Voice and silence:

An exploration of sexual orientation and non-suicidal self-injury

by

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Elevated rates of non-suicidal self-injury (NSSI) have been reported among lesbian, gay, bisexual, queer, or questioning (LGBQ) individuals compared to their heterosexual counterparts, but it remains unclear why rates of NSSI may be higher in this population. Using quantitative and qualitative methods, this study explored the role of silencing, a perceived lack of ability to be open and express oneself in social relationships, and how this may be associated with NSSI among LGBQ young adults. Using quantitative data collected from 107 LGBQ young adults with and without a history of NSSI in Part 1, general silencing in relationships was associated with NSSI outcomes through its effect on emotion dysregulation. Silencing specifically pertaining to one’s sexual orientation was associated with the number of NSSI methods through its impact on emotion dysregulation, but was not significantly associated with lifetime NSSI frequency. Results highlight the potential importance of authenticity in social relationships as a way to mitigate NSSI risk and the need to further explore the relation between authenticity in social relationships and emotion dysregulation. Part 2 was conducted with the goal of exploring how one’s sexual identity may or may not be associated with experiences of silence among those with a history of NSSI. Eighty-eight textual narratives provided by LGBQ young adults with a history of NSSI were thematically analyzed using a top-down approach informed by a theoretical
framework of voice and silence. Themes of voice (i.e., group identification, acceptance from others, self-acceptance) and silence (i.e., explicit references to silence, fear, shame, sexual prejudice, and the presumption of heterosexuality) were extracted from participants’ self-defining memories relating to their sexual orientation. Analysis of participants’ self-defining memories demonstrated the prevalence of silence as it relates to their sexual orientation and the empowerment that is experienced through voice. Results also highlight the impact of social interactions and the sociocultural environment on the development of one’s sexual identity. Clinically, this research underscores the potential importance of social support in mitigating NSSI risk, safe and accepting spaces in which to explore one’s sexual identity, and points to the possible utility of narratives in the context of therapy.
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Voice and Silence: An exploration of sexual orientation and non-suicidal self-injury

Non-suicidal self-injury (NSSI) is the deliberate act of inflicting bodily tissue damage (e.g., self-cutting, burning) to oneself without conscious suicidal intent (Nock & Favazza, 2009). A review of the literature indicates that rates of NSSI are highest among adolescents and young adults (Giletta, Scholte, Engels, Ciairano, & Prinstein, 2012; Klonsky, 2011; Rodham & Hawton, 2009; Swanell, Martin, Page, Hasking, & St. John, 2015). Individuals who identify as lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ1; sexual minority) may have higher NSSI rates than those who identify as heterosexual (e.g., Batejan, Jarvi, & Swenson, 2014; Belknap, Holsinger, & Little, 2012; Deliberto & Nock, 2008; Kerr, Santurri, & Peters, 2013; Serras, Saules, Cranford, & Eisenberg, 2010; Sornberger, Smith, Toste, & Heath, 2013; Swanell, Martin, & Page, 2016; Whitlock et al., 2011; Wilcox et al., 2012) but it remains unclear why higher rates of NSSI have been reported by LGBTQ individuals. Indeed, there is a paucity of research examining why those who identify as LGBTQ may have higher rates of NSSI than heterosexual individuals (e.g., Alexander & Clare, 2004; Blosnich & Bossarte, 2012; House, Van Horn, Coppeans, & Stepleman, 2011; McDermott, Roen, & Piela, 2013; Muehlenkamp, Hilt, Ehlinger, & McMillan, 2015; Sornberger et al., 2013; Walls, Laser, Nickels, & Wisneski, 2010; Wagner & Rehfuss, 2008).

One reason that LGBTQ individuals may be at greater risk for NSSI is due to silencing; that is, a perceived lack of ability to be open and express oneself in social relationships, including but not limited to being open about one’s sexual orientation. In general, silencing has been linked to negative mental health outcomes, including low self-worth (Harter, Waters,

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1 While the present study examined NSSI among those who identified as LGBQ (omitting those who identified as transgender), past research has included transgender participants in studies of sexual minority mental health. “LGBTQ” is used to describe studies that included transgender participants, while “LGBQ” is used to describe studies that did not include transgender participants.
AN EXPLORATION OF SEXUAL ORIENTATION AND NSSI

Whitesell, & Kastelic, 1998), poor self-esteem (Impett, Sorsoli, Schooler, Henson, & Tolman, 2008) and depression (Harper & Welsh, 2007); however, silencing has never been investigated in the context of sexuality and NSSI. The aims of the current project were to examine the degree to which silencing (and the silencing of one’s sexual orientation) may be associated with increased risk of NSSI among those who identify as LGBTQ and to explore how one’s sexual identity may or may not be associated with experiences of silence among those with a history of NSSI.

**Overview of NSSI**

While NSSI encompasses many different acts of intentional tissue damage without suicidal intent (Nock & Favazza, 2009), the most common forms of NSSI are cutting, scratching, burning, self-hitting, and carving words into the skin (Anestis, Khazem, & Law, 2015; Bresin & Gordon, 2013; Muehlenkamp, Brausch, Quigley, & Whitlock, 2013; Sornberger, Heath, Toste, & McLouth, 2012). The typical age of onset for NSSI ranges between 12 to 16 years of age; however, NSSI may begin at any age (Klonsky, 2011; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006; Whitlock et al., 2011). While rates of NSSI are highest among adolescents and young adults, prevalence rates range between 5-30% (Giletta et al., 2012; Muehlenkamp, Claes, Havertape, & Plener, 2012; Nock & Favazza, 2009; Swanell et al., 2014; Whitlock et al., 2011; Wilcox et al., 2012). Among those with a history of NSSI, as many as 50-87% of young adults (Muehlenkamp et al., 2013; Whitlock et al., 2006; Wilcox et al., 2012) and 74% of youth (Plener, Libal, Keller, Fegert, & Muehlenkamp, 2009) do so repeatedly.

Those who engage in NSSI may meet criteria for a clinical diagnosis, while others may only present with subclinical symptoms of mental illness (Glenn & Klonsky, 2009a; Lewis & Santor, 2008; Turner et al., 2015). Various difficulties in emotion regulation have been associated with NSSI in clinical and nonclinical populations (Adrian, Zeman, Erdley, Lisa, &
Sim, 2011; Anestis, Pennings, Lavendar, Tull, & Gratz, 2013; Chapman, Gratz, & Brown, 2006; Chapman, Specht, & Cellucci, 2005; Heath, Toste, Nedacheva, & Charlebois, 2008; Kleindienst et al., 2008; Wilcox et al., 2012). In fact, most individuals who self-injure have heightened levels of emotion dysregulation (Klonsky, 2007, 2009; Lewis & Santor, 2008, 2010; Nock & Prinstein, 2004, 2005; Preyde et al., 2014; Yurkowski et al., 2015). Emotion dysregulation refers to difficulties with emotional awareness, acceptance, and coping (Gratz & Roemer, 2004). Individuals who self-injure tend to have an elevated physiological response to stress (Nock & Mendes, 2008), report higher levels of emotional reactivity than those without a history of NSSI (i.e., easily and persistently aroused with strong emotional affect; Anderson & Crowther, 2012; Glenn, Blumenthal, Klonsky, & Hajcak, 2011; Nock, Wedig, Holmberg, & Hooley, 2008), and have difficulty tolerating this distress (Anestis et al., 2013; Nock & Mendes, 2008). Thus, NSSI, for many individuals, is negatively reinforced due to reported decreases in negative emotions and feelings of calmness and relief following an act of self-injury suggesting that the primary goal of self-injury is to regulate negative affective states (Klonsky, 2009).

Individuals who self-injure are also at risk for varying degrees of physical harm. Severe forms of NSSI (e.g., deep cuts) may result in the need for hospitalization due to injuries (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Olfson, Gameroﬀ, Marcus, Greenberg, & Shaffer, 2005; Whitlock Muehlenkamp, & Eckenrode, 2008). In addition, individuals who self-injure may experience scarring, which comes with its own host of potential difficulties that are often overlooked. For some, scars may be associated with negative emotions (e.g., shame) and may act as reminders of difficult times, which can lengthen the recovery process (Lewis, 2016; Lewis & Mehrabkani, 2015; Rosenrot, 2015). Of utmost concern is the fact that engaging in NSSI increases one’s risk for suicide (Glenn & Klonsky, 2009b; Muehlenkamp & Gutierrez, 2007;
Nock et al., 2006; Whitlock et al., 2006; 2013). This is particularly the case if one has self-injured for a long period of time (i.e., the odds of having suicidal thoughts or behaviours significantly increases if one has self-injured more than 20 times in their lifetime; Whitlock et al., 2013), uses multiple methods (Anestis et al., 2015), experiences no pain at the time of NSSI (Nock et al., 2006), engages in NSSI to serve intrapersonal functions (e.g., to regulate negative emotions) rather than interpersonal functions (e.g., to communicate distress; Klonsky & Olino, 2008; Nock & Prinstein, 2005), or engages in acts of NSSI privately as opposed to with others (Glenn & Klonsky, 2009b; Klonsky & Olino, 2008). In fact, NSSI may be one of the most predictive risk factors of suicidal behaviour (Asarnow et al., 2011; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011; Klonsky, May, & Glenn, 2013). The distress experienced by individuals who self-injure coupled with the habituation to self-injurious behaviours may contribute to one’s desire and capability to attempt suicide, respectively (Klonsky et al., 2013), which is consistent with the interpersonal theory of suicide (Van Orden et al., 2010). In sum, NSSI represents an important mental health issue demonstrated by its high rates (Nock & Favazza, 2009), transdiagnostic nature (Bentley, Nock, & Barlow, 2014), links to emotion dysregulation (Klonsky, 2009; Nock & Mendes, 2008), risk for physical harm and scarring, and, most seriously, its strong association with suicidal thoughts and behaviours (Klonsky et al., 2013; Whitlock et al., 2013).

**Sex and Gender**

Research investigating sex differences in rates of NSSI is currently mixed. While some researchers have found that women are more likely to report a history of NSSI than men (Boudewyn & Liem, 1995; Whitlock et al., 2011), other reports indicate no significant sex differences in lifetime rates of NSSI (Briere & Gil, 1999; Gollust, Eisenberg, & Golberstein, 2006; Whitlock et al., 2006; 2013). This is particularly the case if one has self-injured for a long period of time (i.e., the odds of having suicidal thoughts or behaviours significantly increases if one has self-injured more than 20 times in their lifetime; Whitlock et al., 2013), uses multiple methods (Anestis et al., 2015), experiences no pain at the time of NSSI (Nock et al., 2006), engages in NSSI to serve intrapersonal functions (e.g., to regulate negative emotions) rather than interpersonal functions (e.g., to communicate distress; Klonsky & Olino, 2008; Nock & Prinstein, 2005), or engages in acts of NSSI privately as opposed to with others (Glenn & Klonsky, 2009b; Klonsky & Olino, 2008). In fact, NSSI may be one of the most predictive risk factors of suicidal behaviour (Asarnow et al., 2011; Wilkinson, Kelvin, Roberts, Dubicka, & Goodyer, 2011; Klonsky, May, & Glenn, 2013). The distress experienced by individuals who self-injure coupled with the habituation to self-injurious behaviours may contribute to one’s desire and capability to attempt suicide, respectively (Klonsky et al., 2013), which is consistent with the interpersonal theory of suicide (Van Orden et al., 2010). In sum, NSSI represents an important mental health issue demonstrated by its high rates (Nock & Favazza, 2009), transdiagnostic nature (Bentley, Nock, & Barlow, 2014), links to emotion dysregulation (Klonsky, 2009; Nock & Mendes, 2008), risk for physical harm and scarring, and, most seriously, its strong association with suicidal thoughts and behaviours (Klonsky et al., 2013; Whitlock et al., 2013).
2008; Muehlenkamp & Gutierrez, 2007). Sex differences have also been noted in specific NSSI characteristics. For example, women were more likely to report scratching and cutting while men were more likely to report punching an object in a college student sample (Whitlock et al., 2011). It is important to note that researchers do not always explicitly delineate sex apart from gender. The way in which sex or gender is assessed can be unclear (e.g., not reporting the question used to determine sex and/or gender) and, as a result, sex may be conflated with gender. The sex and gender differences noted in this literature review are based on authors’ usage of these terms.

With respect to gender differences, some researchers have found that identification with the female gender is associated with increased risk for NSSI (House et al., 2011; Liu & Mustanski, 2012; Whitlock et al., 2006; Whitlock, Muehlenkamp, & Eckenrode, 2008). Female-identified participants were more likely to engage in repeated NSSI (Whitlock et al., 2006) or report a history of NSSI (Laye-Gindhu & Schonert-Reichl, 2005) than male-identified participants. Similar to the sex differences described above, gender differences also appear to exist with respect to NSSI method. Women are more likely to engage in scratching or cutting as methods of self-injury, while men are more likely to engage in self-battery (Whitlock et al., 2006; 2008). While gender differences have been identified in some studies, other researchers have failed to find gender differences with respect to NSSI rates (Claes, Luyckx, & Bijttebier, 2014; Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008; Klonsky, 2011; Muehlenkamp & Gutierrez, 2004), indicating that gender differences in NSSI remain unclear.
Sexual Orientation and NSSI

Rates

LGBTQ youth and young adults may be at higher NSSI risk than those who identify as heterosexual or cisgender (e.g., Bakken & Gunter, 2012; Deliberto & Nock, 2008; dickey, Reisner, & Juntunen, 2015; Power et al., 2015; Reisner, Biello, Perry, Gamarel, & Mimaga, 2014; Serras et al., 2010; Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003; Swanell et al., 2016; Tyler, Whitbeck, Hoyt, & Johnson, 2003; Walls, Laser, Nickels, & Wisneski, 2010). A recent meta-analysis of NSSI rates among sexual minority populations found that sexual minority youth and adults are approximately three times more likely to engage in NSSI than their heterosexual counterparts (Batejan, Jarvi, & Swenson, 2014); however, subgroup differences in rates of NSSI among those who identify as LGBTQ have been reported (e.g., Balsam, Beauchaine, Mickey, & Rothblum, 2005; Blosnich & Bossarte, 2012; Gollust et al., 2008; Gratz, 2006; Kerr et al., 2013; Serras et al., 2010; Sornberger et al., 2013; Walls et al., 2010; Whitlock et al., 2006; 2011). Adolescents and adults who identify as bisexual have reported the highest NSSI rates (Balsam et al., 2005; Batejan et al., 2014; Blosnich & Bossarte, 2012; Serras et al., 2010; Swanell et al., 2016; Tsypes, Lane, Paul, & Whitlock, 2016; Whitlock et al., 2011) and are also more likely to repeatedly self-injure compared to those who identify as heterosexual, gay, lesbian, questioning, or other self-identified labels (Whitlock et al., 2006). In a more recent study examining NSSI rates, those with any degree of attraction to both sexes had significantly higher NSSI frequencies and reported using significantly more NSSI methods than those who reported sexual attraction exclusively to the same or opposite sex (Tsypes et al., 2016). In addition, adults and adolescents who reported questioning their sexual orientation or who classified themselves in an “other” category with respect to their sexual orientation were also at
increased risk for engaging in NSSI compared to those who identified as heterosexual or gay/lesbian (Batejan et al., 2014). While large empirical studies of NSSI rates within the transgender community have not yet been executed in order to determine the degree of risk among transgender participants compared to heterosexual and sexual minority participants, 41.9% of transgender or gender-nonconforming participants \((n = 773)\) reported a lifetime history of NSSI (Dickey et al., 2015), suggesting elevated rates within this population as well. Thus, there appears to be subgroup differences among those who identify as LGBTQ with respect to NSSI risk and it is important to determine what about these individuals’ experiences increases their risk for NSSI so as to better inform intervention and prevention strategies.

