasn't an option to come out at school. I couldn't be myself at school so I stopped going.*

(Holly)

For four out of the six participants, same-sex religious education contributed to hesitancy about expressing their identities. Bullying, teasing and the withdrawal of friendships overtly affected the participants. Derogatory comments towards others, such as the comments witnessed by Holly, affected confidence and self-worth. The description of lesbians as “disgusting” by her peers meant that Holly did not feel safe in expressing her true identity. The high school environment became a threatening space. Latent homophobia and marginalisation made it difficult for Holly to have any normality in her life, and to escape this she dropped out of school, which isolated her further from her peers.

The school environment has been shown to be a risk factor for chronic stress due to fear of being hurt, as well as instances of homophobic and transphobic bullying (Clark et al., 2014; Lucassen et al., 2011). Moreover, it is often an environment which produces an over-reliance on traditional ideas of binary gender roles and the expectation of being attracted to,

and attractive to, the opposite sex. Participants spoke of interrogating their identity and playing along with heteronormativity as a way of maintaining their social standing and friendships.

*I questioned it all the time. I didn't want to be gay, so I put on a face for my friends like "that guy's hot" or I really like this male celebrity. But then I would try and mix in the girls as well so it wasn't so intimidating for them.*

(Holly)

*For a long time, I just felt really awkward about it and just try to pretend. Not pretend that I wasn't, but [rather] put on an outward appearance that I wasn't gay.*

(Ruth)

For some of the participants the desire to fit in outweighed the need to be true to their own identities. Young people of gender and sexual minorities experience a sense of shame associated with their emerging identities. Being queer was seen as reprehensible by the participants themselves as a result of external feedback they received, and none of the participants wanted to be responsible for carrying this burden. The culture of shame associated with identity through invalidating environments as contributing factors to NSSI has been addressed in previous research (Alexander & Clare, 2004; McDermott et al., 2015).

There are multiple explanations for pretending to be heterosexual, and exhibiting behaviour which was constituted as socially acceptable. It may have been used as a tool to conform for the purposes of saving face, maintaining a position in the high school hierarchy, escaping overtly bigoted views of classmates, as a tool of preventing bullying, as an avoidance technique – “if I pretend I am not LGBTQ maybe these feelings will go away” -

and for the purposes of maintaining close social bonds. Regardless of the participants' reasons, hiding behind a heteronormative, cisnormative façade was a calculated effort.

## **2.2 Coming out: Isolation and invisibility**

During the period of questioning their identity and the process of coming out, participants isolated themselves both physically and mentally as they lacked a sense of belonging. Loneliness was experienced from a young age.

*I always questioned my sexuality quite young. Probably when I was 11, I was like "Oh ok, so I'm slightly different" - like what's happening for everyone else isn't what's happening for me.*

(Ruth)

*People self-harm because of not feeling like they belong. Pretty much everyone I've spoken to about why - it's been some degree of not fitting in, not belonging, not having a support system and even before I had any idea of sexuality stuff when I was 11, it was still felt, I felt singled out.*

(Charlie)

The bioecological model proposes that children are products of the complex interaction between genes, biology, personal experiences and societal shaping. The course of time also plays a significant role in changing the environments and influences, and therefore human development is not static. Here Ruth and Charlie speak of the isolation they felt prior to having the vocabulary to express their identities. In particular, Charlie indicated that growing up they did not have the rich levels of diversity existent in today's world through the power of internet. As children growing up without online access, Ruth and Charlie would have been exposed to a restricted, less permissive environment compared to adolescents who

have grown up with the digital age. Internet has played a huge role in the lives of LGBTQ youth, particularly those living outside main city centres, and has been used to curate an online identity in order to explore the realms of gender and sexuality in a way which is not permissive offline (McDermott & Roen, 2012). While some online spaces can be a source of vitriol, others can serve an important role in informing and normalising identities.

Participants did not have the exposure to internet, queer role models or supportive adults in their lives, and thus lacked opportunities which would relieve their anxieties about feeling different. This contributed to isolation, which continued into adolescence.

*Sexuality is so bound up in those ideas of self-worth, having meaning as a person and feeling good as a person. And I think also, being queer both in your gender and your sexuality- there can be an incredible loneliness trying to find where you're fitting, but also trying to find people to be with and people who understand you and understand your body. So that was a problem and so I would hurt myself because of that... It's really hard to separate it, now I can look back and say I was thinking those things, but at the time my self-harm was really connected with being lonely and isolated.*

(Sam)

*I wouldn't have self-harmed if I wasn't a lesbian. I wouldn't have, because I wouldn't have met [my ex-girlfriend] and I would be able to talk about things with everyone because it'd be normal, I wouldn't have to hide her or myself.*

(Holly)

There is a compounded stigma of being an individual who engages in NSSI, as well as being non-heterosexual, and in the case of three participants, transgender. In accordance with

the Decompensation Framework (TDF), the effects of ideologies combined with this double or triple minority status disadvantage and put further stress on individuals who are already underprivileged. To add further to this complexity, participants in the process of coming out often spoke of being in the midst of social transition, where they were seeking like-minded people or those whose identities were similar to them. Isolation came, as Sam mentions, when an individual lacked an accessible sense of community.

Outward prejudice and discrimination lead to continuous stress, and result in feelings of confusion, making the participants' question their internal sense of self. For example, Holly initially attributes her self-injurious behaviour to her sexuality, but then self-corrects. Her being a lesbian is not the issue; the problem resides in the core belief that her sexuality is abnormal. She does not ultimately think that she is abnormal, but it is the world around her that has forced her to feel like she has to hide her queer identity.

The process of coming out can be challenging and complex. There is pressure to solidify the formation of a queer identity, and manage mental health while honouring societal expectations. This burden added to existing feelings of isolation rendered some participants invisible.

*I've been sectioned...they didn't try and help is all. It's just like "OOH THIS PERSON IS DOING SOMETHING THAT WE'VE DECIDED IS BAD! LET'S FOLLOW THE "PROCEDURES"! WE'LL JUST CHUCK THEM IN A CELL!" rather than trying to help.*

(Lisa)

Lisa's hospitalisation can be viewed as a physical manifestation of invisibility. For her, the experience of being placed "in a cell" is a literal isolation which creates metaphoric

invisibility. Sectioned for a suicide attempt – which was, in part, a result of the discrimination and abuse she experienced as a transgender woman - she conceptualises her hospitalisation as a way of silencing her legitimate right to choose to take her own life. She frames suicide as something that other people see as “bad”, and implies that she does not see it as such. For Lisa, suicide is a choice that she believes she should have the agency to make. Throughout the interview Lisa speaks of her belief that it is not the responsibility of others to decide whether a person can or cannot engage in NSSI and suicidal behaviours. She likens it to euthanasia in cases of people with cancer and their right to choose to end their life. Being sectioned under the mental health act and subsequent hospitalisation removed that choice for her, and removed her ability to have autonomy. Lisa views this experience as one that silenced her, and as a result, made her and her issues socially invisible. This is perhaps why her remarks echo emotions like anger and desperation. There is a loss of hope as instead of receiving help she is silenced, placed in a “cell”, and further isolated. In Lisa’s opinion, this experience destroyed any potential dialogue, and created no avenues for help.

*It's just invisibility. To me invisibility is like when you have a bird trapped inside and it's just flying against the window over and over again because it doesn't know any other way to get out and it's just.. You don't know there's a door there, you don't know how to open it. And all you can do is keep trying to be what everyone tells you you should be, because you don't know that what you are is an option.*

(Charlie)

For people who heteronormative society deems as non-normative, attempts at conformity can become a form of self-abuse. The metaphor of a bird flying against the window seeking its freedom is a powerful representation of what it means for Charlie to be

trapped in a situation which they do not have the tools to resolve. The door is symbolic and represents a physical manifestation of the path to freedom and knowledge – a way of escaping things feared. The frustration of not knowing how to navigate an identity for which Charlie does not yet have the words, results in them trying to conform to societal norms - some of which are relationships of a sexual and romantic nature:

*I was self-harming because I didn't know the words ace and aro. The best word I had was broken. So I knew something wasn't what I was expected to be but I didn't have any words for it and I blamed myself for a relationship of two years breaking down... I just didn't have the words.*

(Charlie)

As someone who is “ace” (asexual) and “aro” (aromantic), the pressure to have relationships was challenging for Charlie because they did not experience intimate feelings towards others, and felt they were abnormal because of this lack of sexual motivation. These feelings would prompt NSSI behaviours. The desperation displayed by Charlie in the above two extracts is reflective of the desire to relieve the stress, but not knowing how. The alternative to “flying against the window” becomes clearer with experience and time through finding vocabulary, community and peace within their identity, however in this moment, not knowing that there is an alternative contributes to isolation. Similarly, other participants identified terminology as a crucial part of their self-acceptance. Whereas other participants thought of themselves as abnormal and broken, having their experiences reflected and being able to name their feelings within a queer identity served as validation. This shows how language is a valuable commodity in evolving queer identities, with multiple interpretations. Whilst it is the terminology which makes the sex, sexuality and gender diverse communities so notoriously difficult to research, the weight of importance identity labels hold becomes

clear when correct labels are the difference between isolation and invisibility, and normalisation and self-acceptance.

### **2.3 After coming out: Empowerment**

With time, the realisation that they were not alone in their experience helped participants to evolve and solidify their identity. Finding and fitting a new vocabulary to illustrate the internal feelings was particularly affirming.

*Sexuality was just there, that was just like how it was: so it was definitely a chemical, biological thing. But with gender that was more finding out that “oh” - you could be like that. I think just having more of a vocabulary around it that I learned and knowing the community. So I could suddenly label these things that I was feeling for myself and these experiences that I was feeling for myself.*

(Sam)

*Now that I have words for things, it's a lot easier to process what happened in the past because I understand it now and it's not a thing anymore.*

(Charlie)

Confidence was gained through exposure to new terminology. Finding a way to describe and relate to their identity meant that participants were able to move past the questioning of whether or not they were normal. The extracts point to a sense of cohesion gained after a period of identity crisis.

For some participants, the period after coming out and the process of settling into a new-found self-identity was also marked by a decrease in NSSI.