While conflicting evidence exists with respect to sex and gender differences in NSSI rates and characteristics in the population at large, some research has suggested that sexual minority women (referring to both sex and gender) may be at greater risk for NSSI than sexual minority men (Blosnich & Bossarte, 2012; House et al., 2011; Liu & Mustanski, 2012; Walls et al., 2010; Whitlock et al., 2011). Sexual minority female participants (referring to biological sex) were more likely to report NSSI than sexual minority male participants across all sexual orientations (Whitlock et al., 2011). Identification with the female gender has also been associated with higher rates of NSSI within the LGBTQ population (Blosnich & Bossarte, 2012; House et al., 2011; Walls et al., 2010). House and colleagues (2011) reported that the highest rates of self-injury within their sample of LGBT adults was among participants who identified as female and transgender, specifically transgender participants who were living as female. In a sample of sexual minority adolescents, female-identified (i.e., gender) lesbian and bisexual respondents were more likely to have a history of cutting in the past year than male-identified gay and bisexual respondents (Walls et al., 2010). In contrast, men (i.e., gender) with any degree
of same-sex attraction have been found to be at greater risk for self-harm (a broad term which includes non-suicidal self-injurious behaviours, overdosing, and suicide attempts) than women with any degree of same-sex attraction (Skegg et al., 2003).

Taken together, there seems to be several nuanced differences within the sexual minority population with respect to NSSI rates. At the same time, however, there are a number of issues with the current literature examining NSSI and sexual orientation, including how sexual orientation is determined and the assumption that sexual orientation alone may connote risk. There are several ways in which sexual orientation has been assessed. In some cases, self-reported degree of sexual attraction is used to assess sexual orientation (see Whitlock et al., 2011). In other cases, participants are asked to label their sexual orientation using a pre-existing list of options (e.g., Blosnich & Bossarte, 2012; Deliberto & Nock, 2008). Current research rejects the notion of sexual orientation as a dichotomy (i.e., “gay” or “straight”) and recognizes that sexual orientation exists on a continuum (Epstein, McKinney, Fox, & Garcia, 2012; Savin-Williams & Vrangalova, 2013) and may transcend current labelling practices (Adams, Braun, & McCreanor, 2014; Better & Simula, 2015; Callis, 2014; Cohler & Hammack, 2007; Galupo, Mitchell, Gryniewicz, & Davis, 2014). Forced choice assessments of sexual orientation may actually serve to silence one’s true sexual identity as well as misrepresent the experiences of those who are made to choose based on existing nomenclature (Better & Simula, 2015; Matthews, Blosnich, Farmer, & Adams, 2014). Thus, multiple methods of assessment of sexual orientation have been recommended by sexuality researchers to ensure accurate representation and to reflect recent advances in our understanding of sexual identity (Korchmaros, Powell, & Stevens, 2013; Parks, Hughes, & Wekmeister-Rozas, 2009; Saewyc et al., 2004). Parks and colleagues (2009) specifically recommended that assessment of sexual orientation include
measures of sexual behaviour, sexual attraction, and self-identification. With the aforementioned rates of NSSI considered, it is important to highlight that sexual orientation alone does not connote risk; rather, experiences associated with one’s sexual orientation (e.g., sexual prejudice, invalidation of one’s sexual identity) may contribute to increased risk.

**Potential Risk Factors**

To date, few studies have examined why elevated rates of NSSI have been reported within the LGBTQ community (see Alexander & Clare, 2004; Blosnich & Bossarte, 2012; House et al., 2011; McDermott et al., 2013; Muehlenkamp, Hilt, Ehlinger, & McMillan, 2015; Nickels et al., 2012; Sornberger et al., 2013; Walls et al., 2010; Wagner & Rehfuss, 2008 for exceptions). Without investigating the reasons why members of the LGBTQ population may report higher rates of NSSI, we risk pathologizing sexual minority identities by implying that it is sexual minority status that increases one’s risk for NSSI (Bakken & Gunter, 2012), rather than the experiences associated with LGBTQ status that may contribute to increased risk.

Experiences that have been linked to NSSI within the LGBTQ population include sexual prejudice (Alexander & Clare, 2004; Blosnich & Bossarte, 2012; House et al., 2011; Liu & Mustanski, 2011; Walls et al., 2010), fear or shame associated with one’s sexual identity (McDermott et al., 2013; Nickels et al., 2013), and the invalidation of one’s sexual identity (Alexander & Clare, 2004; Wagner & Rehfuss, 2008).

**Sexual prejudice.** Sexual prejudice is a term used to encompass *homophobia* (dislike toward LGB persons, their lifestyle, or behaviours; Herek, 2012) and *heterosexism* (an ideological system that views heterosexuality as superior to non-heterosexuality; Herek, 2000). Sexual prejudice refers to “negative attitudes toward an individual because of his or her sexual orientation” (Herek, 2000, p. 19). As such, sexual prejudice involves a negative judgment or
evaluation of those who do not fit into traditional heterosexual roles (Herek, 2012). Self-harm (a broad term which includes non-suicidal self-injurious behaviours, overdosing, and suicide attempts) and psychological distress among LGBT youth has been directly linked to homophobia (McDermott et al., 2013; Scourfield, Roen, & McDermott, 2008). Sexual prejudice may manifest as social rejection by peers or family members, discrimination, or victimization, all of which have been linked to self-harm or NSSI within the LGBTQ community (Alexander & Clare, 2004; Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Blosnich & Bossarte, 2012; House et al., 2012; Liu & Mustanski, 2011; Walls et al., 2010).

*Discrimination.* Incidents of discrimination based on sexual orientation are particularly high among those who identify as LGBTQ (D’Augelli, Pilkington, & Hershberger, 2002; Herek, 2009; House et al., 2011). In a large, Internet-based survey of LGBT adults, 96.5% of respondents reported at least one incident of discrimination based on their sexual orientation or gender identity, and this was particularly elevated among those who identified as transgender (House et al., 2011). Experiences of discrimination (e.g., social exclusion, familial rejection, prejudices) have been associated with increased risk of NSSI among LGBTQ persons (House et al., 2011) and self-harm among those who identify as bisexual (Blosnich & Bossarte, 2012). In fact, perceived discrimination based on one’s sexual orientation mediated the relation between LGBT status and self-harm (intent not specified) and other mental health difficulties (i.e., depressive symptoms, suicidality; Almeida et al., 2009).

*Victimization.* While there is overlap between the definitions of victimization and discrimination, victimization tends to be operationalized as more overt hostility (e.g., harassment, assault, or property damage). In studies of sexual minority youth and young adults, victimization based on one’s sexual orientation or gender identity, especially victimization by
peers at school, has been linked to an increased risk of cutting (intent not specified; Liu & Mustanski, 2011; Walls et al., 2010). Victimization was the second largest prospective predictor of cutting (superseded only by a suicide attempt history) in a longitudinal study of self-harm among LGBT youth and young adults (Liu & Mustanski, 2011). Indeed, victimization and discrimination based on one’s sexual orientation has been linked to several mental health difficulties within the LGBTQ community (e.g., depressive symptoms, substance use, suicidality, traumatic stress) including NSSI (Almeida et al., 2009; Bontempo & D’Augelli, 2002; D’Augelli et al., 2002; Dragowski, Halkitis, Grossman, & D’Augelli, 2011).

*Internalized heterosexism.* Negative feelings directed towards oneself that arise as a result of sexual prejudice and heterosexism, termed “internalized heterosexism” (or “internalized homophobia” in the literature; see Herek, 1995; Herek, Cogan, Gillis, & Glunt, 1997; Szymanski, Kashubeck-West, & Meyer, 2008), can impede healthy sexual identity development (Herek et al., 1997) and has been linked to NSSI and self-harm (Alexander & Clare, 2004; McDermott et al., 2013). While stigma associated with LGBTQ sexual orientations undoubtedly exists within the broad sociocultural context, the impact of this stigma and the resulting internalized heterosexism varies in severity from person to person (e.g., may cause one to question their sexual identity or, more extremely, engage in harmful behaviours directed at the self; Szymanski et al., 2008). Indeed, high levels of internalized homophobia have been associated with mental health difficulties, such as low self-esteem, depressive symptoms, and anxiety (Herek et al., 1997; Newcomb & Mustanski, 2010). Internalized homophobia has also

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2 The terms “heterosexism” and “internalized heterosexism” will be used for the purposes of this paper (as opposed to “homophobia” or “internalized homophobia”) as these are more progressive, inclusive, and encompassing terms to describe the sociocultural environment which silences and stigmatizes non-heterosexual identities (see Szymanski et al., 2008, for this discussion). Early research which uses the term “internalized homophobia,” is still described in this section and is considered to capture the essence of “heterosexism” and “internalized heterosexism” as it is used today.
been directly and indirectly associated with NSSI and self-harm through shame and self-hatred (Alexander & Clare, 2004; McDermott et al., 2013). Those who identify as LGBTQ sometimes come to believe that they are doing something wrong (Alexander & Clare, 2004; McDermott et al., 2013) and some youth have linked this belief to their feelings of self-hatred and self-harm behaviour (McDermott et al., 2013). Experiences of shame and confusion have also been reported by some lesbian and bisexual women with a history of NSSI when they came to realize their same-sex attraction in an invalidating social environment with limited social support (Alexander & Clare, 2004). While there is limited research specifically examining the association between internalized heterosexism and NSSI, there is evidence to suggest that heterosexism is associated with mental health problems among those who identify as LGBQ due to the stigma attached to one’s sexual identity (Herek & Garnets, 2007). More specifically, the negative emotions directed at oneself (e.g., shame, self-hatred) as a result of the heterosexism and sexual prejudice experienced within the sociocultural environment has been linked to NSSI (Alexander & Clare, 2004; McDermott et al., 2013; Swanell et al., 2016).

**Invalidation of one’s sexual identity.** Invalidating experiences with respect to one’s identity has been associated with NSSI risk in general (Adams, Rodham, & Gavin, 2005) and specifically pertaining to one’s sexual orientation identity (Alexander & Clare, 2004; Shelton & Delgado-Romero, 2011; Wagner & Rehfuss, 2008). There are many ways in which socially prescribed norms about sexuality (or heterosexism) may contribute to feelings of invalidation regarding one’s sexual orientation. While overt forms of invalidation may be obvious (e.g., regarding one’s sexual orientation as “just a phase”; Bradford, 2004), even well-intentioned therapists can invalidate the experiences of LGBQ clients (e.g., over-emphasizing the relief that may be associated with coming out while failing to acknowledge the significant challenges
associated with this form of disclosure; Shelton & Delgado-Romero, 2011). Indeed, such feelings of invalidation have been linked to NSSI specifically within the LGBQ community. For example, lesbian and bisexual women reported experiences of invalidation from mental health professionals when it was suggested that their sexual orientation was a phase that would pass once emotional issues were resolved (Alexander & Clare, 2004). Individuals in certain religious groups may be especially vulnerable to invalidation. For example, conflicts between conservative Christian values and an emerging non-heterosexual identity have also been linked to NSSI (Wagner & Rehfuss, 2008). Depending on one’s religion and the level of identification with religious beliefs, individuals may feel that their sexual identity is morally wrong or may feel alienated from their religious community. Thus, LGBQ individuals may be more susceptible to invalidating identity experiences by virtue of their sexual orientation in the context of a heterosexist social climate, which may increase one’s risk for NSSI (Alexander & Clare, 2004; Wagner & Rehfuss, 2008).

**Interpersonal trauma.** Experiences of interpersonal trauma (e.g., sexual, emotional, or physical abuse, intimate partner violence, witnessing domestic violence) have been associated with increased risk for NSSI in the general population (Cheng, Mallinckrodt, Soet, & Sevig, 2010; Di Pierro, Sarno, Perego, Gallucci, & Madeddu, 2012; Levesque, Lafontaine, Bureau, Cloutier, & Dandurand, 2010) and specifically within the LGBTQ community (Alexander & Clare, 2004; Blosnich & Bossarte, 2012; House et al., 2011). Among LGBTQ adults, a history of interpersonal trauma was linked to an increased likelihood of reporting an NSSI history, especially if participants had also experienced discrimination based on their sexual orientation (House et al., 2011). Intimate partner violence has also been associated with increased risk of self-harm among gay and lesbian young adults (Blosnich & Bossarte, 2012).
While interpersonal trauma has been linked to NSSI in some studies, interpersonal trauma is not necessarily a risk factor unique to the LGBTQ community. In addition, research is not consistent in this domain. Some researchers have not found a relation between NSSI and interpersonal trauma (e.g., Heath et al., 2008; Klonsky & Moyer, 2008). Research examining the link between experiences of trauma and NSSI in the general population suggests it may be the trauma symptomology (e.g., numbness, avoidance) that explains the connection between traumatic experiences and NSSI (e.g., Smith, Kouros, & Meuret, 2014; Weierich & Nock, 2008) or an impaired parent-child relationship among those who experience interpersonal trauma that may mediate this relation (Martin, Bureau, Cloutier, & Lafontaine, 2011). For instance, NSSI may emerge as a way for some people to cope with symptoms of traumatic stress (e.g., dissociation, numbness, flashbacks, intrusive thoughts) through distraction, eliciting physical pain, or as a means to ground one in the present moment (Smith et al., 2014; Weierich & Nock, 2008). Other researchers have suggested that the experience of interpersonal trauma may have been the impetus for engaging in NSSI among youth with existing family relationship problems (Martin et al., 2011). Thus, while interpersonal trauma is related to NSSI, it appears that there are mediating factors that explain the relation between experiences of interpersonal trauma and NSSI in the general population, and likely within the LGBTQ community as well.

**Protective Factors**

Within the limited research base investigating the factors that might mitigate NSSI risk within the LGBTQ population, two main protective factors appear to emerge; these include the effects of establishing a positive sense of one’s sexual identity (Alexander & Clare, 2004; McDermott et al., 2013) and feeling supported by others (Reisner et al., 2014; Walls et al., 2010).
Positive sense of sexual identity. Broadly, a positive sense of sexual identity (i.e., having an awareness of one’s sexual orientation identity, assigning value to and experiencing a sense of pride associated with one’s identity; Hill & Gunderson, 2015) has been rendered a source of resilience in the face of minority stress (Bruce, Harper, & Bauermeister, 2015; Hill & Gunderson, 2015; Meyer, 2015). More specifically, a positive sense of one’s sexual orientation identity has been associated with lower levels of psychological distress (including lower levels of depression) and higher levels of social and psychological well-being among LGBTQ populations (Bockting et al., 2013; Bruce et al., 2015; Kertzner, Meyer, Frost, & Stirratt, 2009).

An important aspect of establishing a positive sense of one’s sexual identity is feeling a sense of belonging to a community (Riggle, Mohr, Rostosky, Fingerhut, & Balsam, 2014), termed “communal-mastery” (Hobfoll, Jackson, Hobfoll, Pierce, & Young, 2002) or “minority coping” (Meyer, 2003; Meyer, 2015). Minority coping is considered a source of resiliency that is distinct from social support because a sense of belonging to a community in and of itself instills protection from the stresses that can be associated with a sexual minority identity. For example, members of a community do not need to receive explicit forms of social support from fellow community members in order to be resilient in the face of stress, rather, group membership alone provides a buffer against the stresses experienced by sexual minorities (Meyer, 2015) and is considered a part of one’s positive sense of sexual identity (Riggle et al., 2014). Thus, a positive sense of one’s sexual identity, which can include identification with a particular community, is one factor that is associated with resilience among LGBTQ populations.

A positive sense of sexual identity has also been linked to resiliency among those with a history of NSSI and self-harm (Alexander & Clare, 2004; McDermott et al., 2013). Indeed, adolescents and young adults with a history of self-harm viewed their LGBTQ identity as a
source of strength and pride (McDermott et al., 2013). Among lesbian and bisexual women with a history of self-injury, establishing one’s sexual identity was viewed as a positive experience and one which resulted in a sense of group membership, belonging, and improved self-esteem (Alexander & Clare, 2004). Consistent with previous research on minority coping (Meyer, 2003), coming out, for some women, represented a turning point that “…provided the foundation for developing the more positive relationships and circumstances that helped to reduce the need to self-injure” (Alexander & Clare, 2004, p. 80). Based on the limited research exploring potential protective factors associated with NSSI within the LGBTQ community, it appears that establishing a positive sense of one’s sexual identity may increase one’s resiliency in the face of stresses that may lead to NSSI.

**Social Support.** While existing research has typically focused on the negative impact of family interactions, preliminary findings suggest that social support serves as a protective factor for self-harm and NSSI among sexual minority youth and adults (Walls et al., 2010; Reisner et al., 2014). Having a relationship with a caring and supportive adult reduced the odds of cutting (intent not specified) among LGBT youth and young adults (Walls et al., 2010). In addition, Reisner and colleagues (2014) identified family support as the only statistically significant resilience factor associated with NSSI in sexual minority adolescents (amongst other resilience factors, including school support, community engagement, and participation in sports teams). The limited research on the impact of social support in reducing NSSI risk highlights the need for researchers to focus on social factors that mitigate NSSI risk, specifically within the LGBQ population.
Voice and Silence

While there is a plethora of research broadly examining why LGBTQ youth and adults may be at heightened risk for general mental health challenges, there is limited research examining specific risk and protective factors for NSSI within the LGBTQ population. One theory that may encapsulate the aforementioned risk and protective factors and provides a mechanism through which many of these factors may contribute to NSSI risk is that of voice and silence. These concepts emerged from feminist literature pertaining to adolescent girls’ transition into womanhood (Brown & Gilligan, 1992). According to Carol Gilligan’s theory, due to the societal expectations of traditionally feminine traits (e.g., subservient, self-sacrificing), adolescent girls are faced with a dilemma: avoiding the expression and development of their true self in order to maintain social relationships or expressing oneself at the cost of these social relationships. By suppressing thoughts, feelings, and opinions in relationships with others, one is silenced and inauthentic relationships may result given that one’s true self has been suppressed in order to maintain them (Brown & Gilligan, 1992).

According to Susan Harter and colleagues (1998), one’s true self can be validated in relationships that promote voice (i.e., relationships in which one feels able to express his or her thoughts, feelings, and opinions with others). Even though different parts of the self can emerge within different contexts (e.g., a professional versus personal identity, a sense of self that emerges in relationship with one’s caregiver versus one’s friend; Syed & McLean, 2015) and may fluctuate over time, Harter and colleagues (1998) describe "the real me" (p. 892), which reflects one’s true thoughts and feelings that serve as the foundation for the true self at a certain point in time. Being able to display "the real me" (i.e., being able to express one’s true thoughts, feelings, and opinions with others) results in relationships characterized by voice. In contrast,
“false self behaviour” (p. 892; the opposite of acting in accordance with “the real me”) includes saying what one thinks others want to hear and withholding one’s true opinions and reflects silence in relationships with others (Harter, Marold, Whitesell, & Cobbs, 1996; 1998). Silence in relationships with others (i.e., the inability to share one’s true thoughts, feelings, and opinions with others; low levels of voice; Harter et al., 1998) is associated with several negative mental health outcomes, including depression (Harper, & Welsh, 2007; Harter et al., 1996; Smolak & Munstertieger, 2002), anxiety (Buchholz et al., 2007) and eating disorders (Buchholz et al., 2007; Manley & Leichner, 2003; Smolak & Munstertieger, 2002). Suicidal behaviours and NSSI have been hypothesized as a way for young girls to communicate when other attempts to communicate have been silenced, unheard, or when immersed in a culture that does not allow for self-expression (Gilligan & Machoian, 2002; Shaw, 2002).

In addition to the above theory, narrative approaches to identity development may also have relevance to voice and silence. Narrative theories of identity hold that it is through the process of telling and retelling stories about the self that one can begin to make sense of life events with respect to who one is, how one has changed, and how one has remained the same over the course of time (McAdams, 2001; McLean, 2015; McLean et al., 2007; McLean & Pasupathi, 2011). Autobiographical accounts of one’s experiences shape one’s identity and sense of self, which are developed through discourse with others (Bruner, 1990; McAdams, 2001; McLean, 2015; McLean, Pasupathi, & Pals, 2007). These accounts are influenced by past experiences, those who have listened (or not listened), and the cultural context in which the story was created (Fivush, 2010; McLean, 2015; McLean et al., 2007). Here, voice and silence refer to dynamic interactional styles affecting the ways in which one is able to make meaning of experiences and establish a coherent sense of self through time (i.e., create a personal sense of
identity; Fivush, 2004a; 2010; McLean, 2015). By sharing experiences with others, the audience guides what aspects of these narratives are considered important and those that should be discarded; this, in turn, influences one’s own interpretation of one’s experiences (Fivush, 2004a).

One may be silenced by the perception of others’ non-acceptance (Fivush, 2010), others’ refusal to listen, others’ lack of belief in what one is sharing, inattention (Pasupathi & Hoyt, 2010; Weeks & Pasupathi, 2009), or by others intentionally reshaping one’s experience (Brison, 2002).

As a result, it is difficult to create a coherent sense of self given that opportunities to tell and retell one’s story are limited and it is through repeated storytelling that one’s understanding and sense of self is created and defined (Fivush, 2004a).

Taken together, voice in the current context is considered an ability to share one’s true thoughts, feelings, and opinions with others (i.e., an ability to be one’s authentic self in relationships with others; Harter et al., 1998; Theran, 2009), which provides the foundation upon which one is able to create a coherent sense of self over time through discourse with others (Fivush, 2004a; 2010; McLean, 2015). The level of voice one experiences in relationships with others is also influenced by the sociocultural environment in which the relationships are embedded. Silence occurs when one perceives that others (or the sociocultural environment) are not open to or accepting of one’s thoughts and opinions; therefore, they mask or withhold their true thoughts, feelings, and opinions (Harter et al., 1998). By incorporating narrative approaches to identity development (Fivush, 2004a; 2010; McLean, 2015), silence in relationships limits the opportunities to develop a coherent sense of self over time through narrative discourse with others and may be associated with challenges associated with identity development (Brison, 2002; Fivush, 2002; 2004; 2010; McLean, 2015).
Risk for Silence Among Sexual Minorities

Both of the above conceptualizations of voice and silence may be particularly salient among LGBTQ individuals given the potential exposure to people who or environments that silence one’s sexual identity. Within the heteronormative social environment where heterosexuality is viewed as the benchmark for defining sexuality (Hyde & Jaffee, 2000), those who identify as LGBTQ may have personal narratives that go against the canonical life story that is dictated by presumed sexual norms (Fivush, 2004a; 2010; McLean, 2008; McLean & Syed, 2015). Those confronted with experiences such as sexual prejudice, perceived invalidation with respect to one’s sexual identity, and internalized heterosexism (all potential risk factors for NSSI) may respond by silencing their thoughts, opinions, and feelings in relationships with others in general but also with respect to their sexual identity. As a result, those who are silenced may have less opportunity to develop a strong sense of self than individuals who are given (or perceive) voice within their social relationships.

The process of coming out, or revealing one’s sexual identity to others, is one unique experience faced by sexual minority individuals. Heterosexual individuals need not disclose their sexual orientation given that heterosexuality is generally assumed and part of the canonical life story. Coming out involves making one’s sexual orientation public (at least within the context of certain relationships), but it is also a narrative process through which one’s sexual identity is continuously shaped (Kim, 2009; Ward & Winstanley, 2005). While coming out is acknowledged as a way to develop, maintain, and shape one’s sexual identity, it is also a process in which voice and silence may be particularly salient.

People’s reactions to the disclosure of one’s non-heterosexual orientation may contribute to the silencing of oneself. Familial rejection following disclosure of one’s sexual orientation...
has been associated with several negative outcomes, including substance abuse (Baiocco, D’Alessio, & Laghi, 2010; Ryan, Huebner, Diaz, & Sanchez, 2009), victimization from family members (D’Augelli, Hershberger, & Pilkington, 1998), suicidality (D’Augelli et al., 1998; Ryan et al., 2009), and health difficulties in young adulthood (Ryan et al., 2009). Rates of victimization (e.g., verbal, physical, social) are particularly high among sexual minority youth and young adults in the context of many social relationships (e.g., familial, peer, work colleagues; D’Augelli et al., 1998; Herek, 2009; Pilkington & D’Augelli, 1995). Individuals who experience rejection on the basis of their sexual orientation are implicitly or explicitly given the message that their sexual identity is inappropriate, something to be ashamed of, and one to conceal. Thus, individuals may respond with silence and concealment as a result of the rejection experienced by some sexual minority individuals or the anticipation of rejection based on cultural or societal norms.

Anticipated negative reactions from others may result in silence as the fear of expected reactions is often a motivating factor for keeping one’s sexual orientation concealed (D’Augelli et al., 1998). While individuals who refrain from disclosing their sexual orientation tend to report less overt victimization (Waldo, Hessen-McInnis, & D’Augelli, 1998), this secrecy may exacerbate isolation and prevent one from finding social support and connecting with like-minded individuals (Gortmaker & Brown, 2006). Indeed, disclosing one’s sexual orientation may, in some cases, increase one’s vulnerability to rejection, loss, victimization, and sexual prejudice (D’Augelli et al., 2002; Valentine, Skelton, & Butler, 2003). At the same time, disclosure of one’s sexual orientation also allows for the chance to connect with the LGBTQ community (Alexander & Clare, 2004; Gortmaker & Brown, 2006) and has been associated with a higher self-esteem and a sense of belonging (Alexander & Clare, 2004). Connecting to the
sexual minority community and a positive view of one’s sexual identity is associated with positive social relationships, self-approval, and a sense of meaning and direction in life (Kertzner, Meyer, Frost, & Stirratt, 2009). Therefore, coming out often provides an opportunity to connect with others who would provide validation and opportunities to voice one’s sexual orientation identity. In contrast, concealing one’s sexuality may prevent one from being open and honest in relationships with others and thwart the development of a positive sense of self.

Similar to, but not synonymous with, initial reactions to the disclosure of one’s sexual orientation is the perception of social support regarding one’s sexuality. Among sexual minority youth, support specifically pertaining to issues of sexuality (rather than general social support) may be perceived as less available by family members and heterosexual friends and more available by friends associated with the sexual minority community. This is important because higher levels of perceived support regarding sexuality predicts less emotional distress overall (Doty, Willoughby, Lindahl, & Malik, 2010). Just as the rejecting responses to disclosure can result in silence, the lack of perceived social support specifically related to sexuality issues may result in feelings of invalidation regarding one’s sexuality and may result in silence. Thus, while one may have generalized social support, but perceives that these supportive individuals are not supportive of his or her sexual orientation, one may refrain from revealing one’s authentic self, resulting in lower levels of voice in these relationships.

Taken together, those who identify as LGBTQ may be at greater risk for silencing given some of the unique stressors they may experience, such as coming out to others in a heterosexist society, rejection on the basis of one’s sexual orientation, and the anticipated negative reactions of others. These experiences have been linked to various mental health problems (Almeida et al., 2009; Baiocco et al., 2010; Needham & Austin, 2010; Rothman, Sullivan, Keyes, & Boehner,
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2012; Ryan, Huebner, Diaz, & Sanchez, 2009; Ryan, Legate, & Weinstein, 2015; Rosario, Schrimshshaw, & Hunter, 2015), including NSSI (Alexander & Clare, 2004; House et al., 2011; McDermott et al., 2013), suggesting that the theory of voice and silence has utility within the LGBTQ community given these unique experiences.

Voice and Silence and NSSI

Constructs akin to voice and silence have been linked to NSSI in the general population, which lends additional support for the potential utility of this model in explaining NSSI risk among LGBTQ individuals given the increased risk for silencing within this population. Studies examining parental relationships among youth and young adults with a history of NSSI suggest that invalidating familial environments (Linehan, 1993; Martin et al., 2011), parental criticism (Yates, Luthar, & Tracy, 2008), alienation from caregivers (Bureau et al., 2010; Martin et al., 2011; Yates et al., 2008), and negative interactions with parents (Hankin & Abela, 2011) are associated with NSSI. Such constructs may also be related to voice and silence. Voice is conceptualized in the present study as the ability to be open and honest about one’s thoughts, feelings, and opinions with others (Harter et al., 1998). Invalidating family environments (i.e., disregarding or rebuking one’s emotional experiences; Linehan, 1993), parental criticism (e.g., punished for mistakes, feeling unable to meet expectations; Yates et al., 2008), alienation from caregivers (e.g., withholding the expression of emotions with caregivers, a lack of trust in the caregiver; Bureau et al., 2010), as well as high levels of conflict and punishment in relationships with parents (Hankin & Abela, 2011) may reflect characteristics of parental relationships which thwart the ability to openly share one’s thoughts, feelings, and opinions. This is not to say that these constructs are equivalent to silence, rather, silence is conceptualized as a broader construct that may result from an invalidating family environment or family relationships characterized by
high levels of parental criticism, conflict, punishment, or alienation. In contrast, relationships characterized by open communication and trust (i.e., feeling understood by others, valuing others’ opinions on important topics; Gandhi et al. 2015a) and a sense of belonging and connectedness to others have both been identified as protective factors against NSSI (Gandhi et al. 2015a; Rotolone & Martin, 2010). These protective factors may reflect voice in relationships (i.e., an ability to openly express thoughts, feelings, and opinions with others; Harter et al., 1998).

Again, these protective factors are not the equivalent of voice, but may lead to higher levels of voice in relationships, depending on the individual and the cultural context.

Given that Susan Harter’s (1998) conceptualization of voice is believed to set the stage upon which one is able to create a coherent sense of self over time (Fivush, 2004a; 2010; McLean, 2015), low levels of voice (or the experience of silence), from a narrative theory perspective, may result in difficulties creating a coherent sense of self over time or synthesized identity. Recent advances in research suggest that NSSI may be a maladaptive strategy used to cope with struggles associated with identity formation (Breen, Lewis, & Sutherland, 2013; Claes, Luyckx, & Bijttebier, 2014; Gandhi et al., 2015a; Gandhi, Luyckx, Maitra, & Claes, 2015b). Using Erikson’s (1968) psychosocial stages of development, connections between identity confusion (feeling unable to act in accordance with or maintain a stable identity; feeling as though one’s life is void of direction; Claes, Luyckx, & Bijdtebier, 2014) and NSSI have been established (Claes et al., 2015; Claes, Luyckx, & Bijttebier, 2014; Gandhi et al., 2015a; Luyckx, Gandhi, Bijttebier, & Claes, 2015a; 2015b). In a sample of adolescents, identity confusion predicted NSSI engagement above and beyond that of age, gender, and depressive symptoms (Claes et al., 2014). In addition, higher levels of identity synthesis (i.e., a coherent sense of self over time and across settings) has been associated with a reduced likelihood of engaging in NSSI.
within adolescent inpatients (Luyckx, Gandhi, Bijttebier, & Claes, 2015). Conversely, lower levels of identity synthesis significantly predicted NSSI above and beyond age, anxiety, and depressive symptoms in a clinical sample of adolescents with eating disorders (Claes et al., 2015). Recent advances in the literature suggest that relationships characterized by open communication may serve to increase one’s sense of identity synthesis and reduce levels of identity confusion thereby also reducing risk for NSSI (Gandhi et al. 2015a). This is consistent with narrative perspectives of identity development by highlighting the role that others play in the construction of the self through their influence on personal narratives (McLean, 2015; McLean & Pasupathi, 2010). Thus, high levels of voice in relationships with others may reduce risk for NSSI through its impact on identity development.

While very limited research has specifically examined how sexual orientation, identity development, and NSSI may intersect (see Gandhi et al., 2015b), adolescents with a history of NSSI reported experiencing more identity distress with regard to their sexual orientation than those without a history of NSSI. More specifically, the impairment caused by this identity distress (i.e., as measured by subjective intensity, duration, and severity) accounted for variance in predicting the presence of an NSSI history above and beyond gender, age, symptoms of anxiety or depression (Gandhi et al., 2015b). Thus, preliminary research suggests that identity distress relating to one’s sexual orientation may play a role in NSSI risk (Gandhi et al., 2015b) and researchers suggest that sexual minorities may use NSSI as a means to cope with minority stress (Gandhi et al., 2015b; Sornberger et al., 2013).