*I just know that when I came out I got a lot better really quickly and I no longer needed to self-harm so much, so I feel like that was a huge relief.*

(Abby)

*Ruth: A lot of my self-harming came out of stressing over who I needed to be and who I should be, not meeting those expectations. And for a long time I didn't have an identity so I would self-harm a lot over being so frustrated over the fact that I didn't know who I was. I'd constantly just be like "Who am I, I don't know who I am and what am I supposed to be doing?" So I was constantly just really stressed about that all the time.*

*Interviewer: And what happened when you figured out "who you were"?*

*Ruth: Haha, I'm still figuring it out. Except not I'm not cutting myself now.*

Finding and owning an identity provided relief from the internalised homophobia participants experienced previously. For Ruth, self-injury was triggered by a feeling of inadequacy – not being able to fulfil traditional roles while not understanding her place in the world. She speaks of not having a solidified sense of self-identity. Adolescents in general struggle with managing emotions and establishing a sense of their independent identity. While there is no doubt that LGBTQ identifying adolescents have similar experiences to the heterosexual and/or cisgender population, gender and sexuality is a particularly pertinent area from which distress can grow. As the participants evolved in their sense of identity, so too did their abilities to self-regulate. However, the theoretical models of self-injury propose a component of undesired internal experiences. As participants reported that being closeted contributed to a multitude of negative thinking, it is possible that upon coming out these self-

punishing thoughts subsided as self-acceptance took their place, contributing to a reduction in NSSI.

Whilst NSSI reduced in some instances, the pressures from the stresses of the environment continued. Although participants may have come to accept their identities, the overarching distress remained, and they still experienced elements of insecurity.

*I stopped self-harming but I was still suicidal... I was seeing [a counsellor] and just being able to talk about [my sexuality] and figuring out who I was and who I wanted to be and then realizing that that was something that could happen –I could make being gay and not self-harming happen.*

(Holly)

For Holly, stopping NSSI was a process which she undertook with a counsellor. The suicidal feelings Holly experienced may have been in part due to her identity, and as a result of other negative life events. Indeed, all participants shared complex background histories, and the process of stopping NSSI was not linear. While it is too simplistic to say that when individuals came out as LGBTQ identifying their problems were resolved, a strong sense of self-identity and higher self-esteem did contribute to a more positive frame of mind. Although engagement in NSSI was not always linked to their queer identities, all participants commented that having to defend the legitimacy of their identity was inextricably linked to NSSI through low feelings of self-worth and societal prejudice. Upon coming out, the combination of escaping a homophobic family and the realisation that her queer identity no longer needed to be resisted, meant that Holly felt a sense of real hope and self-belief.

For others, identity and community played an important role in the cessation of NSSI.

*Interviewer: What has helped you stop self-harming?*

*Abby: Having my friends and my support system, and also figuring this identity stuff out so I don't need to stress out about it anymore. I know what I am, and I'm not broken and I'm not a monster, yes- basic starting points.*

Here, Abby emphasises the importance of her newfound community, which she acquired upon moving to Wellington, Aotearoa/New Zealand. Four participants spoke of establishing positive connections through university. In particular, queer on-campus groups provided the participants with a community many had lacked before arriving at university. For Abby, no longer needing to worry about whether her queer identity was legitimate, allowed her to recognise some of the critical foundations on which her developing sense of self would be established.

### **Theme Summary**

The transition through the timeframe of coming out was constructed around particular experiences and participants went through similar consecutive stages. Denial and rejection of their identity was a common starting point for those first questioning their identity and related largely to ideological systems which the participants were a part of. This prejudice led to participants isolating themselves in order to understand their experience. While being isolated created loneliness, it also allowed time for self-reflection. Some participants felt frustrated by their surroundings and felt invisible. Finding the correct terminology and language which accurately defined experiences inspired hope. As participants moved out of the high school environment, they were able to have more opportunities for self-expression, which contributed to a more positive frame of mind. Another important factor which contributed to a positive sense of identity was fostering positive relationships with people who were non-judgemental and in some cases a part of the LGBTQ communities. The current theme examined internalised attitudes participants had. The following theme addresses the reflection

on reasons for engagement in NSSI, the comradery amongst LGBTQ communities in relation to NSSI, and managing self-injurious urges.

### **Theme 3. Survivorship: “When I came out I got a lot better really quickly and I no longer needed to self-harm so much”**

Although there are multiple motivations for engaging in NSSI, a commonly cited reason for this maladaptive behaviour is for the purposes of relief from temporary stress (Sornberger et al., 2013). This explanation is consistent with both the Experiential Avoidance Model (EAM), and the Integrated Theoretical Model of Self-injury (ITMSI), and implies that NSSI is perceived to be a coping mechanism by those who engage in the behaviour. In particular, the ITMSI includes two NSSI-specific vulnerability factors which relate to this perception. Those who engage in NSSI may have implicit positive attitudes towards self-injury, and view the behaviour as a helpful means of survival. Coupled with how easy it is to access NSSI –the pragmatic factor - it is understandable that self-injury is used over other coping mechanisms. For participants of this study, the engagement in NSSI assisted in the management of adversities, and was also one of the tools used in self-directed suicide prevention.

#### **3.1 NSSI: A necessity of its time**

To date, studies have largely focused on the onset and the maintenance of NSSI. However, understanding the offset of NSSI is critical, as it clarifies the shift from maladaptive to adaptive coping strategies and illustrates the specifics of protective factors which allow the behaviors to cease. At the time of the interviews, participants had stopped engaging in self-injury – a parameter set precisely for this purpose. Participants were able to

be reflective of their experience, and this allowed a unique view of the full timeline of self-injury. Perhaps the most prominent view which was shared by participants was that NSSI was seen as a crucial component of every participant's survivorship.

*I don't think it's necessary for me to self-harm anymore, but in the past it has been.*

(Ruth)

*I think [NSSI] was a way of coping and I didn't want to stop. I felt that it was the best way to cope.*

(Holly)

Self-injury was perceived as a necessity of life for participants. The framing of NSSI as a "necessary", and as the "best way to cope" suggests that participants had explored multiple avenues of other coping mechanisms, but none were as effective as self-injury. This supports the aforementioned major theories of NSSI. Both the EAM and ITMSI suggest that at times, engaging in NSSI is a means of surviving challenging environments, and for the purposes of emotional and social self-preservation.

Participants who elaborated on using NSSI for the purposes of emotional regulation conceptualised it as an effective way of managing both intrapersonal and interpersonal distress:

*I used [NSSI] as a stress relief, as a way that I was coping with things. At times where I was really freaking out about particular things and just getting to a kind of unmanageable state, I used self-harming practices as grounding.*

(Sam)

Participants spoke of using NSSI as grounding techniques in the context of negative environmental events. In the above quote, Sam speaks of getting to an “unmanageable state”, suggesting that they lacked the necessary skills to manage their distress tolerance due to under/over arousal.

Some participants spoke of habituation:

*I needed some way to cope with [family stress] and then [NSSI] just became an addiction and my primary way of coping with stuff.*

(Abby)

Abby refers to NSSI as an addiction, which suggests she is aware of the negative implications this behaviour has. Despite this, she positions the addiction alongside a positive benefit by framing it as a coping device. These two opposing effects are contradictory, and it is difficult to discern which outcome developed first. From the perspective of EAM, Abby’s addiction to NSSI might have manifested through repeated exposure and conditioning, ultimately habituating her to self-injury as a way of coping with adverse life events. Applying ITMSI, it may be proposed that Abby used NSSI as a coping mechanism first - as a result of childhood trauma and deficit in emotional and social functioning - which resulted in her being addicted to the behaviour, and thus making the behaviour cessation a difficult process.

NSSI was also used to keep negative emotions at a distance through self-punishment:

*I think suicide is the desire to kill oneself and that is actually quite different from hurting oneself, that sort of more for punishment. I suppose I was trying to punish myself as a result of the anger felt towards myself and my body.*

(Lisa)

Self-injury is a behaviour that is sometimes utilised for the purposes of self-punishment. In the above interview extract from Lisa, the distinction between suicide and NSSI is defined by the premise that self-injury is a form of repentance. Whereas suicide is a means to an end, NSSI is prolonging the emotional turmoil. Lisa experienced a growth of negative thoughts related to her body and physical gender dysphoria. In the case of Lisa's experience of self-injury, NSSI is implied to serve a dual purpose. In the first instance, anger ensues and self-punishment takes place as a way to put an end to thoughts of questioning gender identity. The second is a direct attack on the flesh which is causing these thoughts in the first place. The goal for Lisa is to minimise dysphoria by using NSSI to shift focus, and to simultaneously tarnish the physical body so it is devoid of desire for a gender transition.

When social supports were inaccessible or non-existent, participants pursued NSSI as a means of communicating with those who may have noticed their self-injury.

*[NSSI] became a way of trying to get attention as well. I was trying to get people to notice that something was wrong.*

(Holly)

Social signalling is one of the NSSI-specific vulnerability factors proposed by ITMSI, and featured in the experiences of some participants. Holly struggled to communicate her distress and used NSSI as a way of drawing attention to her internal state. In particular, she spoke of her queer identity as being something which she was not able to talk about with others, resulting in suppressed emotions and elevated levels of stress. Perhaps Holly felt that carving words into her arms was the most effective method through which she could communicate her distress.

Most participants found that eventually their NSSI behaviour evolved. The urge to self-injure gave way to coping mechanisms learned over time.

*Abby: It no longer gives me what I want. You get the short term effects from it, but long term it's preventing me from achieving my goals. But it's taken me a long time to get to that state of mind.*

Interviewer: *What did it used to give you?*

*Abby: I guess it was just the rush of ... yeah ... it was just a comfort... I don't know why... I still don't know why...*

In this passage, Abby speaks about the emotional connection she had to NSSI and her desire to move beyond the self-injury. The NSSI behaviours which once served an emotional purpose, no longer had the same effect. There was a shift in her thinking: she has stopped concentrating on instant gratification and has become focused on future goals. She admits that changing her perception of NSSI has been a drawn-out process. Her speech is punctuated with long pauses. Within this passage, there is an element of melancholy as Abby tries to make sense of why she engaged in self-injury in the first instance.

Abby reports NSSI to have been an experience that was both pleasurable and destructive. At an earlier time, she was dependent on her relationship to NSSI and the behaviour provided a means of coping. These emotions surfaced during the interview and, when prompted, caused her to withdraw from the interview for a few moments while she thought about these effects. She stumbled to find words and describes NSSI as giving her “comfort”. However, Abby recognised that the word “comfort” seemed peculiar in the context of NSSI. She eventually settled on an uncertain “I still don’t know why” in regards to her motivations for NSSI behaviours.

For the participants themselves, there are no quantifiable mechanisms or frameworks which explain why they engaged in NSSI. Perhaps central to their experience was that self-injury once provided an instrumental coping mechanism but now it is seen as futile.

### **3.2 Shared experiences of survival**

Findings indicate that individuals in rainbow communities self-injure at a greater rate than cisgender, heterosexual individuals. In spite of this - or perhaps because of this - the topic of NSSI is largely overlooked amongst members of rainbow communities and seen as inconsequential.

*In non-straight people, trans people [NSSI] is really common. If you know someone's not straight, not cis and you notice scars; you're just like "oh, here's another one". It'd have to be pretty serious before you'd wonder if there was something other than that.*

(Charlie)

Charlie's account emphasises how unremarkable NSSI is amongst members of queer communities. While NSSI is presented in the literature as a maladaptive coping technique, the TDF helps to explain why those who are marginalised may resort to self-injury. Those who identify as LGBTQ may engage in the behaviour as a way of surviving challenges presented by institutional ideological systems. For example, if the healthcare services addressing specific needs of queer individuals are inaccessible, and society is endemically prejudiced towards rainbow people, then it becomes difficult for a vulnerable person to avoid engaging in more extreme behaviours such as NSSI. This is highlighted in Charlie's account: self-injury is commonplace in rainbow communities because it becomes a tool when there are limited alternatives.

Participants displayed clear insight into the positioning of their community as a whole.

*I think that self-harm happens a lot more in queer communities because we're already under quite a lot of other stresses. We are trying to get work, dealing with mental health and homophobia, so it happens more because people are just trying to deal with their problems... I think for my friend circle, and for a lot of the queer people I know now, it's quite a common experience. It's just too much for one person to deal with!*

(Sam)

*I think people who don't identify under the queer umbrella, they still self-harm and have their reasons for it, but I think if you add in that one extra factor that opens up for so many more adverse life events.*

(Ruth)

There is a conscious categorization between the experiences of heterosexual, cisgender people who engage in NSSI and those who are a part of the rainbow communities. This grouping complements the elements of intersectionality and privilege proposed by TDF. Social categorisations such as of gender, sexuality and class are at interplay with oppression, and notion of privilege. That is not to say that everyone in the queer communities experiences the same marginalisation, as the product of this experience is individualistic and circumstance-dependent. Rather what the participants are talking about, simply put, is an entry-level amount of persecution which affects most LGBTQ individuals and results in a mutual collective experience. The whole community is affected through this shared experience, and the bonds shared become a form of solidarity.

While still taboo to talk about openly, the visible presence of NSSI serves as common ground. There is an unspoken sense of comradery in those who engage in NSSI and identify under the LGBTQ umbrella.

*Abby: People who had been through similar things as me who were queer got where I was coming from. Because I don't think straight people can understand how that can have an impact on your mental health. They're just like "Well you're gay, what's the big deal? Why does that make you mentally ill? Why does that make you cut?" but other queer people kind of get it.*

*Interviewer: Can you explain that in more detail?*

*Abby: I guess because it's kind of like this shared experience of being a minority in a way. You get specific kind of stress put on you just by being the minority that people that aren't in that group don't understand. And I think they don't realize how much of an impact it can have on your health.*

By sharing her personal experience, Abby's claim supports a notion already explored and supported by the literature: minority stress can and does lead to negative health outcomes for LGBTQ individuals. She positions the experience of her queer-identifying friends as significant and meaningful. However, those who are heterosexual are not privy to the intricacies of her queer identity, and thus are ignorant to its complexity. As such, finding people who had gone through similar experiences was valuable and claiming a part in a shared identity contributed to higher self-esteem.

*I started surrounding myself with a lot of older queer women and holding on to their identity to hold on to my identity because I didn't feel like I had one, or one that I was allowed to claim. So I really got a lot of strength from that.*

(Ruth)

Similar to other participants, Ruth places importance on finding and establishing connections with those who were already a part of the LGBTQ communities. The people who Ruth met acted as peers and provided her with the hope and role modelling she needed to ease her isolation. Through these interactions, she found comfort and familiarity and was able to validate her experiences, eventually becoming comfortable with her own identity.

The shared experience, peer support and modelling - or simply holding space - as a means of surviving is an established notion in LGBTQ circles. It Gets Better, a notable project formed from concern about high suicide rates of rainbow adolescents, began in 2010 and focussed on providing online resources. The organisation aimed to “uplift, empower and connect” sexual and gender minority youth and convey the message that queer identity forming was a difficult journey, which would indeed get better (It Gets Better Project, 2017). The experiences of the participants demonstrate that this kind of connectedness - whether online or in real life - and the ability to relate to others in the LGBTQ communities had a greatly beneficial impact on survivorship.

### **3.3 Preventing relapse**

Despite participants ceasing all self-injurious behaviour, persistent thoughts about NSSI were still present.

*I still have the thoughts like “it would help” if I'm feeling down...but I don't act on them.*

(Charlie)

*The self-harming thoughts didn't necessarily go away, but the behaviour and the purpose of the behaviour went away.*

(Ruth)

The thoughts were largely to do with wanting to self-injure again when participants found themselves in high-stress situations. For Charlie, this feeling manifested during times of low mood connected to their gender dysphoria. For Ruth the urges to engage in NSSI were largely connected to stress relief: being brought up in a homophobic family, struggling with friendships due to her sexuality, and self-critical ideas around not meeting expectations placed upon her. When she was able to relieve her external pressures by physically cutting ties with people and aspects of her life she found overwhelming, she was able to rid herself of the NSSI behaviour. Despite this, everyday life stresses continued and as a result, she still struggled with thoughts about NSSI.

Participants found that managing urges of NSSI were an important aspect of preventing relapse. One way of managing thoughts and guarding against future NSSI was to remember why participants stopped in the first place. Recognising NSSI as an unhealthy coping mechanism provided the participants with the ability to choose alternative techniques for managing their emotions. However, there was still considerable struggle with managing NSSI urges:

*There's still that feeling of considering going back to [NSSI], and if that's going to be a weak thing to do, and a failure thing to do.*

(Sam)

Here Sam uses self-criticism to condition themselves into not engaging in NSSI. The perception that going back to NSSI behaviour is a mark of weakness is unfavourable, as it places the blame on the individual if the behaviour does occur and this would contribute to negative self-esteem, which may re-start the cycle of NSSI all over again.

Rather, a more constructive way of understanding NSSI as it applies to participants, may be when it is framed as an addiction. In previous themes, Abby uses the metaphor of NSSI as an addiction (1.3; 3.1). While research comparing self-injury and substance addiction has concluded that the two behaviours differ in their reinforcement methods (Victor, Glenn, & Klonsky, 2012), participants conceptualised their self-injury as an addiction and this perception requires exploration. The power of the NSSI effect was so large that, like an addiction, NSSI was a behaviour which participants characterised by tolerance and withdrawal. For Abby, there is recognition that in order to cease engagement of NSSI, she has to undergo a period of transformation.

As in substance use disorder, NSSI impairs both intrapersonal and interpersonal functioning. It helped participants cope in the short-term but ultimately led to challenges and complications later on in their lives. Participants experienced the same tolerance with NSSI as is the case with substance addiction, leading them to self-injure more frequently with greater severity. The withdrawal was punctuated by craving. Participants also experience stigma associated with the behaviour, through visible scarring.

Parallel to the Twelve Steps programmes for managing addiction, the participants had to acknowledge that they no longer were in control and be reflexive (Alcoholics Anonymous, 2017). Recovery was then dependent on the individual's ability to be resilient and seek help when necessary.

*I still had thoughts about [NSSI] and then I just became more comfortable talking about it with my mum, my friends and then I met [my girlfriend] and I completely changed my focus.*

(Holly)

Here, in combination with openness and frankness with her mother, a new stimulus created an escape from self-injurious thoughts for Holly. The “change of focus” she refers to here is perhaps a desire to start anew with a prospective partner. It is unclear whether her queer identity remained closed from friends and family as there is no indication of it being resolved alongside self-injury ceasing. However, Holly mentions that though finding a partner she was able to explore her queer identity in a way which was previously inaccessible. The support which her partner provided, combined with having a strong sense of identity helped Holly to manage her NSSI and eventually recover. Similar to previous research personal growth, social support and meaningful relationships with others (Whitlock et al., 2015); and a strengthened queer identity and feeling of belonging played a big role in the participants being able to identify the self-injury urges but not engage in the behaviour (McDermott et al., 2008; Scourfield et al., 2008).

### **3.4 Perseverance**

A large part of the participants’ journeys involved the realisation that they no longer needed to engage in self-injurious behaviours. Through this, some positioned themselves as survivors.

*It's taken me a long time to be really okay with [my self-injury] and it's a really difficult thing to try to explain to my family, to my mum. I think a lot of people think of it in really negative terms, but for me it shows that I have been through some things that were really difficult. And that I got over them and I survived them and I'm here. [...] A lot of those symbols- like scars or bruises, for me, it is something that is like "I survived this".*

(Sam)

There is a sense of reducing the burden experienced by participants who no longer self-injure. Like other participants, Sam frames their self-injury as something which contributes to their strength of character. There is a resilience created because of the NSSI. The label survivor reflects the ability to overcome the difficulties in life and to continue to function in spite of challenges.

When asked about whether the experience of engaging in NSSI was largely negative overall, some spoke of positives which occurred as the direct result of their self-injury and adverse life events.

*Every negative experience in my life, I know that I can use it in a positive way now that I've overcome it and I'm able to work through it. And so I think that is a positive experience I got from [NSSI], but it was horrible to go through at the time. It's not something that I would be like "that was worth going through to have this positive experience" but I'm glad that I have had a positive outcome and I'm glad that I was able to survive it so that I can use it as a positive experience.*

(Ruth)

For Ruth, the experiences of her adolescence were something to overcome. There is pride in her survival. Retrospectively, Ruth recognised the importance that NSSI held in her life. It was her primary coping mechanism for difficult times. To make these changes Ruth felt it was necessary to take drastic action. Having a “positive outcome” here relates to being able to access the support she needed, as well as discovering her queer identity. Similarly, other participants chose to take an optimistic approach and view their NSSI as a learning experience.

Participants also framed their past experiences of self-injury as separate to their current identity.

*Now I don't consider myself an active self-harmer.*

(Abby)

The rejection of identifying with NSSI is a form of empowerment. There is a desire be emancipated from the past. The identity of the active self-injurer fades. In essence, this is a second coming out – one that involves having the weight of NSSI lifted.

### **Theme Summary**

For the participants of this study, the act of ceasing self-injury was a slow drawn out process of survival. Participants reported that engaging in NSSI was a conscious choice, at multiple stages of the behaviour's existence. This behaviour allowed them to abstain from suicidal thinking and regulate emotions. When support was lacking, NSSI provided a comfort in place of acceptance. When acceptance was found through a community of like-minded individuals, participants drew on the strengths built before them. The support of others in the community contributed to the self-acceptance of their queer identity. The stigma previously attached to the participants' sense of self, which included NSSI, was replaced by an understanding. This infrastructure provided the necessary tools for the participants to move beyond their self-injury. Despite this, many still struggled with their conditioned cognitions. There was a reflection on the fact that urges remained long after the physical self-injury has ceased. Despite this, participants showed resilience and persevered in giving up NSSI and establishing their queer identity. The following theme addresses the experience of the developed sense of self when faced with the external world.