A review of the literature on NSSI indicates that the theory of voice and silence as defined by Harter et al. (1998) may hold relevance in explaining NSSI risk and resilience. Constructs related to voice and silence (e.g., invalidating familial environments, parental
criticism, alienation from caregivers, negative interactions with parents; Bureau et al., 2010; Hankin & Abela, 2011; Linehan, 1993; Martin et al., 2011; Yates et al., 2008) have been associated with NSSI which may result in voice or silence in relationships with others and, therefore, protect one from or contribute to NSSI risk, respectively. In addition, nascent literature exploring NSSI and identity development suggests that NSSI may also be related to challenges associated with identity formation (Breen et al., 2013; Claes et al., 2014; Gandhi et al., 2015a), and specifically identity distress associated with one’s sexual orientation (Gandhi et al., 2015b). As outlined above, the risk for silencing is potentially greater among those who identify as LGBTQ given the stresses associated with sexual minority status (Gandhi et al., 2015; Sornberger et al., 2013). Given the links between Harter and colleagues’ (1998) conceptualization of voice and silence and narrative approaches to identity development (Fivush, 2004a; 2010; McLean, 2015), the current study aimed to explore the utility of these perspectives as they apply to NSSI and NSSI risk within the LGBTQ population in an effort to inform prevention and intervention efforts for sexual minority youth and young adults who self-injure.

**Current Study**

In the present study, the role of silencing was explored as a sociocultural risk factor for NSSI among LGBQ young adults. Emerging adults were the focus of this study given the high rates of NSSI within this age group and to minimize cohort effects. Emerging adulthood (between 18 and 25 years) is also a developmental period in which identity formation is particularly salient (Arnett, 2000; 2016; Erikson, 1968; McLean & Breen, 2016). It is not until adolescence that people begin to develop the “cognitive tools” (e.g., the ability to sequence events in time, create connections between events and personal traits, and account for both continuity and change over time) needed to create a coherent sense of self over time (Habermas,
& Bluck, 2000) and sexual identity, in particular, continues to develop well into young adulthood (Diamond, 2000; Floyd & Stein, 2002; Morgan, 2013).

To date, no research has examined NSSI risk among LGBQ young adults in the context of silencing, yet constructs related to voice and silence have been linked to NSSI (e.g., Bureau et al., 2010; Hankin & Abela, 2011; Linehan, 1993; Martin et al., 2011; Rotolone & Martin, 2010; Yates et al., 2008). Since not all LGBQ young adults self-injure, those who are not silenced (or perhaps silenced to lesser degrees) may not self-injure as much or at all. Examining silencing in the context of one’s sexual orientation may therefore be fruitful in identifying what factors play a role in elevating risk for NSSI (e.g., more pronounced silencing) and which may protect against it (e.g., voice) within the sexual minority population. Understanding how silencing may linked to NSSI among LGBQ individuals may help determine targets for intervention and prevention programs in order to provide specialized help for those most in need. For example, findings from this research may help inform primary NSSI prevention and awareness campaigns about the challenges faced by sexual minority youth and young adults. This information may be useful for families of and clinicians working with sexual minority youth and young adults so that they may be in a better position to provide voice for those who may be silenced and, in turn, providing nurturing environments for identity exploration and formation.

To meet these ends, quantitative and qualitative approaches were employed to explore how silencing may confer risk for NSSI among LGBQ young adults. Part 1 used a quantitative approach to determine whether silencing (or lower levels of voice in relationships with others) was associated with NSSI outcomes among LGBQ young adults in order to establish the utility of the theory of voice and silence. Determining whether silencing is linked to NSSI among sexual minority young adults may shed light on why rates of NSSI are reportedly higher within
this population. The qualitative component of Part 2 explores how voice and silence may be present in the self-defining memories of LGBQ young adults with a history of NSSI. By gaining insight into the sexual identity formation process of young adults with a history of NSSI, the connection between voice, silence, and identity formation among LGBQ young adults with a history of NSSI may become clearer and provide directions for this burgeoning field of research.

**Part 1**

Part 1 was conducted to determine how quantitative measures of silence (or level of voice; Harter et al., 1998) in general and specifically related to one’s sexual orientation would be associated with NSSI outcomes among LGBQ young adults with and without a history of NSSI. Lifetime NSSI frequency and the total number of NSSI methods were used as NSSI outcomes given that higher lifetime NSSI frequency and the use of more NSSI methods are associated with more impairment and suicidality (Hamza & Willoughby, 2013; Whitlock et al., 2013). These outcomes have also been used to assess NSSI risk within the LGBQ population (Tsypes et al., 2016) and to delineate between different classes of self-injurers (Hamza & Willoughby, 2013; Whitlock et al., 2008). Other quantitative measures of social support, degree of outness, and emotion dysregulation were included in this investigation to determine the unique contribution of silencing separate from other factors. The aim of Part 1 was to provide a preliminary investigation of the utility of the theory of voice and silence as it applies to NSSI within the LGBQ population.

**Hypotheses**

Given that low levels of voice (and constructs akin to silencing) have been associated with negative mental health outcomes including NSSI (Buccholz et al., 2007; Bureau et al., 2010; Hankin & Abela, 2011; Harper & Welsh, 2007; Harter et al., 1998; Martin et al., 2011;
Yates et al., 2008), it was expected that level of voice would be negatively correlated with NSSI outcomes such that lower levels of voice in general and specifically related to participants’ sexual orientation would be associated with higher lifetime frequencies of NSSI and the use of more NSSI methods. Higher levels of voice, in general and with respect to participants’ sexual orientation, were expected to be associated with lower lifetime frequencies of NSSI and the use of fewer NSSI methods (H1).

Given that emotion dysregulation has often been linked to NSSI risk and its underlying functions (Klonsky, 2007, 2009; Lewis & Santor, 2008, 2010; Nock & Prinstein, 2004, 2005; Preyde et al., 2014), and that those who identify as LGBQ tend to report higher levels of emotion dysregulation than their heterosexual counterparts (Hatzenbuehler, 2009), it was hypothesized that level of voice (general and sexuality-specific) would be negatively correlated with emotion dysregulation. Individuals who report higher levels of voice in general and specifically related to their sexual orientation were expected to report lower levels of emotion dysregulation. Those who reported lower levels of voice were expected to report higher levels of emotion dysregulation (H2).

In an effort to explore the utility of the theory of voice and silence to help explain the relation between NSSI risk and sexual orientation, it was hypothesized that level of voice would account for a significant proportion of variance in NSSI outcomes above and beyond that of emotion dysregulation (H3).

Finally, the experience of low levels of voice (or silencing) was hypothesized post hoc to impact NSSI outcomes through increased levels of emotion dysregulation (H4), given the intercorrelations between level of voice, emotion dysregulation, and NSSI outcomes. The proposed mediation model would align with Hatzenbuehler’s (2009) model in which minority
stress sets the stage for the development of processes that increase one’s risk for mental health challenges. Thus, silencing can be conceptualized as a source of minority stress which may contribute to weaker emotion regulation skills and may result in NSSI (see Figure 1).

*Figure 1.* Hypothesized mediation model in which level of voice impacts NSSI outcomes through emotion dysregulation.

**Participants**

LGBTQ emerging adults between the ages of 18 and 25 ($M = 20.93$, $SD = 2.25$) were recruited from 60 online forums and websites based in primarily English-speaking countries (i.e., Canada, United States, England, Ireland, Scotland, Australia) that serve as community support groups for LGBTQ adults, adults with mental health concerns, and adults who engage in NSSI.

Passwords were requested by a total of 247 interested participants; however, only 129 of those individuals logged on to complete the online questionnaires. This may have been due to a realization of ineligibility (e.g., under 18 years of age, English was not their primary language) or due to the delay in assigning passwords. The first author was required to manually assign each prospective participant a password via email. Thus, by the time participants received the password, they may not have been able to participate (e.g., not in a private location, at work) or may have lost interest. Five participants logged into the study website but did not respond to any
questions while three participants were locked out of the questionnaires as their reported ages fell outside the acceptable range (over 25 or under 18) for this study. An additional three participants were removed from analyses given that these participants did not identify as LGBTQ, as measured by any of the three indices of sexual orientation used in this study (i.e., self-identification, sexual attraction, and sexual behaviour; see Sexual Orientation for a detailed description). For the purposes of avoiding overgeneralization of experiences and limiting this study to an examination of sexual orientation, rather than gender identity, and NSSI, participants who identified as transgender ($n = 11$) were removed from the analyses. While researchers often include individuals who identify as transgender in studies of sexual minority populations (as reflected by the common usage of acronym, LGBTQ), gender identity is often conflated with sexual orientation (Fassinger & Arseneau, 2007; Kuper, Nussbaum, & Mustanski, 2011). Those who identify as transgender may or may not identify as heterosexual (Kuper, Nussbaum, & Mustanski, 2011) and the experiences of individuals who identify as transgender may be different as compared to those who are cisgender yet identify as LGBQ in some way (Fassinger & Arseneau, 2007; Su et al., 2016; Veale, Saewyc, Frohard-Dourlent, Dobson, Clark, & the Canadian Trans Youth Health Survey Research Group, 2015; Worthen, 2013). Thus, the final sample consisted of 107 individuals who self-identified as LGBQ, reported any degree of same-gender attraction, or who had sexual experiences with someone of the same biological sex within the last 5 years.

**Residency, ethnicity, and religion.** Fifty-one participants (47.7%) resided in the United States, 26 in the United Kingdom (24.3%), 23 in Canada (21.5%), and five in Australia (4.7%). One person reported living in another country and one person did not disclose their country of residence. Eighty-five respondents reported their ethnicity as Caucasian (79.4%), 11 identified
as Asian (10.3%), eight reported coming from mixed ethnic backgrounds (7.5%), and 3 people reported other ethnic backgrounds (2.8%). Sixty-five participants (60.0%) indicated coming from a religious background (48.6% Christian, 2.8% Jewish, 1.9% Hindu, 2.8% mixed religious backgrounds, and 4.7% other) while 16 (15.0%) reported no religious background. Twelve participants (11.2%) indicated coming from an atheistic background and 8 participants (7.5%) from an agnostic background.

**Sex and gender.** The majority of respondents indicated that their biological sex at birth was female ($n = 95, 88.8\%$). Eleven participants indicated that their biological sex at birth was male (10.3%) and one participant was intersexed (.9%). Eighty-nine participants (83.2%) self-reported their gender as “female” or “woman” and 11 participants (10.3%) self-reported their gender as “male.” For all male participants, their biological sex at birth was congruent with their current gender identification. The remaining seven participants (6.5%) used alternative labels to describe their gender identification (e.g., “genderfluid,” “genderqueer”).

**Sexual orientation.** All participants identified as LGBQ in some way (i.e., participants either self-identified as LGBQ, experienced some degree of same-gender attraction, or had engaged in sexual behaviour with someone of the same biological sex in the past 5 years). Twenty-six participants (24.3%) self-identified as “gay,” “lesbian,” or “homosexual.” Thirteen participants (12.1%) self-identified as “bisexual” and two participants self-identified as “heterosexual” (1.9%). Eleven participants self-identified as “pansexual” (10.3%), five as “queer” (4.7%), three as confused or questioning of their sexual orientation (2.8%), and two as “asexual” (1.9%). The remainder of and majority of participants described their sexual orientation using words or labels that do not adhere to the traditional nomenclature of sexual orientation (e.g., “homoflexible,” “woman who prefers women partners,” “bicurious”; $n = 33$;
30.8%) or as some combination of labels (e.g., “gay, slightly bicurious,” “lesbian, though vaguely bi;” n = 12; 11.2%). Consistent with Kinsey-style approaches to determining sexual orientation (e.g., Whitlock et al., 2010) and recommendations by sexuality researchers (Korchmaros et al., 2013; Parks et al., 2009; Saewyc et al., 2004; Saewyc, 2011), participants’ biological sex at birth, their self-reported sexual attraction to specific genders, and the biological sex of sexual partners in the last five years were also used to assess sexual orientation (see Table 1).

NSSI. The majority of respondents reported a history of NSSI (n = 96; 89.7%). Among those with a lifetime history of NSSI, cutting was the most frequently reported method of NSSI (n = 81; 84.4%), followed by severe scratching (n = 69; 71.9%), and banging or hitting oneself (n = 63; 65.6%). The majority of participants with a history of NSSI self-identified cutting as their main form of NSSI (n = 67; 69.8%). The total number of self-injurious incidences reported by participants with a history of NSSI irrespective of method ranged from 1 to 5,645 (M = 547.49, \(SD = 858.90\)) \(^3\) and participants reported using up to ten different NSSI methods (M = 4.65, \(SD = 2.27\)).

Measures

Demographics. Participants completed a brief demographics questionnaire inquiring about sex, gender, age, ethnicity, religion, and how the participant was referred to the study website (Appendix A).

Sexual orientation. A multi-method approach to the assessment of sexual orientation was employed due to the lack of consistency and often vague descriptions of sexual orientation

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\(^3\) The total number of NSSI incidences is an underestimate of true lifetime occurrences given that participants were restricted to including a 3-digit number. Thus, many people reported the maximum number of occurrences allowed (i.e., “999”).
assessment and based on recommendations of sexuality researchers (Korchmaros et al., 2013; Parks et al., 2009; Saewyc et al., 2004; Saewyc, 2011). Therefore, sexual orientation was assessed according to self-reported (a) sexual attraction to specific genders, (b) the biological sex of recent (within five years) sexual partners, and (c) open-ended self-identification (Appendix B).

Sexual attraction. To determine sexual attraction, a continuous measure based on Kinsey’s continuum of sexual attraction (see Whitlock et al., 2011; Skegg et al., 2003) was used (Appendix B). Participants reported the gender of those to whom they are sexually attracted or aroused by from a pre-existing list (e.g., only women, mostly men, about equally men and women). Based on this measure of sexual attraction and the participants’ biological sex, sexual orientation could be described as: (a) straight (women saying “only men;” men saying “only women”), (b) mostly straight (women saying “mostly men;” men saying “mostly women”), (c) bisexual (men/women saying “more to men by significantly to women,” “about equally men and women,” or “more to women but significantly to men”), (d) mostly gay/lesbian (women saying “mostly women;” men saying “mostly men”), or (e) gay/lesbian (women saying “only women;” men saying “only men”).

Self-labelled sexual orientation. To overcome the obstacle of forcing participants into categories that may not accurately describe their sexual orientation, participants were given the opportunity to describe their sexual orientation in an open-ended manner (Appendix B). This provided participants with the freedom to use their own language to describe their current sexual orientation without being bound by assumptions and pre-existing labels.
**Sexual behaviour.** Participants were asked to indicate the biological sex of those with whom they have had sexual experiences with in the last five years (Appendix B). The options aligned with the assessment of sexual attraction (e.g., only men, mostly men, more with men, but significantly with women) such that sexual orientation could be described in the same manner.

**NSSI.** The Inventory of Statements about Self-injury (ISAS; Klonsky & Glenn, 2009) is a self-report NSSI measure and was used to assess the lifetime frequency of 12 of the most commonly reported self-injurious behaviours (e.g., cutting burning, carving words into the skin; Appendix C). It also gives participants the opportunity to describe any other NSSI acts that they have engaged in and its frequency. Respondents are asked to self-identify their main form of self-injury. The ISAS was developed for use with young adult college samples and demonstrates good reliability for the 12 different NSSI methods ($\alpha = .84$), as well as good test-retest reliability and construct validity (Klonsky & Olino, 2008).

**Difficulties in Emotion Regulation Scale (DERS).** The DERS (Appendix D; Gratz & Roemer, 2004) was used to assess emotion dysregulation, a feature strongly associated with NSSI (Gratz & Chapman, 2007; Heath et al., 2008; Kleindienst et al., 2008; Klonsky, 2009; Nock & Mendes, 2008). The DERS is a self-report measure which contains 36 items assessing six different domains of emotion dysregulation: “(a) lack of awareness of emotional responses, (b) lack of clarity of emotional responses, (c) nonacceptance of emotional responses, (d) limited access to emotion regulation strategies perceived as effective, (e) difficulties controlling impulses when experiencing negative emotions, and (f) difficulties engaging in goal-directed behaviors when experiencing negative emotions” (Gratz & Roemer, 2004, p. 52). Participants

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4 Adapted from Parks and Hughes’ (2005) and Ornstein’s (2001).

5 NSSI is defined as the deliberate destruction of bodily tissue without the intent to die.
were asked to rate the frequency by which each item relates to them on a 5-point scale (i.e., 1 = almost never; 5 = almost always). A total DERS score was obtained by reverse-coding the appropriate items and summing the scores, with higher scores indicating higher levels of emotion dysregulation. Within the current sample, the overall measure demonstrated good reliability (α = .822; \( M = 108.19, SD = 26.60 \)).

**Voice and Silence.** Silencing was assessed using two adapted versions of Harter et al.’s (1998) Adolescent Level of Voice Questionnaire. This self-report questionnaire is intended to measure the degree to which one feels they have voice (e.g., “express their opinions,” “share what they are really thinking,” “let others know what is important to them”) in five different relational contexts (i.e., parents, teachers, male classmates, female classmates, close friends). Using a structured alternative format, participants are given two options and asked to choose which option is most like them (e.g., “Some teenagers share what they are really thinking with their parents” or “Other teenagers find it hard to share what they are really thinking with their parents”). After selecting the statement that best reflects their personal situation, participants are asked to rate how much the selected statement applies to them. Thus, participant responses are measured on a 4-point scale with higher numbers indicating higher levels of voice (i.e., less silencing). Items are counterbalanced so that options reflecting voice and silence are presented first an equal amount of times.

Pursuant to consultation with the author of the measure who indicated that this measure can be adapted for young adults and for specific issues without compromising its psychometric properties (Personal Correspondence, Harter, July 2011), two adapted versions of the Adolescent Level of Voice Questionnaire (1995; 1998) were used to assess participants’ perceived level of voice in general and specifically pertaining to one’s sexual orientation in multiple relational
contexts (i.e., parents, teachers/mentors, siblings, close heterosexual friends, close non-heterosexual friends, romantic partners and acquaintances/co-workers). The same items used to assess general levels of voice in relationships were adapted to specifically address level of voice pertaining to one’s sexual orientation with the addition of another item suggested by Harter (i.e., “Some people are able to discuss their sexual orientation with their parents” but “Other people find it hard to talk about their sexual orientation with their parents”; Personal Correspondence, July 2011). Given that high levels of voice in relationships reflects one’s authentic self in those relationships (Harter et al., 1998), evidence from existing research suggests that high levels of authenticity (i.e., behaviours enacted by one’s own volition; authentic self-expression) across multiple relational contexts is associated with improved psychological and physical wellbeing (Sheldon, Ryan, Rawsthorne, & Ilardi, 1997). In addition, these relational contexts do not occur in isolation from one another. Relationship quality in the context of one relationship is correlated with the quality of other relationships (Flynn, Felmlee, & Conger, 2014). Similarly, with respect to the experience of voice and silence within the LGBQ community, voice in one relational context may not fully counteract the silence experienced in another relational context. Thus, aggregate mean levels of voice were used to explore the utility of the theory of voice and silence in explaining NSSI among LGBQ participants. Mean levels of voice in general and specifically pertaining to one’s sexual orientation were computed for each participant by taking the average level of voice across relational contexts. Both subscales (i.e., general level of voice and level of voice pertaining to one’s sexual orientation) yielded good reliability (α = .917 and .945, respectively).

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6 Due to copyright, these measures are not included in the appendices.
“Outness.” Using the same measure as Weststrate & McLean (2010), participants were asked to rate the degree to which they were “out” in 11 different social relationships (e.g., mother, father, best friend, siblings, closest coworker) and in six different social settings (e.g., at home, in the workplace, in private, in public) using Likert scales (e.g., 1 = not at all; 7 = very much). Mean levels of “outness” were computed across social settings and across relationships ($M = 4.29, SD = 1.07$).

Social support. Participants were also asked to rate the how supportive others were of their non-heterosexual identity using a 7-point scale (i.e., 1 = not at all; 7 = very much; Weststrate & McLean, 2010) in 11 different relational contexts (e.g., mother, father, best friend, siblings, closest coworker). Mean levels perceived social support were computed across all relational contexts ($M = 5.46, SD = .97$).

Procedure
Following clearance from the Research Ethics Board at the University of Guelph, LGBTQ participants with and without a history of NSSI were recruited from online forums and community support groups intended for LGBTQ young adults, those with mental health concerns, and those who engage in NSSI (support groups). Websites were found using Google and the search terms “self-injury,” “self-harm,” “depression,” “LGBTQ,” “LGB,” “lesbian,” “gay,” and “bisexual.” Three hundred and ninety administrators were contacted for permission to post study information on each website. Study information was approved to be distributed through 60 of the contacted sites. Nineteen website administrators explicitly declined to post study information, 295 administrators did not respond to the posting inquiry, and 16 administrators responded to the inquiry but did not explicitly accept or reject the request and failed to respond to follow-up inquiries. Study information was posted to websites, Facebook pages, Twitter accounts, and/or sent to their mailing lists based on administrator approval.
Participants accessed the informed consent form online (available in downloadable pdf format at all times during participation) and were required to disclose their age prior to participation. Participants provided their email address after reading the informed consent form (indicating their informed consent) at which time a unique password was emailed to each participant along with a URL where the participant could access the questionnaires online. Other researchers have also implemented an online route to collecting this information as it provides a safe, secure, and private setting with which to openly discuss private matters such as these (e.g., House et al., 2011). First, demographic information was collected from participants. Next, participants completed counterbalanced measures of sexual orientation in an effort to prevent responses on one measure of sexual orientation from impacting responses on another measure. Participants then completed the ISAS (a measure of NSSI) and the DERS (a measure of emotion dysregulation), which are often administered together (e.g., Heath et al., 2008) given the established association between emotion dysregulation and NSSI (Klonsky, 2009; Nock & Mendes, 2008). Following the DERS, participants completed the general and sexuality-specific Level of Voice questionnaires. Lastly, measures of “outness” and social support were included to ensure that the measures of voice and silence were not capturing the same constructs as degree of “outness” (i.e., concealment of one’s sexual orientation) or perceived level of social support. These questionnaires were administered last so that participants’ reflection on the degree of “outness” and the perceived level of social support they receive did not impact their responses on the Level of Voice questionnaires.

Analytic Plan

Prior to study completion, an a priori power analysis was conducted using G*Power software to determine the sample size needed to detect a medium effect size ($f^2 = 0.15$; Cohen,
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1992). Based on this analysis, to achieve a power of 0.80, a minimum sample size of 55 participants was suggested.

The dataset was initially analyzed for outliers and missing data among key variables. Missing data were estimated and substituted using the expectation-maximization method. Distributions of key and demographic variables were also examined for normality using Shapiro-Wilk’s test and by visually inspecting histograms, normal Q-Q plots, and box plots. Spearman’s rho correlations were computed to describe associations between key variables, including level of voice with NSSI outcomes (H1) and emotion dysregulation (H2). To test the hypothesis that level of voice is predictive of NSSI outcomes above and beyond emotion dysregulation (H3), hierarchical binary regressions were computed given that NSSI outcome variables were not normally distributed. Finally, ordinary least squares path analyses were used to test the hypothesized mediation model (i.e., level of voice was predicted to impact NSSI outcomes through emotion dysregulation; H4) using Hayes’ PROCESS v2.15 macro for SPSS (January, 2016).

Results

Initial screening for missing data revealed that twenty item responses were missing on the DERS. Little’s Missing Completely At Random (MCAR) test was conducted to test whether the missing data points were likely to have occurred at random as opposed to systematic omission. Results of this analysis revealed that the missing data most likely occurred randomly, \( \chi^2 (340) = 353.33, p = .30 \). Thus, these twenty item values were replaced using the expectation-maximization method for each subscale of the DERS. All future analyses were conducted using the data set with estimations for these missing values.
Outliers were identified as data points that exceeded the upper quartile by three times the interquartile range (using box plots in SPSS). With respect to lifetime NSSI frequency, four participants were identified as outliers; however, these participants were retained for analyses given that it was deemed important to include participants across the spectrum as they are representative of the population as a whole.

Key variables of interest (i.e., mean levels of voice in general and relating to one’s sexual orientation, mean levels of “outness,” mean levels of support, lifetime frequency of NSSI, number of NSSI methods used, emotion dysregulation) were also examined for normality using Shapiro-Wilk’s test and by visually inspecting histograms, normal Q-Q plots, and box plots. The distributions representing emotion dysregulation (DERS) and aggregate mean scores of level of voice in general and relating to one’s sexual orientation all approached normality ($p > .05$). The distributions of other variables (i.e., lifetime NSSI frequency, number of NSSI methods, mean levels of outness, and supportiveness) did not approach normality ($p < .05$). To account for the skewed distributions, log 10 transformations were conducted for the aforementioned three variables (e.g., Gratz, Dixon-Gordon, Chapman, & Tull, 2015; Kiekens et al., 2015). Negatively skewed variables (i.e., lifetime NSSI frequency, mean levels of outness, mean levels of social support) were reflected prior to the transformation (i.e., subtracting the original values from the maximum value for that variable plus a constant). For the total number of NSSI methods, a constant was added during the transformation to account for participants without a history of NSSI. The distribution of values for mean levels of outness was successfully normalized following the transformation ($p > .05$); however, the distribution of the social support, NSSI methods, and lifetime NSSI frequency variables remained skewed. As such, statistical analyses
which hold the assumption of normality could not be conducted and original (non-transformed) variables were used for all subsequent analyses.

**Correlations between key variables.** Given that some key variables were not normally distributed and could not be successfully normalized following a transformation, Spearman’s rho correlations were computed between demographic variables (i.e., age, mean levels of “outness”, mean level of sexual identity support) and key variables of interest (i.e., mean levels of voice, lifetime frequency of NSSI, number of NSSI methods used, emotion dysregulation; see Table 2) using non-transformed variables. Aggregate scores of general and sexuality-specific level of voice were significantly correlated with all variables (see Table 2). Average degree of supportiveness from significant others and average degree of “outness” were both positively correlated with measures of silencing such that those who reported greater levels of voice (i.e., both general and sexuality-specific) also reported higher levels of social support and a greater degree of “outness” across social settings and with people.

Emotion dysregulation was positively correlated with both lifetime NSSI frequency and the number of NSSI methods such that higher levels of emotion dysregulation were significantly associated with a greater lifetime NSSI frequency and increased usage of different NSSI methods. Emotion dysregulation were also negatively correlated with measures of social support and “outness” such that higher levels of emotion dysregulation was associated with lower levels of social support and lower levels of “outness”. Average levels of “outness” and social support were not significantly correlated with NSSI outcomes (i.e., lifetime NSSI frequency nor the number of NSSI methods), with the exception of the relation between social support and NSSI frequency. Lower levels of social support was associated with higher lifetime NSSI frequency.
Hypothesis 1: Level of Voice/Silencing. Spearman’s rho correlations were computed to test the hypothesis that level of voice would be negatively correlated with NSSI outcomes (lifetime NSSI frequency and the total number of NSSI methods used). To this end, aggregate scores reflecting general level of voice in relationships with others and level of voice specifically pertaining to one’s sexual orientation were both negatively correlated with lifetime NSSI frequency and the total number of NSSI methods (see Table 2). Participants who reported experiencing higher levels of voice in relationships with others (both in general and specifically relating to their sexual orientation) reported lower lifetime NSSI frequencies and using less NSSI methods overall. Similarly, participants who reported feeling more silenced in relationships with others (in general and relating to their sexual orientation) reported higher lifetime NSSI frequencies and reported using more NSSI methods.

Hypothesis 2: Emotion Dysregulation. Spearman’s rho correlations were also conducted to test the hypothesis that lower levels of voice (general and sexuality-specific) would be associated with higher levels of emotion dysregulation. This hypothesis was supported. Lower levels of voice in general and specifically relating to one’s sexual orientation (i.e., silencing) were both associated with higher levels of emotion dysregulation (see Table 2).

Hypothesis 3: Predictive Utility of Silencing. To test the hypothesis that level of voice \( r_s \) would account for a significant proportion of variance in NSSI outcomes above and beyond emotion dysregulation, hierarchical binary regressions were computed given that the assumption of normality was violated by both dependent variables (lifetime NSSI frequency and the number of NSSI methods). Based on existing literature delineating different classes of young adults who engage in NSSI (Whitlock et al., 2008), lifetime NSSI frequency was divided into two groups which represented participants with a less frequent NSSI history (i.e., 10 or fewer lifetime
incidents of NSSI; \( n = 20, 18.7\% \) and participants with a more frequent NSSI history (i.e., 11 or more NSSI incidents in their lifetime; \( n = 86, 80.4\% \)). Based on Whitlock and colleagues’ (2008) latent class analysis, participants were also divided into two groups based on the number of NSSI methods reported in their lifetime: participants who reported using three or fewer different NSSI methods in their lifetime (\( n = 45, 42.1\% \)) and participants who reported using four or more different NSSI methods in their lifetime (\( n = 62, 57.9\% \)).

Four hierarchical binary regressions were computed (using non-transformed variables) to determine whether level of voice predicted more frequent NSSI outcomes (i.e., a lifetime NSSI frequency greater than 10 or using 4 or more NSSI methods). Average level of “outness” and the average degree of supportiveness were entered in Block 1 of the regression given their significant correlations with all predictor variables, as well as the significant correlation between social support and lifetime NSSI frequency. Emotion dysregulation was entered in Block 2, followed by level of voice in Block 3. Emotion dysregulation was standardized (\( M = .00, SD = 1.00 \)) for use in all binary regressions so that the odds ratio could be accurately interpreted.

**Lifetime NSSI Frequency.** Two hierarchical binary regressions were computed to determine if general level of voice in relationships with others or sexuality-specific level of voice accounted for a significant proportion of variance in lifetime NSSI frequency (i.e., a lifetime frequency greater than 10 instances; see Table 3). While the overall models were both significant, the model was driven by the amount of variance accounted for by emotion dysregulation. Neither average levels of “outness” nor average levels of social support accounted for a significant proportion of variance in lifetime NSSI frequency status. Similarly, neither general level of voice nor sexuality-specific level of voice accounted for a significant proportion of variance in lifetime NSSI frequency status above and beyond “outness”, social
support, or emotion dysregulation. Only emotion dysregulation accounted for a significant proportion of variance in lifetime NSSI frequency status (see Table 3). Each increase in one standard deviation in emotion dysregulation was associated with a six to seven percent increase in the odds of having a lifetime history of NSSI greater than ten.

**Number of NSSI Methods.** Two hierarchical binary regressions were computed to determine if general level of voice in relationships or level of voice specifically pertaining to one’s sexual orientation accounted for a significant proportion of variance in NSSI method status (i.e., more than three different NSSI forms; see Table 4) above and beyond social support, degree of “outness”, and emotion dysregulation. Consistent with results pertaining to lifetime NSSI frequency status, both models (i.e., using general and sexuality-specific level of voice to account for variance in NSSI method status) were significant; however, each model was driven by emotion dysregulation. Average levels of “outness” and social support did not account for a significant proportion of variance in NSSI method status in Block 1. Only emotion dysregulation accounted for a significant proportion of variance in NSSI method status when entered in Block 2, which accounted for 26% of the variance. For both models, level of voice (general and sexual orientation-specific) did not account for a significant proportion of variance in NSSI method status above and beyond emotion dysregulation (Nagelkerke $R^2 = .26$ and .26, respectively). Each increase in one standard deviation of emotion dysregulation resulted in a 3% increase in the odds of having used more than three NSSI methods in one’s lifetime.

**Hypothesis 4: Exploratory Mediation Analyses.** Ordinary least squares path analyses were used to test the aforementioned mediation model (see Figure 1) using Hayes’ PROCESS v2.15 macro for SPSS (January, 2016). As per recommendations by Hayes (2013), bias-
corrected bootstrapped confidence intervals were used to test the indirect effect of level of voice/silencing on NSSI outcomes based on 10,000 bootstrap samples.

**General Level of Voice.** General level of voice in relationships with others indirectly influenced NSSI outcomes (i.e., lifetime NSSI frequency and the number of NSSI methods) through its effects on emotion dysregulation after controlling for social support from others and level of outness. With respect to the model predicting lifetime NSSI frequency (see Figure 2 and Table 5), a one unit increase in participants’ general level of voice in relationships with others was associated with a 23 unit decrease in emotion dysregulation \((a = -22.92)\). In addition, a one unit increase in emotion dysregulation was associated with an increase in almost 13 NSSI incidences \((b = 12.65)\). The confidence interval for the indirect effect of level of voice on lifetime NSSI frequency through emotion dysregulation \((ab = -289.98)\) was entirely below zero (-560.53 to -139.89), indicating that the indirect effect is statistically significant. There was no evidence that general level of voice influenced lifetime NSSI frequency independent of its effect on emotion dysregulation \((c' = -131.73, p = .522)\).