#### **Theme 4. Assimilation: “Sometimes it is just difficult”**

The fourth theme addresses the effects of experiences: the relationship between participants’ establishment of the queer identity, juxtaposed with residual effects of NSSI. This theme explores the underlying implications of what it means to be a rainbow identifying individual in the world at large. The after-effects of NSSI are also explored by this theme. Participants reflect on the past, look forward to their futures, and make a joint appeal for action.

##### **4.1 Claiming space**

The principle of claiming space is underpinned by feminist theory, and addresses the systematic gendering of material and metaphoric spaces, and as a result, women’s necessity to claim (or in some cases reclaim) the environments. Adapted to queer theory, the term “claiming space” has been used to challenge the negative notion of the “gay agenda” pushed by religious institutions to make the LGBTQ communities appear deviant (Walton, 2014). The concept of claiming space in the context of rainbow communities addresses the act of asserting queer identities in public spaces. Thus, the right to take up and claim space resonates with the desire to be visible, heard, and accepted.

Claiming space exists on a large collective scale in the form of pride parades and LGBTQ protests and marches. However, it is also an individual, nuanced process. The act of being out and visible in society can be communicated through multiple facets of the constructed identity such as body language, outward appearance and behaviour. Participants experienced the claiming of space through their interaction with the world around them and were strategic in choose which personal information was shared.

*So the school that I work with now, I do not feel safe talking about my gender at all. I go by a name there that I don't go by anymore...I think it's good that I'm there in terms of sexuality issues because quite often I'll speak up on sexuality issues, about homophobic bullying and I feel comfortable in that space to be able to do it, but even that is really hard...Even something stupid like having to put down a Miss for a title on my pay slip is terrible.*

(Sam)

Despite changing their feminine name given at birth to a gender-neutral one, as well as using gender-neutral pronouns with friends and family, Sam is not willing to disclose their non-binary identity at their workplace. They are acutely aware that speaking out about their gender identity in the Catholic school at which they work might cause confrontation. However, Sam recognizes that queer visibility is important and can foster a sense of hope in young people they work with. They provide this visibility in the context of being non-heterosexual, or if they are not entirely out in their sexuality, they make a point to at least frame themselves as an ally.

Feeling “safe” to be able to express their concerns about sexuality, but not gender diversity, might be indicative of the relatively recent cultural shift. While differing sexualities are becoming increasingly normalized, individuals who are gender diverse, including those who identify as transgender, experience more overt discrimination. Nearly half of all respondents in the Transgender Survey reported instances of verbal harassment, physical attacks and sexual assaults (James et al., 2016). In the same report, those who felt that they were easily identifiable as transgender and thus perceived as such by others, reported verbal and physical assault at around double the rate of those who were rarely or never perceived by

others as transgender. This fear of deep-seated discrimination is perhaps what Sam demonstrates here.

Being out in the public eye can be challenging. However, participants found that certain groups and workplaces were considerably more tolerant than others, and had largely positive experiences of claiming spaces with their queer identity intact.

*I've had to argue with people a bit about pronouns, most of my friends are at least trying. I have had some verbal abuse, and wrong pronouns used, but mostly people have been alright. It helps that I was already in activists circles in Wellington and a lot of the very prominent people there are non-binary.*

(Charlie)

*With my other job it's a lot more accepted, some of my workmates use my pronouns, but it's a sort of a work in progress. Sometimes it is just difficult.*

(Sam)

Both Charlie and Sam wish to be treated with respect surrounding their pronouns and gender identities, however, they also recognize that it is a process of learning for the people around them. Both accept that misgendering and the use of incorrect pronouns comes with that journey. They accept that mistakes are made and maintain an internal drive which propels them to continue educating their friends and colleagues. The people around Sam and Charlie who attempt to use the correct identity markers are looked upon favourably.

Despite this, both participants seem disheartened, and this is shown through their vocabulary. "At least trying...mostly people have been alright...sort of work in progress...it is just difficult." While both are grateful that people around them are trying, and acknowledge the fact that it is an adjustment for their friends and colleagues, to them, their identity is

elementary. This vocabulary is congruous with the circumstances, as needing to correct others repeatedly and defend the authenticity of their identities would eventually become tiresome.

All but one of the participants were concerned about ways in which their gender and sexuality were perceived, and how their identity interacted with existing ideologies. Lisa presented a different view:

*I think a lot of people focus on WHAT they are instead of WHO they are. I think that people should focus on what they believe, what they do, their accomplishments. Not based on trivial factors like being transgender. I don't see me being trans as all that relevant.*

(Lisa)

Here Lisa illustrates that her gender identity is a relatively insignificant part of who she is. There is a necessity to communicate beyond her outward appearance as a transgender woman. She places emphasis on the desire to be reflected in all her complexity, and criticises those who do not see merit beyond the superficial first impression. To Lisa, her queer identity should not be a factor which impacts other people's views of her. As such, she does not want to be categorised by her gender and sexuality because she views herself to be more complex than those identities. Lisa rejects her queer identity in favour of more traditionally sought-after qualities, such as the strength of character. However, for the remainder of participants, the queer identity was synonymous with their strength of character, which was something to be embraced and presented to the world.

The challenges of claiming space experienced by the gender diverse participants of this study are, to a lesser extent, reflected in the non-heterosexual participants.

*When I removed myself from homophobic people, I removed a lot of conflict in my life - I think that's partly why I stopped self-harming, because of claiming an identity for myself and having calmness over that, being able to say "this is who I am", taking up that space, and not having to stress about it.*

(Ruth)

Ruth was able to remove herself from the situation where she experienced discrimination. She infers that without the prejudice of homophobic people she was able to find her sense of belonging. This favourable experience, in turn, helped to reduce the strain that was driving her to engage in NSSI, and allowed Ruth to mature and gain confidence. Being comfortable in accepting her queer identity, meant that Ruth was able to accept her sense of self and view it as intact. She was no longer intimidated, as now her experience was visible and through this, her identity had a voice.

Holly, a participant whose coming out was generally accepted in her family and the wider community, still experienced discomfort as her right to claim space was challenged. Here, she addresses one particular instance of microaggression:

*I think the only thing that really I feel is, with my friend group, they openly talk about their boyfriends and their sex lives but any time I try to they go "that's disgusting and gross" so that's the only thing that I don't like.*

(Holly)

Holly's friends, who were largely accepting of her lesbian identity, still showed that they had ingrained heteronormative ideas about relationships. The extract reflects that there is a limit to how much Holly's friends are able to accept her. She is free to speak about herself as an individual. However, when talking about any potential sexual or romantic partners she

is met with resistance from her friends, who are repulsed by her same-sex relationships. One underlying message this could send to Holly is that they will tolerate her queerness, as long as she remains single. This apparent heterosexism distances Holly from her tangible experiences of love and sex. It should be noted that although Holly is displeased, she does not dispute this obvious injustice. This brings us to the question of why she allows this behaviour to happen. If she, as mentioned previously, is now stable in her queer identity, then why does she not hold her friends accountable when they are being discriminatory?

To answer the question above, it is useful to examine the contextual experience of participants. It takes courage to be true to oneself at the cost of potentially sabotaging relationships. Furthermore, friends may be held to a different standard compared to strangers, and thus be allowed to express themselves more freely – and as a result, be absolved. The conflict between becoming an authentic self and maintaining relationships is a delicate balance.

*My identity is even more solidified because of all [my life] changes. Now it's become really important because everything else is all over the place. And moving away from people to Wellington, and also being a little bit more assertive with my family. Saying to them "You have to accept this, it's not going away, you have to deal with this now". Or at least "you just have to not actively object to this now". In the past it's just been - they are my family so I would compromise a lot of my behaviour to fit in with them and I just didn't talk to them about any of this. Now because everything else is out of kilter, it is really important that other people know those things about me, whereas previously I might not have done that.*

(Sam)

For Sam, defending their identity is synonymous with remaining grounded when everything else is uprooted. Addressing their family by having a conversation about their queer identity is a way of asserting the right to claim an identity and exist within it free from guilt. The removal of any preconceptions about earlier times when the topic of queerness was dismissed, allows Sam to have a frank discussion with their family. Realising that the only way forward is to remove barriers to communication, Sam enforces new boundaries for how they would like to be portrayed. The many changes which they experience in their life are a catalyst for communicating assertively about their queer identity. The extract illustrates a novel attempt at gaining control. When they were younger, one of the ways Sam would manage situations out of their control was through NSSI. Now, no longer a person who self-injures, it is as if they have come to a realisation: the way to gain control of situations is not through engagement in NSSI, but rather goal-directed self-assertion.

#### **4.2 Living with scars**

As they aged, the participants of this study found themselves in two predicaments. The first, addressed above, related to navigating life in their queer identity. The second was positioning themselves in a new paradigm as somebody with a prior history of self-injury. Those who had visible scarring long after the behaviour has ceased still experienced stigmatisation.

*I'm perfectly comfortable with my queer identity now, I'm fine with that. Self-harming, it's something I still struggle with. I have a lot of scarring on my arms and I don't hide my arms - if I'm hot I'll wear short sleeves, but I do get stares and have had the odd comment. Especially at work, in retail people seem to have no boundaries, which is kinda inappropriate and so I struggle with it. I'm looking into getting skin grafts at the moment because I feel like*

*it's gonna hinder me in my career in the future. But I'm not ashamed of being a self-harmer, being an ex-self-harmer. I'm happy to talk about it if people ask me. I don't think there's anything wrong with it. It was a way of coping with some really bad shit that was happening and it's fine. So I'm not ashamed, but I do struggle with it a bit.*

(Abby)

The strain which Abby reveals here relates to how she is perceived. As with most participants, the conflict arises from other people's perceptions of the NSSI, rather than the participant's own experience of it. Abby is understanding of her own ordeal and is unabashed about her scars. She does not attempt to hide her scars at the cost of being comfortable, though this can result in uncomfortable interactions and, at times, confrontation. She addresses her NSSI as a matter of fact experience; however, the potential for stigmatization in the future is the dominant reason why Abby wishes to have scar-free arms. The need for skin grafts is propelled by external influences: although Abby does not have discomfort about her scars, she knows that there are social consequences to having NSSI scars. Thus, her "struggle" is regarding the fear of not being taken seriously nor recognised for her attributes, and instead being judged on face value in the future.

Whilst some participants were comfortable explaining their previous NSSI to those who asked, others were more cautious.

*[Points to arm to reveal scars] These are the most noticeable ones for people. Yeah, those are the ones that I hate the most because people do ask occasionally. I've responded differently to different people; if I don't really know them then I'll say it was just a really bad cat scratch - because I do scar really easily. I do have cat scratches all over! But if I'm closer to the person*

*I'll say "I had really bad teenage years" - I just kind of joke about it to make it more comfortable for the other person - and yeah - that's how I address it.*

(Holly)

*Back when the scars were darker, I would always wear something over them, but you can hardly see them now.*

(Charlie)

These extracts present an expression of the ambivalence participants felt when dealing with the after-effects of NSSI. Holly is selective about whom she shares her self-injurious past with. With strangers, Holly deflects the attention from the possibility of the scars being from NSSI, to scars which can be explained by socially sanctioned behaviour like cat scratches. When she does speak frankly about her experience with NSSI, she uses humour to diffuse the situation, and perhaps as a way to hide how uncomfortable she is with the questions. Charlie no longer needs to address their scars, as they have faded with time. However, a mention of past behaviours reveals that Charlie was previously avoidant, perhaps as a way of not wanting to create any further conflict or due to internal feelings of embarrassment, shame, or guilt. While it is impossible to speculate which emotions Charlie felt, what can be inferred is that by hiding the scars Charlie felt uncomfortable with displaying them. The reasons for this may be numerous, one being that as a non-binary person already stigmatised by society, Charlie does not want to be further invalidated.

Lisa acknowledges that she is aware that others may notice her scars, but is generally ambivalent to the implications of this.

*People will make their own assumptions and whatever but I don't care. In most cases they don't ask about [scars] and that's fine by me!*

(Lisa)

Lisa acknowledges that sometimes she is asked about her scars, but does not go into detail about how she addresses this. Her lack of reactivity towards the subject is reflected in her overall tone of the interview. She is unconcerned about the opinion of others when it comes to her gender, mental health and NSSI. Furthermore, she sees her self-injury as irrelevant and illustrates a dismissive attitude towards questions about her past NSSI behaviour. Like Lisa's queer identity, the identity created through previous engagement in NSSI currently has no importance to her.

The repercussions of past NSSI behaviour are not isolated. There is an intertwining between self-acceptance of prior history of NSSI and the perceived societal judgement of how deliberate scarring is perceived. These influence the way participants approach the topic of self-injury.

*While I was in high school I'd say anything to get out of talking about [my self-injury] experiences. I really minimized the fact that it was a long term thing for a long time and that things were not ok for a variety of reasons. Now I think that I can talk about it more, with particular people as well, but often I'll talk around it, I'll use euphemisms and won't talk directly to it. Because it still feels enormously unresolved and enormously private information.*

(Sam)

The extract above deals with the acceptance of self and past behaviours. Sam is learning to become comfortable with themselves and their experience. However, they are presented with a culture of shame, fostered through negative portrayals of NSSI. They feel a need to censor information. This seems to stem from two places – external influences, in the

form of how Sam relates to the person asking about the NSSI experiences, and internalised feelings about NSSI which contribute to fear and shame. By suppressing the information they share, Sam is able to manage their feelings towards NSSI.

By contrast, Ruth has found that speaking about her past NSSI allowed her to counsel others.

*“I definitely see [NSSI experience] as a positive now. Especially because of how I can use it now to talk to other people about it, especially friends who say: ‘I just don't know any alternatives’ and I'm like “oh I've done this, this is what I've tried in the past, this is what worked for me” - and I can use that help people. So I love that.”*

(Ruth)

Through maturing and understanding her experiences, Ruth has mitigated the effects of NSSI stigmatisation. By holding space for others, she is able to make a valuable contribution and to create a positive outcome out of her disadvantage. Her altruism evolved into a useful mechanism for her coping. Transforming the way she views her NSSI experience has allowed her to claim it. In the same way, that acceptance of the queer identity in participants has been a journey, so too is the recovery from self-injury.

### **4.3 Building a caring community**

Throughout the interviews, participants discussed the role societal influences played. There was shared frustration around the pervasive nature of conservative ideologies, gender and sexuality norms and the need for healthcare to be more sensitive to the needs of LGBTQ individuals. Below, Sam discusses their experience of compound minority stress:

*My sexuality in general, it's just such a part of me, like it is awesome, there's*

*nothing about that that's ever been bad, it's part of me. But its things that happened because of those things, like bullying and isolation. It gets connected up. So I never felt that my sexuality or gender was making me self-harm. But trying to live in a society or in a situation that was really not okay with it, that was more of the issue.*

(Sam)

Sam did not experience difficulty in articulating their queer identity. Indeed, the psychological distress came from other people in the wider society. Sam saw coming to terms with their gender and sexual identities as a process, informed by external feedback. They attempted to live in the environment, however, found it too difficult to manage. This is the exact principle of decompensation which is proposed by Riggs and Treharne (2017). Although anguish was felt due to living in an invalidating environment, the primary message of this extract is Sam attributed the NSSI specifically to the world around them rather than any internal anguish.

The participants of this study expressed that a more accepting approach was necessary towards rainbow individuals, and proposed ways in which consciousness could be raised.

*Just having [non-binary/asexual] as a word that people know would help. Like when you're doing the some people are gay talk to your five-year-old: "some people like boys and girls, and some people aren't boys or girls, and some people don't like anyone"-it just needs to be an option that people know about and then people will have words if they're feeling like that.*

(Charlie)

Charlie argues that educating children at a young age will help to combat potential uncertainty about their future identities. Knowing all the available options is vital, as it helps to normalise all sex, sexuality and gender diverse identities. Through developing awareness and tolerance, the culture of prejudice inherent in today's society could be dismantled. Teaching children to be more accepting would ensure that the pitfalls experienced by previous generations of LGBTQ identifying individuals would not repeat. There are personal reasons attached to this argument; Charlie did not find the terminology for their identity until later in life. This contributed to negative life events for Charlie, and is perhaps why they articulate a strong focus on disseminating information early on in the lives of young people.

The explanation that society overall contributes to negative health outcomes of minority groups such as the LGBTQ communities is frustrating at best. While research can show correlation between NSSI and identifying as sex, sexuality and gender diverse, it can also open floodgates which implicate the act of *being* LGBTQ as being – essentially - the masters of their own fates. However, it is not the responsibility of individuals, but rather a culture permissive of prejudice. Homophobia, biphobia and transphobia create adverse life events through discrimination. While targeting and then dismantling these concepts is not a linear process, one of the suggested steps to help change perception addressed the need to educate people in caring professions on LGBTQ issues.

*Abby: There needs to be better education for young people in general. At schools, in hospitals, educating people about queer stuff. You know “you might be queer and that's cool”. And intervening earlier, monitoring people better.*

*Interviewer: What do you mean by intervening earlier?*

*Abby: If people, especially people that are queer, if they show signs of struggling, just intervening before they get too set in their ways.*

(Abby)

*People need to know that these things are an option and that it's okay if that's how you identify. We need to have professionals who can actually work with people, people who aren't gonna go "oh so you're depressed, but what's this thing you're saying about pronouns?" Getting misgendered by someone when you're going in and saying "help I'm depressed" does so much harm, it makes people withdraw from the system and themselves. So educating doctors and making sure people know young that these are things you can be and just having the support there.*

(Charlie)

Abby is persistent about the need to assist those who identify as queer and show signs of struggling, for, as she has experienced, there are real dangers which can occur without support. Charlie communicates that health professionals needs to honour people's personal identities and preferred pronouns, as misgendering is disrespectful and can cause rainbow individuals to abstain from seeking help altogether.

Participants felt that advocating for LGBTQ rights amongst the caring professions was an effective way to affect change. Currently across Aotearoa/New Zealand, school-based programmes are run by InsideOUT, which aim to educate teachers and students on sex, sexuality and gender diversity (InsideOUT, 2017). Education in the health sector has been scarce, and training on how to manage the specific needs of those in rainbow communities is largely absent from the curriculum. Many health professionals do not feel confident in

responding to the needs of LGBTQ identifying individuals (Somerville, 2015). However, understanding the intricacies of the queer identity is paramount to being able to provide adequate healthcare. Rainbow individuals seeking help have consistently reported instances of verbal abuse from health professionals and some have been refused treatment entirely on the basis of their sexual or gender identity (James et al., 2016). These experiences have also been explored by the participants of this thesis, and reluctance to seek help has evolved out of fear of being stigmatised and mistreated.

Providing tailored support without judgement means that individuals are more likely to seek support when they need, instead of isolating themselves further. Through eliminating maladaptive coping techniques such as NSSI, there is a strong possibility for reduction in suicidal behaviours and subsequent suicide attempts. What the participants are alluding to here is that normalising queerness is the first step, and supporting those who are in need of help is the necessary follow-up.

The concluding remarks of some participants' interviews related to their ideal world and a different future for the LGBTQ youths. The sentiment behind their extracts was one of fostering acceptance. Participants realised that in order to achieve this, ultimately, society needed to become more tolerant of rainbow individuals.

*My ideal world would be one where characteristics like sex and gender identity and sexual orientation are irrelevant. Then there would be no judgement, and it wouldn't put anyone at risk of anything.*

(Lisa)

*I think society needs to shift, I just don't know how on earth it's going to*

*happen. I think more access to help is the best thing. It's definitely not on the individual.*

(Abby)

*There needs to be complete, true equal rights. So we feel completely accepted into society. So you can say and do whatever and for that to be okay.*

*Completely okay and not strange, not like “Ew that guy is buying a dress”, just normal, just normalised.*

(Holly)

These three extracts point out that whilst there are changes which can be made on the individual level, tolerance and understanding cannot be built by the LGBTQ communities alone. What this minority is largely challenged by are the ideologies which dictate what is normal and what is outside those norms. The issue of queer discrimination is one that needs to be resolved at a wider level, building connections between those who are LGBTQ, their communities, the allies and society at large. The potential to change a culture where homophobia and transphobia prevail is dependent on people working together. As Lisa points out, if sex, sexuality and gender diversity are irrelevant then there is no cause for aggression. Abby is sceptical of being able to change values in society and focuses her attention on access to more care for those LGBTQ individuals who are struggling. However by acknowledging that this is “not on the individual”, she implies that this is a communal effort, which goes beyond aiding those who are in need. Holly conceptualises her position through human rights and freedom of expression. True equality begets normality, and for the participants of the thesis is the ultimate goal.

## **Theme Summary**

The previous three themes addressed the risk and protective factors of LGBTQ participants who engaged in NSSI. The current theme integrated those experiences and examined the process of rehabilitation. Participants had largely become secure in their identity; nonetheless, most were presented with obstacles in the world around them. This was evident when interpreting themes of queerness, as well as themes surrounding self-injury. A major milestone in reaching adulthood was learning how to navigate adversities such as discrimination without NSSI whilst staying true to their queer identity. Participants spoke of the positive impact wider society could have on the lives of rainbow individuals. Whilst each person had individualised and differing opinions on how equality could be achieved, all six unanimously concluded that fostering a culture of acceptance was one of the major ways to shift the stigmatization of the LGBTQ communities, which in turn could reduce the rates of NSSI. Educating care providers and society at large was proposed as the first step.