![Figure 2](image)

*Figure 2. Simple mediation model demonstrating how general level of voice indirectly influences lifetime NSSI frequency through emotion dysregulation.*
With respect to the model predicting the number of NSSI methods used by participants (see Figure 3 and Table 6), a one unit increase in participants’ general level of voice in relationships with others was associated with a 24 unit decrease in emotion dysregulation ($a = -24.41$). A one unit increase in emotion dysregulation was associated with an increase in the number of NSSI methods used ($b = .05$). The confidence interval for the indirect effect of level of voice on the number of NSSI methods reported by participants through emotion dysregulation ($ab = -1.20$) was entirely below zero (-1.98 to -.64), indicating that the indirect effect is statistically significant. There was no evidence that general level of voice influenced the number of NSSI methods reported by participants independent of its effect on emotion dysregulation ($c’ = -0.56, p = .33$).

![Figure 3](image)

*Figure 3. Simple mediation model demonstrating how general level of voice indirectly influences the number of NSSI methods through emotion dysregulation.*

**Level of Voice Pertaining to Sexual Orientation.** Level of voice pertaining to one’s sexual orientation in relationships with others indirectly influenced the number of NSSI methods reported by participants, but not lifetime NSSI frequency, through its effect on emotion dysregulation after controlling for social support from others and mean levels of “outness.” With respect to the model predicting lifetime NSSI frequency in which a mediation model was not supported (see Figure 4 and Table 7), a one unit increase in participants’ level of voice regarding
their sexual orientation in relationships with others was associated with a 10 unit decrease in emotion dysregulation \((a = -10.20)\); however, this was not statistically significant. A one unit increase in emotion dysregulation was associated with an increase in 13 NSSI incidences \((b = 13.16)\). The confidence interval for the indirect effect of sexuality-specific level of voice on lifetime NSSI frequency through emotion dysregulation \((ab = -134.22)\) contained zero \((-328.58 \text{ to } 8.27)\), indicating that the indirect effect was not statistically significant. Level of voice regarding one’s sexual orientation in relationships with others also did not appear to influence lifetime NSSI frequency independent of emotion dysregulation \((c' = -125.37, p = .521)\).

**Figure 4.** Simple mediation model demonstrating how sexuality-specific level of voice indirectly influences lifetime NSSI frequency through emotion dysregulation.

With respect to the model predicting the number of NSSI methods used by participants (see Figure 5 and Table 8), a one unit increase in participants’ sexuality-specific level of voice in relationships with others was associated with a 13 unit decrease in emotion dysregulation \((a = -12.81)\). A one unit increase in emotion dysregulation was associated with an increase in the number of NSSI methods used \((b = .05)\). The confidence interval for the indirect effect of sexuality-specific level of voice on the number of NSSI methods reported by participants through emotion dysregulation \((ab = -.66)\) was entirely below zero \((-1.40 \text{ to } -.04)\), indicating that the indirect effect is statistically significant. There was no evidence that sexuality-specific level
of voice influenced the number of NSSI methods participants used independent of its effect on emotion dysregulation ($c' = -.35, p = .51$).

Figure 5. Simple mediation model demonstrating how sexuality-specific level of voice indirectly influences the number of NSSI methods through emotion dysregulation.

**Discussion**

Despite significant correlations between measures of silencing and NSSI outcomes, silencing did not predict NSSI outcomes above and beyond emotion dysregulation within this sample of LGBQ participants as initially hypothesized. Rather, silencing was related to NSSI outcomes through its influence on emotion dysregulation, one of the strongest established correlates of NSSI outcomes (e.g., Klonsky, 2007, 2009; Lewis & Santor, 2008; 2010; Nock & Prinstein, 2004, 2005; Preyde et al., 2014; Yurkowski et al., 2015). The experience of silence in relationships with others (e.g., not being able to be open and honest in relationships with others by sharing thoughts, feelings, and opinions with others; Harter et al., 1998) was associated with increased levels of emotion dysregulation (e.g., a lack of awareness, clarity, and acceptance of one’s emotional responses, access to few effective emotion regulation strategies, impulsivity when experiencing distress; Gratz & Roemer, 2004), which, in turn, was associated with the use of more NSSI methods and higher lifetime frequencies of NSSI. Findings from this study also support the indirect effect of silencing with respect to one’s sexual orientation on one NSSI
outcome (i.e., the number of NSSI methods used) but not another (i.e., lifetime NSSI frequency) through emotion dysregulation. Thus, general level of voice in relationships appears to have a stronger association with NSSI through emotion dysregulation, rather than voice in relationships specifically pertaining to one’s sexual orientation.

While being open and honest about one’s thoughts, feelings, and opinions about issues relating to one’s sexual orientation may also be important, results of the current study suggest that it is the opportunity to be authentic in relationships with others (i.e., sharing what one really thinks and feels), that may minimize one’s risk for NSSI by reducing levels of emotion dysregulation. Indeed, relationships in which one can be genuine with others may serve as the foundation for developing healthy emotion regulation skills and strategies (Cassidy, 1994; Morris, Silk, Steinberg, Myers, & Robinson; 2007). These relationships serve as venues in which people can glean support, voice their inner most thoughts, feel validated, and feel genuinely understood, according to the stress buffering hypothesis (Cohen & McKay, 1984).

One way in which silence (i.e., not being able to voice one’s thoughts, feelings, and opinions) in relationships with others may disrupt the development of adaptive emotion regulation skills is by encouraging the suppression of thoughts, feelings, and opinions with others. While emotional suppression (e.g., withholding overt signs of emotional expression) is said to have some social benefits (i.e., preserving relationships), it also comes at a cost (Richards & Gross, 1999). Young adults who tend to suppress their emotional expression also tend to experience less positive affect, more negative affect, and have difficulty recovering from low mood (Gross & John, 2003). Emotional suppression appears to be a strategy used more prominently in younger years, with the use of more complex emotion regulation strategies developing over time with both increased experience and developmental maturation (Gullone,
Hughes, King, & Tonge, 2010; John & Gross, 2004). Indeed, emotion regulation skills develop within the context of social relationships through observation, modelling, and social referencing, in which one looks to others for the appropriate mode of expression (Morris, Silk, Steinberg, Myers, & Robinson; 2007). Thus, youth who experience low levels of voice in relationships may not be given as much opportunity to practice more adaptive emotion regulation skills, resulting in higher levels of emotion dysregulation.

Within the NSSI literature, the suppression of unwanted thoughts (often associated with negative emotions and akin to experiential avoidance) has been associated with NSSI (Najmi, Wegner, & Nock, 2007). Relevant to the current study, Najmi and colleagues (2007) theorized that a cyclical pattern exists with respect to thought suppression and the experience of unwanted negative thoughts: an unwanted thought emerges which triggers an attempt to suppress that thought. Rarely is thought suppression an effective way to remove or distract one from the unwanted thought (e.g., try to stop thinking about a pink elephant). In fact, ineffective attempts to suppress thoughts may actually increase the number or intensity of negative thoughts that arise (Najmi & Wegner, 2009). As a way to cope with the unsuccessfully suppressed negative thoughts that give rise to unpleasant and unwanted emotions, individuals engage in NSSI to reduce the unwanted negative affect (Najmi et al., 2007). Thus, silencing may reduce opportunities to learn and practice effective emotion regulation skills (as described above) and may also increase negative affect. Individuals may turn to NSSI as a way to manage the negative affect that accumulates when one is silenced in relationships. This is consistent with feminist literature suggesting that NSSI is one way to communicate when unable to use other forms of communication (Shaw, 2002).
The results of this study are also consistent with Hatzenbuehler’s (2009) psychological mediation framework, which has recently been applied to NSSI risk among sexual minority college students (Muehlenkamp et al., 2015). Hatzenbuehler (2009) expanded upon the minority stress framework (Meyer, 2003) and posited that sexual minority populations experience increased levels of social stressors due to the stigma attached to their sexual identity and this stress causes maladaptive thinking patterns, emotion dysregulation, and interpersonal problems, for example, that make one more susceptible to mental health challenges. This is particularly relevant given the strong predictive value of emotion dysregulation for NSSI outcomes. Low levels of voice in relationships (or silencing) can be conceptualized as a social stressor that may increase one’s risk for NSSI through its impact on emotion dysregulation. Indeed, stressful life events have been linked to mental health difficulties through emotion dysregulation (McLaughlin & Hatzenbuehler, 2009). Silencing, itself, could be considered a prolonged exposure to a stressful life event leading to higher levels of emotion dysregulation. This is also consistent with suggestions made by researchers that NSSI may be one coping mechanism in the face of minority stresses (Gandhi et al., 2015b; Sornberger et al., 2013).

Findings from the present study also appear to align with narrative approaches to identity development, which focus on the creation of a coherent sense of self over time through the process of storytelling (Fivush, 2004a; 2010; McLean, 2015; McLean & Breen, 2015). The ability to be open and share one’s true thoughts, feelings, and opinions with others sets the stage for developing a coherent sense of self over time given that narrative identity development relies on sharing stories with others (Fivush, 2004a; 2010; McLean, 2015; McLean et al., 2007). The audience is an integral part of narrative identity development as others help to construct the stories that shape one’s sense of self over time (Fivush, 2004a; 2010; McLean, 2015; McLean et
Those who are silenced (i.e., unable to share their thoughts and opinions with others) may have fewer opportunities for storytelling and may have more difficulty creating a coherent sense of self over time. This may be especially pertinent for individuals who have experienced difficult, stressful, or even traumatic life events given that individuals who are silenced may not have sufficient opportunities to process the negative event through relational and narrative means (Fivush, 2004a; Pals & McAdams, 2004). Those who have difficulty creating a coherent sense of self over time may also experience identity distress (Gandhi et al., 2015b) and researchers have suggested that NSSI may be one way in which individuals cope with such stress (Gandhi et al., 2015b). Engaging in NSSI may also serve to provide a reference group with whom one can identify (Breen et al., 2013) for those who are struggling with identity-related challenges.

Overall, results from Part 1 highlight the importance of voice in reducing NSSI risk among LGBQ young adults through its effects on emotion dysregulation. Indeed, there is a need to explore the relation between silence in relationships with others and how this may impact emotion dysregulation. Results of the current study provide support for Hatzenbuehler’s (2009) theory that the stress associated with one’s LGBQ status may impact processes that make one more susceptible to mental health challenges. More specifically, silence in relationships with others (Harter et al., 1998) can be conceptualized as a source of minority stress that increases emotion dysregulation and one’s risk for NSSI. Silencing may also be related to NSSI as a result of increased negative affect due to emotion or thought suppression (Gross & John, 2003; Najmi et al., 2007; Wegner, 2009), fewer opportunities to develop healthy emotion regulation skills (Gullone et al., 2010; John & Gross, 2004; Morris et al., 2007), and challenges associated with
identity development as a result of silencing (Fivush, 2004a; 2004b; 2010; Gandhi et al., 2015b; McLean, 2015; McLean et al., 2007; Breen et al., 2013).

**Implications**

Findings from this study suggest that it is overall levels of voice across multiple relational contexts (e.g., parents, siblings, friends, coworkers) that are related to NSSI through emotion dysregulation. Taken together with past research highlighting the strong association between emotion dysregulation and NSSI (Klonsky, 2007, 2009; Lewis & Santor, 2008, 2010; Nock & Prinstein, 2004, 2005; Preyde et al., 2014; Yurkowski et al., 2015), it is evident that emotion dysregulation also plays a key role in NSSI risk within LGBQ young adults. In an attempt to promote resiliency in the face of minority stress, it may be helpful for NSSI prevention and intervention programs within the LGBQ community to place emphasis on developing healthy emotion regulation skills (e.g., increasing emotional awareness, normalizing or validating emotional responses in an attempt to increase acceptance and understanding of one’s own emotional responses, increasing one’s repertoire of healthy emotion regulation strategies; Gratz & Roemer, 2004). It is important to note that findings from this research are not intended to “blame the victim.” Increasing an individual’s capacity to cope with stress by developing adaptive emotion regulation skills may help to reduce NSSI frequency or prevalence rates in the face of stress; however, this does not remove the stresses (e.g., sexual prejudice) that contribute to NSSI risk. Thus, changes in the sociocultural environment (e.g., increasing general acceptance of the continuum of sexual orientations, reducing sexual prejudice) are needed in order to reduce risk for mental health challenges among LGBQ youth and young adults, including NSSI.
Findings from the current study suggest that increasing one’s level of voice in relationships with others may be one way to make changes to the social environment, which may decrease levels of emotion dysregulation thereby reducing NSSI risk. Indeed, every social environment should be providing a space free from sexual discrimination; however, the results of this study suggest that this is not enough. Increasing opportunities for LGBQ youth to develop social relationships with others in which they can display their authentic self (i.e., share their thoughts, feelings, and opinions with others) may be especially important in terms of laying the foundation for the development of a coherent sense of self over time, given that it is through interactions with others that we are able to make sense of who we are and how we have changed or remained the same over the course of time (Fivush 2004; 2010; McLean, 2015). Social relationships characterized by voice may serve to protect one from difficulties with emotion dysregulation, and in turn, NSSI.

**Limitations and Future Directions**

Given the composition of the sample (i.e., predominantly female with a history of NSSI) and the range of labels participants used to describe their gender identity (e.g., genderless, genderqueer, genderfluid), it was impossible to meaningfully examine sex or gender differences among key variables (e.g., NSSI outcomes, level of voice, emotion dysregulation). In addition, it was impossible to make meaningful comparisons between those with and without a history of NSSI on key variables of interest (i.e., NSSI rates and levels of voice). The high lifetime prevalence of NSSI found within the current sample is very likely a function of the recruitment method (i.e., participants recruited from online forums and community support groups intended for LGBTQ young adults, those with mental health concerns, and those who engage in NSSI) rather than a reflection of true rates of NSSI within the LGBQ population. This recruitment
method may also aid in accounting for the overrepresentation of female participants or participants who identify with the female gender, given that the female gender is associated with higher levels of help-seeking and online support usage (Oliver, Pearson, Coe, & Gunnell, 2005; Tsan & Day, 2007). Further, the overrepresentation of female participants may also reflect higher rates of NSSI among women (based on sex and gender) within the population (House et al., 2011; Liu & Mustanski, 2012; Whitlock et al., 2006; 2008; 2011).

A strength of this study was the multi-method assessment of sexual orientation; however, this method of assessment also prevented comparison of NSSI rates between participants using the traditional, but limited, classification methods for sexual orientation (e.g., gay, bisexual). Differences in rates of NSSI between these groups were not calculated, first and foremost, to respect participants’ contempt for labels. In addition, considering the fluidity of sexual orientation over time (Diamond, 2005) and the futility of categorization given that different participants would fall into different categories depending on sex, gender identification, and the method of assessment (i.e., sexual behaviour, sexual attraction, or self-identification), differences in rates of NSSI would be of little value. While the continuous measure of sexual attraction and sexual behaviour used in the current study is an improvement over forced choice methods by acknowledging sexual orientation exists on a continuum, it does not account for non-binary sexual identities (e.g., pansexual) and may serve to classify individuals into groups that they do not personally identify. Findings from this study highlight the complexity of sexual orientation, the need for multiple modes of assessment of sexual orientation, and the need for researchers to be explicit about how sexual orientation is assessed. It also calls for researchers to be cautious in the conclusions drawn from such research given that participants may fall into different categories depending on the method of assessment. On a broader level, it may be useful to avoid
using traditional nomenclature due to its inaccuracy when compared to participants’ self-identification and the silencing that may be inadvertently experienced by participants when forced to describe themselves using labels that may be disrespectful or inaccurate.