## Chapter 4: Discussion

The aim of this study was to understand how LGBTQ individuals who have engaged in NSSI made sense of their experience. The interviews and analysis were carried out using IPA, and the focus of interpretation was on finding out what mattered to the participants and what it meant for them. The goal was to contribute to the already existing - albeit scarce - body of literature for the purposes of aiding the understanding of the specific mental health needs of those in the rainbow communities, who engage in NSSI. The following research queries guided this process:

1. Exploration into the participants' backgrounds and contexts which have shaped them.
  - a. Family, friends and social support
  - b. Experiences with stigma, discrimination and/or acceptance
2. The nature of the interaction between the participants' sexual/gender identity and NSSI, in particular during:
  - a. The onset and offset of their self-injury
  - b. The process of their coming out
  - c. Whether the participant's identity was influenced by NSSI and vice versa
3. The role NSSI played in participant's lives as shown by self-reflection.
  - a. How they were helped or hindered in their recovery
  - b. What observations did they come to on their journey
4. How the theoretical frameworks of NSSI and TDF reflect the experience of the participants.

## **What was the experience of LGBTQ individuals engaging in NSSI?**

The most effective way of understanding the experiences was to create a timeline throughout the interview and inquire about milestones in the participant's lives. Through this, the participants were able to provide the backdrop necessary to understand the evolution of their identities and the NSSI behaviour. The main stages of their journeys and shifts in thinking were experienced in the following way: childhood experiences and family influences, the first questioning of gender and/or sexual identity, the first NSSI experience, maintenance of NSSI throughout the processes of coming out, being out and finding a community, the cessation of NSSI behaviours, and learning how to deal with stresses without NSSI.

### **Early life experiences and backgrounds**

In adolescence, the primary source of the participants' understandings of gender and sexuality came from their immediate environments: their family, school, and friendships. Family, an established protective factor for NSSI in sexual minority youth (Taliaferro & Muehlenkamp, 2017), played an important role in the establishing sense of queer identities. Family members who displayed prejudiced views towards LGBTQ individuals contributed to the displacement of the participants' queer identities, resulting in internalized homophobia and transphobia. Parents were also generally perceived to be unhelpful surrounding the topic of NSSI, which meant that both the participants and their parents were largely avoidant.

Lack of support within school environments combined with persecutory behaviours of classmates contributed to internal stresses and negative self-esteem. This was evident in experiences of both NSSI and the emerging sexuality and/or gender identity. In order to maintain social relationships, participants suppressed their queer identities to fit in. Support from adults, meaningful friendships, and feeling safe in the school environment has been

found to be additional protective factors against NSSI (Scourfield et al., 2008; Taliaferro & Muehlenkamp, 2017). For the participants, these support systems were largely lacking. Sexual minorities are three times more likely, and gender minorities four and a half times more likely to experience bullying in Aotearoa/New Zealand schools, and both groups fear being harmed at a rate double the heterosexual, cisgender youths (Clark et al., 2014; Lucassen et al., 2014). The results from the current study are consistent with this data and show that the school environment can contribute to overall negative health outcomes for those who are LGBTQ. It must be noted that friendships were more negatively impacted by the stigma surrounding rainbow youth than by NSSI, and some participants did have friendships where they were not discriminated against on the basis of their self-injury.

### **Interaction between identity and NSSI**

While participants had complex histories that contributed to NSSI, everyone saw their experience of NSSI as being intrinsically connected to their sense of their queer identity. Adolescence was a challenging time for participants as they grappled with self-injury and their queer identity. The process of coming out was an experience which was seen as a double-edged sword: it was both a protective factor through the possibility of enhanced social support with like-minded people and reduced internalised homophobia, and a risk-factor which could lead to isolation and make the participants more prone to bullying. This dual relationship has been explored before (DiStefano, 2008).

After coming out, participants came to a place of self-acceptance. Finding names for the identities which fit their experiences was empowering. During this time the perceived necessity for NSSI behaviours reduced. The event of coming out often coincided with leaving the school environment and being able to be in control of which people the participants surrounded themselves with. However, some participants faced further challenges in the

working environment. There is no doubt that the passage of time played a factor in the growth, development and newfound maturity of participants which allowed them to find new coping techniques. In addition, participants also explicitly stated that the act of coming out contributed to a more positive and grounded sense of identity which meant they were able to reduce the need for NSSI. This sense of confidence contributed to personal growth and contributed to positive perceptions of one self, despite the contextual and environmental difficulties.

### **Participant's self-reflection**

Self-injury was largely used as a way of coping with high-stress stimuli, cognitions and feelings. On reflection, participants reported that it was a necessary behaviour for them at the time of its engagement. The majority saw NSSI as an experience that contributed to their ability to survive, and spoke of positive outcomes associated with NSSI such as becoming stronger and more resilient in spite of their negative experiences.

Self-injury was intertwined with the identity of participants, and learning to let go of that part of themselves was at times challenging. Participants spoke about thoughts of desire to continue NSSI, but were able to curb them. As NSSI served an important function for a prolonged period of time, learning to live without relying on NSSI was significant, and positioned as a secondary coming out. The identity of someone who engages in NSSI was replaced by the status of being someone who has previously engaged in NSSI but no longer does. There was a sense of ownership of past behaviours and pride in their new identities.

### **Role of the LGBTQ communities and society at large**

Two vital aspects, the role of the community and the influence of society, emerged through the research which the aims did not explicitly seek to address. Participants spoke at

large about the importance of finding their LGBTQ community and building connections. The feeling of belonging was paramount to the ability to accept the participant's own identity. Some were positively influenced by the individuals they met through connections in the rainbow communities, and modeled their behaviour on older queer people that they admired. This provided a space to safely experiment with their sense of identity and inspired gratitude. The influence proved to be so powerful that when the participants were able to claim their space, they wanted to give back to the community by guiding others. This notion of cyclical peer support ensures that the rainbow communities are able to maintain pride in the identity, whilst also providing support in an effort to compensate for the stigma and discrimination that exists beyond the safety of rainbow communities.

Participants also spoke at large of the ruling ideologies which contributed to their unstable identities, their experiences with seeking help and expressed a desire to see a change in the systems which at times failed them. The quality of care in health services which were accessed during periods where the participants sought help varied greatly. While the actions and behaviours of some health professionals were extremely beneficial to the overall well-being of participants, other healthcare providers perpetuated stigmatization, and the participants felt that the quality of care was inadequate. Those who had negative experiences with health professionals surrounding their NSSI and queer identity were averse to seeking support again. As is consistent with the literature, some health professionals lacked the skills for tailoring support to LGBTQ individuals. This served as a confirmation bias for participants negatively affected by their experiences of support seeking.

Furthermore, participants were challenged in their daily life regarding both their queer identity and their previous history of NSSI. Both of these aspects of their lives resulted in discrimination from members of the public. As a result of these experiences, participants felt it was necessary to change the systemic judgments around the culture of NSSI and the

unfavourable views about gender and sexuality. Displaying altruism, most participants had concerns about future generations of LGBTQ individuals and the negative health outcomes associated with growing up in the existing climate, and suggested that educating the world at large on queer identities was the first step towards equality and acceptance.

### **Application of theoretical frameworks of NSSI**

The experiences of participants were reflective of the established theoretical frameworks for NSSI and stress theory. As per Experiential Avoidance Model (EAM), NSSI served as a negative reinforcement for the purposes of emotional regulation. Participants may have lacked the adequate tools to manage their emotions effectively, and spoke of NSSI as being the most effective way of reducing stress. Some also spoke of hyperarousal, which combined with high emotional intensity led them to engage in NSSI as a way of grounding and escaping unwanted thoughts and emotions.

While the suppositions of EAM are supported by the experiences of participants, NSSI was not always as linear a process as the model suggests. The internal emotions, while overwhelming, were not the only reason why participants engaged in NSSI, and the process was less automatic and far more nuanced. For this reason, the Integrated Theoretical Model of Self-injury (ITMSI) was a better fit. This model accounts for participants who had experienced trauma in childhood, as it considers the influence of distal risk factors. The result of growing up in an unstable environment meant that participants were unable to seek support from their families, affecting their interpersonal and intrapersonal functioning. When stress was present, more appropriate responses were inhibited due to the participant's prior experiences. Together, these factors meant that participants were particularly vulnerable to under or over arousal of emotions or may have perceived certain social demands as unmanageable.

The ITMSI proposed six NSSI specific vulnerability factors, which could contribute to the emergence of the behaviour in participants. In her interview, Holly mentioned that she started engaging in NSSI as a result of modeling from a peer, or, as ITMSI would call it, social learning. Lisa expressed that her self-injurious behaviour stemmed from feelings of anger she felt towards herself; this can be described as in line with the self-punishment hypothesis. The implicit identification hypothesis was supported in a number of accounts, as NSSI was identified to be the most effective coping mechanism over others. Both Holly and Abby described using NSSI for the purposes of social signalling. Participants also reported experiences consistent with the pain analgesia/opiate hypothesis. Finally, NSSI was indeed seen as pragmatic, for its ease of accessibility and time efficiency. Participants engaged in NSSI for a multitude of reasons, approaching different instances of self-injury through different emotions and mental states. For this reason, the application of experiences to the ITMSI will always seem far too simplistic, however, this model is able to quantify the rationales behind the onset and maintenance of NSSI.

### **Application of the Decompensation framework**

Through the application of the Decompensation Framework (TDF), it is possible to see with some clarity why LGBTQ individuals might resort to NSSI. The social stresses placed on sex, sexuality and gender diverse individuals is persistent and impacts on the quality of life. The main principle behind TDF is that the human existence is inherently and unquestionably connected to overarching ideals, demographic factors and the qualities of experience which an individual is subject to throughout life. These are addressed by ideology, intersectionality and privilege.

From a young age, LGBTQ individuals are exposed to social norms which assume heterosexuality and cisgender identity. These heteronormative and cisnormative ideologies

destabilise the identities of those who do not identify as such, contributing to stress. This particular stress does not come from the minority status, but rather from fighting and challenging a system which constantly invalidates one's existence.

Each participant had multiple ideologies attached to their existence, which is why the perspective of intersectionality needs to be considered. Each participant challenged a broad range of ideologies. The overarching ideologies of sex, gender, sexuality, class and disability were all part of the participants' experiences and ones that the participants had to compensate for. This contributed to compounding effects of stress.

Some participants were more privileged and this was particularly evident in the experiences of those who identified as cisgender. In particular, there were notable differences in help-seeking. This suggests that health professionals may be more equipped to deal with the needs of non-heterosexual individuals, while transgender and non-binary individuals remain disadvantaged.

While there are individual differences between the effects of compounding stress, the rainbow communities remain marginalised. Thus, the effect of constantly having to compensate and stand against discrimination can be draining. Decompensation is deflating to individuals who have to assert their right to claim space. Stress results from the challenges queer people face every day. For this reason, change cannot occur at the individual level. In order to gain true equality, the ideologies which permit the oppression of LGBTQ individuals, need to undergo a dramatic metamorphosis.

### **Limitations of this study**

The research within the LGBTQ communities is subject to a number of limitations. A major difficulty with researching such a diverse group is representation. While umbrella

terms used for the purposes of recruitment, it was impossible to include all identities and aggregated research finding can never represent this group entirely. As such, there was a lack of ethnic diversity, and indigenous sexualities and genders were unaccounted for. Due care was taken to include these identities on recruitment posters; however a different recruitment method may have been more effective in involving ethnically diverse queer individuals. The recruitment poster did not explicitly state the inclusion of specific indigenous queer identities, as the LGBTQ label was thought to be sufficient. However, the label MVPFAFF (mahu, vakasalewa, palopa, fa'afafine, akava'ine, fakaleiti, fakafifine) would have been useful to demonstrate inclusion of not only gender and sexualities, but also diversity of ethnicities and cultures. At the time of recruitment the author was unfamiliar with this acronym and so it was not included. This is an unfortunate paradigm within rainbow research; however it represents the growing diversity and intersectionality of rainbow communities. Research has identified that LGBTQ ethnic and racial minorities experience further stressors which contribute to high numbers of NSSI and suicidality (Black & Kisely, 2017; Bostwick et al., 2014). As such, it is a subgroup which needs particular attention.

Similarly, this research did not include any male identifying individuals. While there were two male identifying potential participants who emailed the researcher, they did not respond to the researcher's efforts to organise interviews. As the potential participants were known to the researcher, it is possible that upon reading the Participant Information Sheet, they did not feel comfortable with disclosing their experiences.

While the participants came from varying backgrounds of social class and education , given the constraints of this thesis, this was not specifically addressed in the research. As the principle of intersectionality guided the research process, it would have been beneficial to enquire more into the social categories of the participants and how these engaged in interplay when applied to TDF. As the interviews were semi-structured, the questions given by

researcher mainly explored queer identities and the participants' experience of NSSI, and this was the primary target of the research.

The sampling of sexuality and gender minorities via internet mediated research methods can provide effective response rates to address research concerns; however, it may also exclude those without internet access (Meyer & Wilson, 2009). Similarly, the age range proved to be limiting, and older individuals emailed and provided the feedback that the experiences of NSSI in the rainbow communities were not age-restrictive. The limited age range was set by the researcher because adolescence is a time during which the majority of people engage in NSSI (Nock, 2010). However, exploring the lives of older LGBTQ individuals is pertinent to the field of self-injury, as it may provide further insights into the way the social climate played a role in shaping behaviours.

The literature on LGBTQ individuals proved to be very inconsistent and while certain publications focused only on sexuality, others merged the results of gender and sexual minorities together. There are known differences between the rainbow subgroups, and this provides implications for treatment (Smalley, Warren, & Barefoot, 2016). While this thesis has explored the overarching ideas and themes pertaining to NSSI in the rainbow communities, at times the voices of those who identified as cisgender varied when compared to the transgender and non-binary participants. This is an important distinction, and future research could benefit from focusing on specific subgroups, in order to identify the differences of experience.

Finally, this kind of research can present itself as pathologising and maintain the very stigma it is trying to dismantle. It is important to note that on average sex, sexuality and gender diverse individuals do not engage in NSSI, have supportive families and maintain positive and healthy lives (Lucassen et al., 2015).

## **Recommendations for future research and practice**

The inherent issues addressed in this research are about the need to dismantle systemic structures which contribute to the culture of oppression in LGBTQ individuals. Future research which seeks to explore further how pervasive heteronormative and cisnormative ideologies contribute to negative health outcomes for rainbow individuals is needed. On a practical level, the implementation of continued education for those in caring professions could be beneficial. Exploratory studies with health professionals, educators and the general public could provide insight into what resources need to be made available to allow for better understanding of LGBTQ communities.

Future research with those who are sex, sexuality and gender diverse could explore further the experiences of help-seeking, which could provide insight into the challenges and impacts LGBTQ individual face. Another area of research could explore what role community plays in the identity-forming of those who are coming out. By contrast, research into the experiences of older members of the rainbow communities is also required, as literature in this field is largely absent. Research into NSSI should seek to understand the mechanisms behind what makes individuals stop the behaviour, as the offset of NSSI can provide information for relevant clinical application.

The results of this thesis can also be used as a means of validating clinical practice. Minority stress theory has been adapted and applied in clinical work with transgender and gender non-conforming clients (Hendricks & Testa, 2012), however, TDF is a much more robust framework through which health professionals may identify particular stressors. Health professionals need to be inclusive of LGBTQ individuals, implementing practices that are responsive to their needs. Promoting hopefulness (Hirsch, Cohn, Rowe, & Rimmer, 2017), using gender inclusive norms (Carabez et al., 2015), learning about terminology and

the historical background which informs the existence of LGBTQ people today (Clarke et al., 2010) are all tools which health professionals should use to contribute to positive emotional and behavioural outcomes of rainbow individuals.

## **Conclusion**

This research aimed to understand the experience of NSSI in those who identified under the LGBTQ umbrella. Four main themes were identified: Support seeking, which addressed the need for better supports in place; Hesitant sense of self, where the participants' journey illustrated that coming out is a complex process, further complicated by social environments and internalised homophobia and transphobia; Survivorship, which identified a time where NSSI was seen as a necessary tool, reflected on the importance of the LGBTQ communities, and showed a transition of participants to a life with their established queer identity and without NSSI; and Assimilation, a theme exploring the ongoing prejudice towards queer identities who engaged in self-injury and the necessity to build a caring community.

Discrimination and oppression occurred at the collective level, and the burden of stress negatively impacted the participants. Participants experienced NSSI like a symptom of that stress. In order to break down the pervasive ideologies and pathologising views which exist towards members of the rainbow communities to this day, people in caring professions, and in particular, health professionals need to act as allies and facilitate opportunities whereby empowerment can take place.

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## Appendix A - Participant Information Sheet

### *Experiences of non-suicidal self-injurers in LGBTQ communities: A qualitative exploration.*

#### PARTICIPANT INFORMATION SHEET

24 May 2016

My name is Dasha Fedchuk. I'm undertaking this research project to fulfill the requirements for completing a Masters of Science degree in Psychology, at Massey University (Wellington). Dr. John Fitzgerald at the School of Psychology is supervising this project.

#### **Project Description**

While there is a higher chance that a person might self-injure if they are non-heterosexual, this topic has largely been overlooked in published research. The purpose of this study is to explore sex, sexuality and gender diversity and its relationship to non-suicidal self-injury (NSSI). The focus is on exploring the reasons people give for engaging in self-injuring behaviours, and how these behaviours helped or harmed the shaping of the participant's current identity.

- NSSI is anything that involves self-inflicted damage to body tissue, without the desire to commit suicide.
- I'm interested in finding out what has led to your self-injury, the way you view your identity and whether you think there is a connection between being a self-injurer and being LGBTQ.
- I'm also interested in exploring commonalities in experience, through which it might be possible to raise awareness on this topic in the future.

Please read this information sheet thoroughly, including the consent sheet that is separately attached and let me know if you still want to participate.

### **Researcher's relationship with the LGBTQ community**

**All participants in this study have the right to have their information kept confidential. Because of the small LGBTQ community in Wellington it is possible that we may know each other, or meet in the future, as I am also a member of this community. Despite this I will ensure that I keep your participation in this study confidential, along with any data you contribute. If there has been, or may be any future social contact between us, and you think this would be awkward, then you should not volunteer for the study. I am happy to discuss any concerns or questions you might have.**

### **Participant Information**

- You must be between 18-30 years of age, identify as sex, sexuality or gender diverse (LGBTIQ), have personal experience with self-injury and be fluent in spoken English.
- You must **not** have self-injured within the past 3 months.

### **Project Procedures**

- You will be invited to take part in a confidential one-on-one interview.
- If you decide to go ahead with the interview, and have read this sheet and the Consent Form (and are happy to sign it) we will set up a meeting – by contacting me at the email address given at the end of this Information Sheet - at either of the following locations.
- Interviews will be held in a private library meeting room at either Massey University or Victoria University campus. (I will attach the maps to the location if you need). I will let you know what room and level of the library we will be on when I book the room. I can also meet you at the front doors of the library.

- When you arrive for the interview we will re-read the Consent Form together and if you are happy to proceed, you will be asked to sign this form. The interview will start.
- The interviews will take approximately one hour and will be audio-recorded. It is made up of a series of semi-structured questions.
- During the interview you will be invited to talk about your experiences of being a self-injurer, including questions about your identity under the LGBTIQ umbrella and how it relates (or does not relate) to your self-injury.
- You will have 7 days to withdraw your data, after which I will begin to transcribe (write-up) the interviews.
- As a ‘thank you’ for your time you will be given a \$20 supermarket voucher.

### **Participant Risk**

It is anticipated that no risk or harm is likely to occur as the result of participating in this project. However, the interview may bring up upsetting memories or make you feel uncomfortable due to the personal nature of the questions. Information about services available for support and assistance will be provided to all participants. Some of these services are free, but some will incur a fee if you choose to utilize them (you will have to pay for the paid services). If I am concerned that you are feeling distressed I will contact my supervisor and discuss this while keeping your identity confidential.

### **Data Management**

- The recordings, transcriptions and any associated notes will be used solely for the purposes of the research project.
- My supervisor and I will be the only people able to access recordings of interviews.
- The recordings will be used to create a transcript.
- Recordings of the interviews will be destroyed when the transcription is finalized.
- All data is confidential and will be made anonymous upon transcription.
- If you would like a copy of your transcript I will provide one to you via email.
- You are able to request a summary of findings, which will be emailed to you upon the completion of the project.

## **Participant's Rights**

You are under no obligation to accept this invitation to participate. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study (up to 7 days after your interview takes place);
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used;
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview.

## **Project Contacts**

You may contact me or my supervisor at any point if you have any questions about this project, or to discuss concerns or give feedback. Thank you for considering participation in this study. If you are willing to proceed with an interview, then please let me know via the email address and I will email you back to arrange a suitable time, date and venue for the interview.