Assessment of NSSI was limited to lifetime NSSI frequency and the number of NSSI methods used by participants. In the future, it would be important to gather information regarding participants’ NSSI recovery (i.e., whether or not they currently still use NSSI; the date of their most recent NSSI act), the age at which participants began self-injuring, and participants’ engagement in broader forms of self-harm (e.g., overdosing, intent not specified). In terms of silencing, it may be useful to explore more nuanced ways in which silencing may associate with NSSI among those who identify as LGBQ. The current study employed an aggregate score to get a sense of participants’ level of voice in relationships given the interconnection between relationships (Flynn et al., 2014) and that authenticity across multiple relational contexts is associated with improved psychological and physical wellbeing (Sheldon et al., 1997), but it may be useful to explore the association between NSSI and silencing in subjectively close interpersonal relationships (Theran & Han, 2013). It may also be useful to consider a broader construct of voice developed by Chu and Way (2009), which would also include measures of how understood and unconditionally accepted one feels. Indeed, silencing as measured in the present study reflects the degree to which one feels that they can share their thoughts, feelings, and opinions with others, and these additional constructs speak to one’s perceived value or worth in these relationships, which may provide additional important information.
Part 2

From a narrative theory perspective, voice is integral to the development of a coherent sense of self and strong sense of personal identity (Bruner, 1990; Fivush, 2004a; Fivush, 2010; McAdams, 2001; McLean, Pasupathi, & Pals, 2007). Sexual minority youth and young adults have the task of developing a sexual identity that contests the canonical heteronormative life story that may result in a sexual identity that is not given the same opportunities to be voiced and may be silenced. Silence has been associated with negative mental health outcomes (see Study 1; Harper & Welsh, 2007; Harter et al., 1998; Impett et al., 2008) and may be one factor that could account for the increased risk of NSSI among sexual minority youth and young adults. Given that this is the first study to explore the connection between the theory of voice and silence (Harter et al., 1998) and NSSI within the LGBQ community, a qualitative component to this line of inquiry was included to answer the following question: How are themes of voice and/or silence present within LGBQ individuals’ self-defining memories relating to their sexual orientation for participants with a history of NSSI? The main purpose of Part 2 was to explore how experiences of voice and silence (Harter et al., 1998) may characterize the self-defining memories provided by LGBQ participants with a history of NSSI in order to gain a more in depth understanding of how the theory of voice and silence may relate to this population. This analysis was intended to provide a clearer picture of how participants’ sexual orientation is or is not associated with experiences of silence and, given the theoretical underpinnings of this research, including the individual voice of participants is essential. Self-defining memories are particularly salient as these memories are acknowledged by participants to have played a significant role in the development of sexual identity. Thus, Part 2 was conducted to complement the quantitative approach by exploring how Harter and colleagues’ (1998)
conceptualization of voice and silence may be present in participants’ self-defining memories pertaining to their sexual orientation while also considering how concepts of voice and silence (Fivush, 2004a; 2004b; 2010) may impact narrative identity development.

**Participants**

The participants who shared self-defining memories in Part 2 are a subsample of the participants used in Part 1 ($n = 96$). Participants without a history of NSSI were excluded from Part 2 given that the main purpose of Part 2 was to explore how the theory of voice and silence may characterize the self-defining memories provided by LGBQ participants with a history of NSSI. The majority of remaining participants reported that their biological sex at birth was female ($n = 90$). One participant reported that they were intersexed at birth. The majority of participants also identified with the female gender ($n = 85$), five identified as male, and the remaining six reported their gender using non-traditional labels (e.g., “genderfluid,” “mostly female,” “genderqueer”). The mean age of participants in Part 2 was 20.85 ($SD = 2.28$). The majority of participants identified as Caucasian (83.3%), followed by Asian (8.3%). Participants resided in the United States (47.9%), the United Kingdom (25.5%), Canada (21.3%), and Australia (5.3%) at the time of participation. See Part 1 for a description of NSSI characteristics.

**Procedure**

Following the completion of questionnaires used for the quantitative component of this project, all participants were asked to describe a self-defining memory pertaining to their sexual orientation in a designated text box. Participants were prompted to recall a particularly important and emotionally evocative event (positive or negative) that helped them understand who they are as a non-heterosexual individual. This method has been used in the past when exploring narratives of sexual identity formation (Weststrate & McLean, 2010).
Analytic Plan

Of the 96 participants with a history of NSSI, eight participants did not provide a self-defining narrative (e.g., left blank or indicated that they could not recall a self-defining memory). Thus, 88 participants provided textual narratives that could be analyzed for the purposes of this study. These narratives were thematically analyzed (Braun & Clarke, 2006; 2013) by the author using a top-down approach informed by a theoretical framework of voice and silence (Harter et al., 1998) and how concepts of voice and silence may impact narrative identity development (Fivush, 2004a; 2004b; 2010; McLean, 2015). Acknowledging the unavoidable subjectivity in which qualitative analyses are conducted, the data were approached from the perspective of a heterosexual female with a professional background in clinical psychology and with specific research interests in NSSI. This project was driven by a need to fill gaps in the literature pertaining to NSSI risk within the LGBQ community. Part 2 was conducted with the underlying understanding that sexual orientation does not confer risk for NSSI, but adverse social experiences related to one’s sexual orientation (e.g., sexual prejudice) that can occur within the context of a heterosexist sociocultural environment may result in silence, and, as a result, increase one’s risk for mental health difficulties, including NSSI (Szymanski, Kashubeck-West, & Meyer, 2008). This thematic analysis was conducted with the goal of improving intervention and prevention programs for LGBQ youth who self-injure and identifying protective factors specifically within the LGBQ population.

The following steps were taken to conduct the thematic analysis according to Braun and Clarke’s (2006; 2013) thematic analysis guidelines:

1. Reading the data repeatedly while looking for patterns relevant to the research questions.
2. Identifying meaningful segments of data (codes) across all narratives that will be compiled under broader themes.

3. Using the identified codes from step two, identify which codes seem to work together under a broader subtitle (theme) that are relevant to the research question.

4. Reviewing themes to ensure that the themes best describe your research in relation to your research question.

5. Finalize the names of each theme to best describe what the theme is intended to represent.

Given that the thematic analysis was informed by Harter and colleagues’ (1998) conceptualization of voice and silence, while also considering narrative approaches to identity formation (McLean, 2015; Fivush, 2004a; 2010), coding was completed with two theory-driven (deductive) codes in mind; namely, voice and silence (i.e., an ability and inability to be one’s authentic self in relationships with others by expressing one’s true thoughts, feelings, and opinions with others, respectively; Harter et al., 1998). Several additional codes were extracted from the data over the course of steps one and two of the thematic analysis. To complete the first step of the thematic analysis, the author reviewed the entire set of textual narratives four times while extracting codes across the dataset to address the aforementioned research question: How are themes of voice and/or silence present within LGBQ individuals’ self-defining memories relating to their sexual orientation for participants with a history of NSSI? A codebook was then created which defined each code that had been extracted. An additional researcher was recruited to independently code 20 of the narratives using the codebook after having familiarized herself with the theoretical background. A similar method has been employed by other researchers using thematic analysis (Frisén & Holmqvist, 2010). The input of an additional researcher was used to confirm the themes extracted from the narratives by the first author and to further refine
the codebook in light of this additional perspective. Of the 51 codes identified by the first author across the 20 randomly selected narratives, the additional researcher consistently identified 32 of these codes (63% agreement). All discordant codes were discussed and resolved through discussion. As a result of these discussions, additional codes were also identified. Thus, the first author reviewed the entire dataset an additional time with the updated codebook. Following the finalization of codes, the author completed the final three stages of the thematic analysis as described above.

**Results and Discussion**

While the main purpose of the thematic analysis was to examine how experiences of voice and silence may characterize the self-defining memories provided by LGBQ participants with a history of NSSI, it is helpful to highlight the events that were frequently recalled as well as the way in which these events were described in order to give context to the self-defining memories. Self-defining memories relating to participants’ sexual orientation were often recalled within the context of coming out to others or realizing that one was experiencing some form of same-sex attraction. In addition, the language used to describe many of the self-defining memories implied that discovering one’s sexual identity was a process that unfolded over time. Explicit references to this period of sexual identity discovery included: “…I was still in the process of questioning my sexuality. I had settled on bi, but I wasn't sure yet…” (P47) and “…I wasn’t sure of myself and my sexuality yet. I didn't know how to define myself because it was my first relationship with a girl…” (P103). Less direct uses of language that also implied a period of sexual identity discovery included references to discoveries of one’s sexual identity over time and periods of confusion with respect to one’s sexual orientation.
References to periods of contemplation or confusion are consistent with previous stage theories of sexual identity development (Cass, 1979; Troiden, 1988) as well as more recent theories of sexual identity development that describe this as an ongoing process over the course of the life span (D’Augelli, 1994 as cited in Bilodeau & Renn, 2006; Diamond, 2006). Diamond (2006) indicates that this period of confusion or questioning can be revisited multiple times over the course of one’s life given the fluidity of sexual identity. Participant 65’s self-defining narrative highlights the confusion she experienced as a teenager when she realized her romantic feelings toward a same-sex peer:

“My self defining memory, was when i was nearly 15 and had great feelings for a girl at my new school. We were both extremely confused about our feelings towards each other and both began to feel ashamed and scared about the prospect of being gay, or having differentiating sexualities…” (P65)

Her experience is important to highlight as it demonstrates the negative feelings that she experienced early in her sexual identity discovery, which can be a vulnerable time in which one may struggle with both self-acceptance and acceptance from others (Cohler & Hammack, 2007). The reactions and support of others may be particularly salient during this formative period of discovery (Hammack, Thompson, & Pilecki, 2009; Rosario, Schrimshaw, & Hunter, 2009; Rothman, Sullivan, Keyes, & Boehmer, 2012; Snapp, Watson, Russell, Diaz, & Ryan, 2015). Given the influence that others can have on the personal narratives that shape one’s sense of self (Fivush, 2004a; 2004b; 2010; McLean, 2015; McLean & Breen, 2015), positive reactions and support from others could foster the development of a coherent sense of self and confidence in one’s sexual identity by providing voice (Fivush, 2004b; Pasupathi, 2001). Alternatively, the reactions of others during this formative period could instill a sense of shame, guilt, or could
communicate implicitly or explicitly that a non-heterosexual orientation is not accepted or supported. This alternative reaction may result in silencing (Harter et al., 1998) and may contribute to the development of mental health challenges, such as NSSI (Bureau et al., 2010; Gilligan & Machoian, 2002; Hankin & Abela, 2011; Harper, & Welsh, 2007; Impett et al., 2008; Manley & Leichner, 2003; Martin et al., 2011; Shaw, 2002; Smolak & Munstertieger, 2002; Yates et al., 2008).

Indeed, themes of both voice and silence were extracted from the self-defining memories shared by participants. The majority of narratives began by describing a hardship or difficulty in which some form of silence was experienced. For narratives that included themes of voice, these themes were often extracted following periods of described hardship. This is consistent with Cohler and Hammack’s (2007) description of “the narrative of struggle and success.” Cohler and Hammack (2007) describe a master narrative of gay youth identity development characterized by the experience of hardship in a heterosexist sociocultural environment and adverse mental health difficulties followed by the experience of success and resilience in the face of such hardships. In the current study, themes of voice rarely emerged without some description of the experience of silence. Thus, themes associated with silence will first be discussed followed by themes associated with voice, as this is the order in which they frequently presented in the self-defining memories (see Figure 6 for a thematic map).

**Silence.** The deductive theme of silence was based on Harter and colleagues’ (1998) conceptualization of silence (i.e., the inability to express or the perceived absence of support to share one’s thoughts, feelings, or opinions in relationships with others). In the context of participants’ self-defining memories pertaining to their sexual orientation, themes of silence were extracted when participants narratives contained references to an inability, perceived or actual, to
speak to others about their sexual orientation or a sense that their sexual orientation was not supported or considered unacceptable by others. Five subthemes of silence were extracted from the self-defining memories; namely (1) explicit references to silence (i.e., being “closeted”), (2) experiences of fear, (3) shame, (4) sexual prejudice, and (5) the presumption of heterosexuality (see Figure 6), which are described in detail below.

Figure 6. Thematic map.
Explicit references to silence. The most explicit theme of silence that was extracted from participants’ self-defining memories pertaining to their sexual orientation was descriptions of being “closeted” (P7), which included references to concealing one’s sexual orientation from one or more parties as well as overtly denying one’s sexual orientation. References to being “closeted” were recalled passively or as the focus of the self-defining memory. Passive references to being closeted were communicated to contextualize the self-defining memory, such as the introduction of Participant 7’s self-defining memory: “I was still closeted and walking through campus with a friend…” (P7). Other participants described their concealment as one of the defining features of their memory. Participant 29 described concealing her sexual orientation due to the negative repercussions associated with disclosure:

“…I didn't tell my parents about the relationship until after it was over, because they are homophobic and had previously threatened to withdraw financial support if I was living with a girlfriend…” (P29)

Some participants also described experiences in which they outwardly denied their sexual identity. Descriptions of denial were unique in the sense that concealment did not simply occur through omission of information; rather, there was an active part of the self that outwardly denied one’s true sexual identity. Participant 10 described the shame and guilt she experienced following an instance in which she denied her sexual identity:

“…I had previously expressed to the friend to whom I was closest that I'd considered the possibility that I was homosexual, but when this came up in the group conversation I felt uncomfortable and took back the statement, claiming I didn't understand what the word meant. Afterwards I felt ashamed and guilty, and like I'd denied an important part of my identity…” (P10)
In this particular instance, her discomfort led to silence (i.e., she did not feel able to open and honest about her sexual orientation), which led to her experience of negative emotions.

Participant 27 shared her personal experience of denial and her perspective that denial can emerge from traditional and outdated methods of classifying sexual orientation:

“I then looked inside myself, and realized that I’ve known I was not heterosexual since I was thirteen... The feelings had been there for months, but I was denying them because, in my head, I was saying "I’m straight"... People shouldn’t be forced to put labels on themselves. It causes too much pain. For example, when society tells you you have to pick one, and you say you’re a gay man, but then you develop feelings for a woman, you deny it. Living in denial isn't okay...” (P27)

Participant 27’s perspective is consistent with more recent shifts toward decategorization and the increased awareness of the fluidity of sexual attraction (Cohler & Hammack, 2007; Diamond, 2006). According to participants in the current study, attempts to force classification may cause silencing and emotional pain when people feel the need to deny their romantic attraction due to limitations of existing labels. Indeed, the self-defining memories shared by Participants 10 and 27 reveal the negative consequences of denying some aspect of the self.

From the theoretical framework of voice and silence (Harter et al., 1998), concealment of one’s sexual orientation (through omission of information or denial) is the most explicit form of silence (i.e., withholding of one’s sexual orientation due to heterosexism). From a narrative theory perspective, being “closeted” may be likened to “self-silencing” (i.e., attempting to avoid thinking or talking about a particular event; Fivush, 2004b). Fivush (2004a; 2004b) posits that by silencing the self or by repeatedly being silenced (by others or as a result of the sociocultural context), one’s sense of coherence over time may be jeopardized. Concealment of one’s sexual
orientation may prevent this aspect of the self from being integrated into one’s sense of who one is, how one has changed, and how one has remained the same over time (McLean & Syed, 2015). Difficulties creating a coherent sense of self over time may be linked experiences of identity-related distress, which has been associated with NSSI in the past (Gandhi et al., 2015b), which may help to explain how silence is linked to NSSI.

The negative repercussions that concealment of one’s sexual orientation may have on sexual identity development (McLean & Syed, 2015) and the fact that silencing (Harter et al., 1998) is associated with mental health difficulties (Harper & Welsh, 2007; Harter et al., 1998; Impett et al., 2008) highlight the importance of creating a climate of acceptance, lack of judgment, and support for LGBTQ youth and young adults. Indeed, coming out in a supportive social environment is associated with more positive outcomes (e.g., increased wellbeing, positive personal growth, reduction in psychological distress; Rothman, Sullivan, Keyes, & Boehmer, 2012; Ryan, Legate, & Weinstein, 2015; van Dam, 2014; Vaughan & Whaeler, 2010; Wright & Perry, 2006); however, coming out may also result in increased risk for sexual prejudice (D’Augelli et al., 1998) and anxiety (Rosario, Schrimshaw, & Hunter, 2006). Thus, in order to promote more positive outcomes among youth and young adults who come out, emphasis should be placed on creating a supportive and accepting environment in which to come out. In addition, moving away from a classification system that relies so heavily on pre-existing labels may also lead to improved mental health of those who struggle within the LGBTQ community so as not to silence identities that do not fit with traditional nomenclature.