- *Researcher: Dasha Fedchuk* [dasha.fedchuk@gmail.com](mailto:dasha.fedchuk@gmail.com)
- *Supervisor: John Fitzgerald* [J.M.Fitzgerald1@massey.ac.nz](mailto:J.M.Fitzgerald1@massey.ac.nz) (04 979 3620)

*This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 16/09. If you have any concerns about the conduct of this research, please contact Dr Rochelle Stewart-Withers, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83657, email [humanethicsouthb@massey.ac.nz](mailto:humanethicsouthb@massey.ac.nz)*

**Appendix B - Participant Consent Form**

*Experiences of non-suicidal self-injurers in LGBTQ communities: A qualitative exploration*

**PARTICIPANT CONSENT FORM - INDIVIDUAL**

25 May 2016

- I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- I agree/do not agree to the interview being sound recorded.
- I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.
- I consent to my interview being transcribed (written up) and used for the purposes of the researchers thesis and any publications that may ensue.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study until 7 days after my interview.
- I agree to participate in this study under the conditions set out in the Information Sheet.
- I wish/do not wish to receive a summary of the results from the study.

**Signature:**

**Date:**

.....

**Full Name -  
printed**

.....

## Appendix C - Interview Schedule

Interviewee code name:

Date/time:

### Background and context

1. Tell me about when you started self-harming?
2. Tell me about when you started identifying with an X (non-heterosexual, or LGBTQ, whatever the interviewee identifies with) identity?
3. Why do you think you began self-injuring?
4. What kind of experiences have you had with telling friends/family/anyone else about your self-injury?

### Current insight

5. What has been your experience of being LGBTQ?
6. What has been your experience of being a self-injurer?
7. Do you think your sexuality/gender identity relates to your self-injury? Why/why not?

### Experiences w being a LGBTQ self-injurer

8. What experiences have you had as a result of self-injuring?
9. What experiences have you had as a result of identifying the way you do?
10. In your opinion, do you think there is a connection between self-injury and being LGBTIQ? Why/why not?
11. Do you think that the LGBTQ community is at risk of self-injury more so than the heterosexual community? Why/why not?

### Final

12. What has helped you stop self-injuring?
13. Have you got any further comments or questions?

## Appendix D – Glossary

**Aromantic** – (Aro for short) A romantic orientation. “An aromantic is a person who experiences little or no romantic attraction to others. Where romantic people have an emotional need to be with another person in a romantic relationship, aromantics are often satisfied with friendships and other non-romantic relationships” (RainbowYOUTH, 2017).

**Asexual**- (Ace for short) “Asexuality is the lack of sexual attraction to others or the lack of interest in sex. People who identify as asexual may still identify with other sexualities and be romantically attracted to other people and have fulfilling relationships. Because of this, some asexual people do choose to engage in sexual activity” (RainbowYOUTH, 2017).

**Biphobia**- Biphobia involves a set of beliefs and actions which discriminate against bisexuality and the denial that bisexuality is a genuine sexual orientation (Clarke et al., 2010).

**Bisexual**- “Bisexuality is romantic or sexual attraction to people of the same and different genders. Bisexuals may be predominantly attracted to others of the same gender, predominantly attracted to others of a different gender, and/or equally attracted to both. For some people this may change over time, and it depends on every individual” (RainbowYOUTH, 2017).

**Cisgender**- (Cis for short) is used to describe someone whose gender identity matches their assigned sex at birth (Treharne & Beres, 2016). “If your birth certificate is marked ‘Female’ and when you grow up you identify as a female woman, this means that you have a cisgender gender identity” (RainbowYOUTH, 2017).

**Cisgenderism**- “The ideology that delegitimises people’s own designations of their genders and bodies” (Ansara & Hegarty, 2014, p. 2)

**Cisnormativity**- “This is a viewpoint that is based on the assumption that being cisgender is the ‘default’ or ‘normal’ gender identity, instead of being just one of many possibilities. Cisnormativity is often expressed subtly, but can be seen in advertising, print and electronic

media, education, law makers, and a range of attitudes expressed by society in general” (RainbowYOUTH, 2017).

**Closeted** – “An LGBTQ person who does not reveal their sexual/gender identity” (Clarke et al., 2010, p. 258)

**Coming out** – “This means both coming to recognise and identify oneself as non-heterosexual or trans, and disclosing that information to others (often referred to as ‘coming out of the closet’). Coming out as non-heterosexual or trans is only necessary because of the normativity of heterosexuality and of the social dominance of a binary sex/gender system, in which we are presumed to be either male or female, always and forever” (Clarke et al., 2010, p. 258)

**Conversion therapy**- Sometimes known as “reparative or re-orientation therapy”. A range of dangerous and discredited practices that falsely claim to change a person's sexual orientation or gender identity or expression (Clarke et al., 2010).

**Fa’afafine**- “Fa’afafine are Samoan biological males who behave in a range of feminine-gendered ways. Fa’afafine falls into a third gender, separate from male or female. They have been an integrated part of Samoan communities for centuries” (RainbowYOUTH, 2017).

**Gay**- “Gay is a term that is often used for males attracted to males, however it is also used as a general term for both males and females who are attracted to the same sex. There is no “typical” gay person – gay people are just as diverse as straight people” (RainbowYOUTH, 2017).

**Gender**- Used to describe someone’s internal sense of identity. Gender is a multi-dimensional construct, which features elements of identity, expression and relationship to one’s body. There are more genders than male/female and for this reason gender is conceptualised as a spectrum, instead of a binary. Gender is distinct from sex and sexual orientation.

**Gender expression** – “The performance and enactment of gender” (Jourian, 2015, p. 14).

**Gender identity-** “Person’s own self-conception of gender” (Jourian, 2015, p. 14).

**Gender-queer-** “Usually an umbrella term used to describe those whose identity is non-normative (not male or female). It can also be used as a stand-alone gender identity itself , pertaining to feelings of being neither male or female, both, or somewhere in between. Genderqueer is also a term used to refer to a political standing, similar to gender nonconforming, where one rejects the binary of gender or the assigning of characteristics or behaviours to one gender identity” (RainbowYOUTH, 2017).

**Gender neutral-** see Non-binary/Gender-queer

**Gender nonconforming** – see Non-binary/Gender-queer

**Heteronormativity-** “This is a viewpoint that is based on the assumption that heterosexuality is the ‘default’ or ‘normal’ sexual orientation, instead of being just one of many possibilities” (RainbowYOUTH, 2017).

**Heterosexism-** The assumption that heterosexuality is inherently “normal and superior to homosexuality and that everyone is or should be heterosexual. Heterosexism infuses social institutions and everyday interactions. A non-heterosexist approach avoids such assumptions” (Clarke et al., 2010, p. 262).

**Homophobia-** “Homophobia involves a set of beliefs and actions which discriminate against homosexuality (or other sexual orientations)” (RainbowYOUTH, 2017).

**Internalised homophobia-** “Negative feelings towards oneself as a lesbian or gay man resulting from having internalised the negative attitudes of others and of the wider society towards homosexuality” (Clarke et al., 2010).

**Intersex-** “The term intersex is a general term assigned to those whose reproductive or sexual anatomy doesn’t fit the typical definitions of either male or female. Genital variance can usually be assigned by doctors at birth, and can lead to a child having corrective surgery to make them appear male or female before they are old enough to consent. Variance in one’s

reproductive system may not be discovered until later in life during puberty and the development of one's body" (RainbowYOUTH, 2017).

**Lesbian-** "Lesbian is used to describe sexual or romantic attraction between females. It is a broad term, and those who identify as lesbian may express their identity in lots of different ways" (RainbowYOUTH, 2017).

**LGBTQ-** Synonymous with 'queer and trans', 'rainbow communities', 'sexual and/or gender minorities' and 'sex, sexuality and gender diverse' and other variations. Used as umbrella terms to describe individuals who are not straight and/or not cisgender. There is no agreed upon term in these communities, and these are interchangeable. However, some individuals prefer certain umbrella terms over others for personal societal and political reasons.

**Microaggression** – "Subtle forms of discrimination, often unconscious or unintentional, that communicate hostile or derogatory messages, particularly to and about members of historically marginalized social groups" (Nadal et al., 2016, p. 1).

**Non-binary-** "Usually an umbrella term for those who do not prescribe to the separate definitions of male and female (for example: gender variant, gender nonconforming, genderqueer, gender-neutral). A non-binary person can carry this as a gender identity, where they feel neither male or female or both at any given time, or a political identity (or both) where they reject and critique the western binary models of male and female gender identities" (RainbowYOUTH, 2017).

**Pronouns-** Singular pronouns used to address individuals. Can be male he/him, female she/her, or gender neutral they/them. In some cases gender neutral pronouns can be ze/zir or xi/xyr. Each person has pronouns they would like others to use, otherwise called "preferred pronouns".

**Queer-** "Queer is reclaimed word that serves as an umbrella term encompassing diverse sexualities and those who are not sure. This word is used by many people, but it may not be the preferred term for everybody" (RainbowYOUTH, 2017). Queer is a term that can be used to explain one's standalone gender identity (as in gender-queer) or one's sexuality (as in queer, which is to say non-heterosexual).

**Questioning-** “People who are questioning their sexuality or gender identity may not yet be sure how they identify. This is okay! Many people find that they identify in different ways over the course of their life, and some may never decide on a single term to describe themselves” (RainbowYOUTH, 2017).

**Sex-** “How one’s genes, hormones, biochemistry, and internal and external anatomy combine to affect the physical body. The most common sex assignments are male and female, despite a wide range of variation in sexual development in human beings that do not neatly fit into either” (Jourian, 2015, p. 14). It is distinct from gender.

**Sexual orientation/sexuality-** “One’s romantic, sexual, and/or emotional attractions to others” (Jourian, 2015, p. 14). It is distinct from sex and gender.

**Takatâpui-** “Takatâpui is a term that historically refers to a partner of the same sex. Today, it is also used by people who identify as both Māori and queer. It may include sexuality or gender, and can mean different things to different people. It’s a culturally specific term – which means it does not comply with western ideas of gender identity or sexual orientation” (RainbowYOUTH, 2017).

**Transman** – “A natal female who transitions to his preferred male gender identity, through hormonal and/or surgical treatment” (Clarke et al., 2010, p. 260)

**Transwoman-** “Natal males who transition to their preferred female gender identity, through hormonal and/or surgical treatment” (Clarke et al., 2010, p. 264)

**Transgender-** (Trans for short) “An umbrella term encapsulating gender identities where an individual’s self-identification or gender identity does not match the one associated with their assigned sex at birth. A transgender individual may identify with any gender identity (not only male or female), and may or may not have undergone gender reassignment surgery or hormonal treatment” (RainbowYOUTH, 2017).

**Transphobia-** “An irrational negative response to transgender and intersex people, as well as other gender identities. Transphobia often carries the assumption that gender is natural, rather than learned and conditioned” (RainbowYOUTH, 2017).