**Fear.** Fear was a prevalent emotion expressed within the context of participants’ self-defining memories relating to their sexual orientation and was identified as a subtheme under silence. Fear was experienced broadly by participants and in reaction to many different elements
of the events contained in their self-defining memory. For some participants, the fear was experienced in reaction to some realization of the possibility of same-sex attraction.

“The first time I ever thought that I might be gay, when it appeared in an episode of neighbours I was really scared and didn’t think about anything else for a week. Then I told my best friend at the time who just said that she had been feeling the same way...

Even though I still thought about it all the time, I didn’t have that sense of fear that I was hiding a big secret anymore.” (P82)

Participant 82 linked her fear to the potential of going through an experience on her own as well as living her life with a “big secret.” In a social environment where sexual minority identities are given voice, one would have increased exposure to the continuum of sexual orientations that exist and the need to keep one’s sexual orientation a secret would be conceivably lessened and associated with less anxiety. Other participants highlighted the fear they experienced when coming out to others or the fear that one’s non-heterosexual identity would be discovered:

“I remember coming out to my dad. It was probably the most terrifying experience. I was driving to the gym with both of my parents. I was shaking so much...” (P14)

“…I remember feeling ashamed and worried that she might think I was something other than straight.” (P104).

In each instance, the fear of being discovered and the fear of others’ reactions served to silence these participants for a time, rather than being able to explore their attraction and sexual orientation openly.

Fear has been linked to silencing in the literature pertaining to LGBQ youth and young adults’ experiences and past research has found that LGBT individuals may be at heightened risk for anxiety compared to heterosexual individuals given the increased number of social stressors
that they may face (King et al., 2008; Roberts, Schwartz, & Hart, 2011). Due to fear of their family’s responses, some LGBQ youth delay or avoid coming out to their family (D’Augelli, Grossman, & Starks, 2005; 2008). Others conceal their sexual identity due to fears of victimization (D’Augelli et al., 2002). In fact, LGBQ youth were found to be absent from school more often than their heterosexual counterparts due to fear of victimization (Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998). Thus, youth and young adults may be more likely to conceal their sexual orientation or withdraw from others due to fear of others’ responses and to protect themselves from victimization. As discussed above, concealment of one’s sexual orientation may prevent one from presenting their authentic self (i.e., the “real me”) in relationships with others (Harter et al., 1998) which may impact one’s identity development by limiting opportunities to develop a coherent sense of self over time through narrative discourse with others, according to narrative theory perspectives (Fivush, 2004a; 2010).

**Shame.** Shame is an emotion directed at oneself (Brown, 2006) and reflects one’s appraisal of the self as unworthy or inadequate (Lewis, 2003). In contrast, guilt is experienced when one feels regret or remorse about one’s actions or behaviours. When feeling shameful, one may feel as though there is something wrong with him or her as a person, rather than just their actions (Brown, 2006). Shame was extracted as a theme present in several of the self-defining memories and was typically associated with participants’ belief that something was “wrong” with them. For example, in addition to fear, Participant 14 also described feeling ashamed after coming out to her father:

“…At the gym, I cranked my music and ran, trying to drown out and run away from how ashamed I was. We got in the car to go home, and it was two weeks before my dad would
even look at me or speak to me. I felt dirty - as though I had said and done something wrong, and should have just kept my mouth shut...” (P14)

Participant 14 explicitly described experiencing shame and how her father’s reaction contributed to this shame. In the current study, participants described experiencing shame due to the belief that they were being judged by others and also due to their own internalization of heterosexist views (or internalized heterosexism; Szymanski et al., 2008) as in Participant 50’s recollection of his first gay dream:

“…I distinctly remember waking up from that dream and for at least several days if not weeks afterwards having deep feelings of hatred and revulsion at myself for having it. Thoughts of "What is wrong with me?" stuck in my head for a long time afterwards from that date and it took a few years of desensitisation to the idea that I wasn't heterosexual.” (P50)

Both of these narratives demonstrate how the experience of shame in these instances is a product of having a sexual minority identity in a heterosexist society. Feelings of shame seem to be the result of a sociocultural context that conveys the message that an LGBQ identity is something to be shameful about – that there is something “wrong” with a non-heterosexual identity – and the negative attitude toward LGBQ identities turns inward (Herek et al., 1997; Szymanski et al., 2008). This is further demonstrated through Participant 100’s experience as a youth in a classroom in which her peers began making anti-gay jokes without intervention from the teacher. Participant 100 describes the long-lasting impact of this experience and the shame that it induced years following the incident:

“…Though I was not identifying as gay or lesbian at the time, I definitely had an awareness of myself as different from my peers and knew that I was not attracted to boys
(though I had not fully acknowledged my attraction to girls). At the time of the incident, I felt confused about why everyone was laughing and why it was so funny to call someone a faggot. A year or so later, when I was coming to terms with my (then) identity as a lesbian, I recalled this incident and felt feelings of shame and derision…” (P100)

According to this narrative, the experience of shame was described as a result of sexual discrimination which occurred at the sociocultural level. It is accounts such as these that demonstrate the strong influence of the sociocultural context and the perceived attitudes of others on one’s sense of self (Fivush, 2004b; McLean, 2015).

Indeed, cultures define what narratives are acceptable (and can therefore be voiced) and what narratives should be silenced (Fivush, 2004b). The experience of shame associated with participants’ self-defining memories pertaining to their sexual orientation may be explained by the master narrative framework of identity development (McLean & Syed, 2015) which incorporates the influence of culture on an individual’s sense of self. Master narratives are generally accepted shared cultural stories that dictate “normalcy” within a given culture. Master narratives are ubiquitous but typically unspoken and provide guidelines for understanding oneself and others while also outlining behavioural and emotional expectations (McLean & Syed, 2015). For those whose sexual orientation defies the master narrative of the heterosexual life course (McLean & Syed, 2015), one may feel as though there is something “wrong” with them and experience a sense of shame, depending on the meaning they make of their experiences (Hammack & Cohler, 2011). Shame experienced in relation to one’s sexual orientation may serve to silence this aspect of the self, resulting in difficulties creating a coherent sense of self.

Past research has linked homophobia (and internalized homophobia) to feelings of shame among LGBT individuals (Allen & Oleson, 1999; Brown & Trevethan, 2010; McDermott, Roen,
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& Scourfield, 2008) which may increase their risk for self-harm (a broader term which includes suicidal behaviour; McDermott et al., 2008). In addition, shame has been linked to NSSI such that higher NSSI frequencies have been associated with increased levels of shame-proneness (Schoenleber, Berenbaum, & Motl, 2014; VanDerhei, Rojahn, Stuewig, & McKnight, 2014). Shame also predicted future NSSI behaviour in a sample of participants diagnosed with borderline personality disorder (Brown, Linehan, Comtois, Murray, & Chapman, 2009). A common motivation for engaging in NSSI is self-punishment (Klonsky, 2007; Nock, 2009). According to the self-punishment hypothesis, NSSI may represent a learned behaviour in which repeated criticism or maltreatment from others turns inward (Nock, 2009). This appears to parallel the mechanism by which heterosexism can become internalized for LGBQ individuals. Repeated exposure to anti-gay attitudes may result in the internalizing of these negative attitudes resulting in negative feelings towards the self (Malyon, 1981-1982 as cited in Allen & Oleson, 1999). Given these parallels and the association shame has with both NSSI and LGBQ identities subsumed within a heterosexist society, shame may be one link that accounts for increased rates of NSSI among those who identify as LGBQ.

**Sexual Prejudice.** A common theme extracted from participants’ self-defining memories relating to their sexual orientation is the recollection of experiences that reflect others’ sexual prejudice. While sexual prejudice broadly refers to negative attitudes held toward someone or towards a group based on their sexual orientation (e.g., lesbian, gay, or straight), it is most commonly directed towards individuals who identify as LGBQ (Herek, 2000; 2004). The term ‘sexual prejudice’ was used to describe this theme as it is a broader term than others (e.g., homophobia), and encompasses the many different ways in which negative attitudes can be expressed (e.g., through prejudice, discrimination, invalidation, etc.). In addition, ‘sexual
prejudice’ does not make assumptions about the root cause underlying such negative attitudes (e.g., a “fear” of contagion, as with the original conception of the term ‘homophobia’; Herek, 2004). Themes relating to experiences of sexual prejudice were identified and grouped into three different subthemes that appear to capture how experiences of sexual prejudice were recalled by participants.

*Explicit communication of antigay attitudes.* At a most basic level, participants’ self-defining memories contained references to sexual prejudice by recalling people’s expressions of explicit antigay attitudes. These expressions took many forms, including the communication of negative stereotypes, discriminatory actions, as well as threats to physical safety. Participants recalled times in which general antigay attitudes were expressed in their presence; however, these comments were not specifically targeted at the participant recalling the event:

“I was in the girls locker room changing for track practice...one of my teammates... mentioned her dislike of a gay male teammate, on the basis that gay people were ‘perverts’. Someone else chimed in to say he was bi, not gay, which led to a third person saying bisexuals were gross. The whole thing devolved into a discussion about whether bi people or gay people were worse pervs, at which point they finally agreed on something--that having a queer in the locker room would be the Worst Thing Ever. Part of me was angry-- I’d had crushes on guys and girls at this point, so I knew I was bi-- because I knew I wasn’t a creeper. But mostly I felt totally lonely and exposed. Like my private feelings had become this outer identity that other people could pick apart.” (P67)

Participant 67’s self-defining memory is a poignant display of the lasting impact of the expression of antigay attitudes in a general forum. Others’ hateful comments and expressed attitudes now serve to define her sexual identity. Rather than a moment in which she felt
affirmed, loved, and accepted, her self-defining memory pertaining to her sexual orientation is characterized by feelings anger, lonesomeness, and unwanted exposure.

Participants’ self-defining memories also contained references to times in which they were the targets of sexual prejudice and antigay attitudes expressed by others. Participant 57 recalled her father’s reaction when he believed she had befriended someone who was gay:

“…[he] got very, very angry and told me gay people were just trying to convert others to being gay. The next day, my mother spoke to me and told me that if I were gay, she and my dad would be very disappointed, but that I would be allowed to do whatever I wanted when I was 18... I don’t recall what I said- there wasn’t much to say, I suppose.” (P57)

These reactions effectively communicated her parents’ negative attitudes toward the LGBQ community and Participant 57 alluded to the silencing she felt in response to her parents’ antigay attitudes. She was explicitly instructed to silence the expression of her sexual orientation in the home until the age of adulthood.

Within participants’ self-defining memories pertaining to their sexual orientation, participants also experienced sexual prejudice in the form of threats to personal safety. For example, Participant 91 recalled an incident in which a stranger uttered a threat to her and her girlfriend:

“I was once walking downtown with my girlfriend, holding hands, when this man who was walking towards us leaned over us intimidatingly and spoke something to us. I didn't catch a lot of what he said, but I very distinctly heard the word "death" end his sentence...” (P91)
Each of these accounts highlights the different forms of explicit sexual prejudice that can be experienced. Depending on the protective and resiliency factors present in each person’s life, these experiences may contribute to the silencing of one’s sexual orientation.

Implicit communication of negative attitudes. In contrast to the explicit forms of sexual prejudice described above, some participants recalled instances in which negative attitudes toward the LGBQ community were inferred through nonverbal gestures and the tone of voice used to describe non-heterosexual relationships or encounters. While these experiences were void of explicit communication of negative attitudes, the individuals recalling these events received a clear message that LGBQ sexual orientations were not accepted and not something that should be openly discussed. For example, Participant 56’s self-defining memory outlines the moment when her mother told her that her female cousin was in a romantic relationship with another female.

“… It never seemed weird or different to me... it just was what it was. That was until the day came that my mom told me that they were in a relationship together. I remember her telling me and by the sound of her voice I remember feeling like it was a really bad thing. I remember thinking that it is something that should never be discussed again.” (P56)

While antigay attitudes were not explicitly communicated, the tone of voice used to divulge the information was such that Participant 56 learned that she should not discuss her cousin’s romantic relationship and that same-sex relationships are a “bad thing.” Similarly, Participant 78 described the moment when she learned the terms ‘gay’ and ‘lesbian’:

“… I asked my parents what "gay" was and they told me about homosexuality in men, but kind of in hushed voices one would use to talk about taboo things. I knew I liked girls at the time, so I asked them if there was a female version of that and when they said yes,
lesbians, and I realized at the same time that there were other girls that liked girls, and also that it was a socially inappropriate thing to do, and that "normal" people didn't like people of the same gender. I decided this was something about myself that I would not share with others because of the "taboo" feeling I got from my parents explaining homosexuality.” (P78)

Again, the tone of voice used to educate their child about gay and lesbian relationships communicated the disapproval and contributed to this person’s concealment of her own sexual orientation.

Consistent with research on silencing, the impact of the listener can impact how one recalls the stories they tell about their life and may impact the development of one’s identity (McLean, 2015; Pasupathi & Hoyt, 2010). Words need not be spoken in order for messages to be conveyed and for one’s sexual identity to be silenced. This sort of implicit communication of sexual prejudice, while not outwardly expressing antigay attitudes, may have an impact on how one’s sexual identity is developed (as evidenced by the participants in this study) and speaks to the heteronormative sociocultural environment in which one’s sexual identity is formed. The implicit communication of unacceptance of LGBQ orientations prevented these participants from being open and honest in their relationships with their family members and others. Participant 78 took away the message that not only could she not share this part of herself with her family, but as she states, she would not share this part of herself with many others. Thus, the implicit communication of antigay attitudes may silence one’s sexual identity and may impact one’s ability to integrate this part of the self into a coherent sense of self over time (Syed & McLean, 2015).
Denial of one's sexual orientation. This subtheme reflects participants’ references to moments in which others communicated disbelief in or denied the existence of participants’ sexual orientation in the “real” world. As part of Participant 43’s self-defining memory, she recalls how her father invalidated her sexual orientation upon coming out to him: “…He denied it, and told me that it was just a phase, and eventually I'd like men…” (P43). Other participants’ self-defining memories also referenced responses of denial upon coming out to family members. Participant 107’s mother explicitly denied her daughter’s romantic relationship with another woman:

“…Before leaving that night, I casually told my mum "M and I are dating", and she responded with "No, you're not. You're just good friends and you want to keep it that way…” (P107)

Upon coming out to her father, Participant 59 describes the difficulty she experienced in trying to explain her sexual orientation to her father and his attempts to dissuade her from endorsing a non-heterosexual identity:

“…his reaction was obviously one of confusion and disbelief. He tried to talk me out of it, and tried to reason with me. I answered as best I could, as honestly as I could, but it felt like we were speaking two different languages…” (P59)

In each of these accounts, family members denied the veracity of the participants’ sexual identity. According to past research, reactions of family members to sexual orientation disclosures can have a significant impact on one’s mental health (Rothman et al., 2012; Ryan et al., 2009). In fact, family support has been identified as a stronger predictor of positive mental health outcomes compared to support provided by friends and the community (Snapp, Watson, Russell, Diaz, & Ryan, 2015). By responding with explicit denial of one’s sexual orientation,
these participants received the message that their sexual orientation was unacceptable. Similar to implicit communications of non-acceptance, the outright denial of LGBQ sexual orientations silences one’s ability to be open and honest with others in relationships regarding this part of their self. The silencing of this aspect of the self may impact one’s ability to integrate this domain into their sense of self given that it is through dialogue and sharing stories with others that a coherent sense of self takes shape (Fivush, 2004a; 2010; McLean, 2015; Syed & McLean, 2015). While trends in the literature underscore the importance of a supportive family environment, it may be useful to explore the meaning that individuals make of their family’s disapproval and how this may impact one’s mental health.

Participant 29 describes how she incorporated her mother’s denial of her sexual orientation in her self-defining memory:

“...I thanked my mom for being so emotionally supportive even though she didn't support my bisexuality, and I'll never forget what she replied: "Of course, honey. We know it's real in your head." I felt that this was worse than if they hadn't been at all supportive. It expresses their opinion about homosexuality in a nutshell: they believe that people, like me, who experience same-sex attraction are simply mistaken about their feelings, that they are confusing strong feelings of friendship for romantic feelings. My sexual identity wasn't just morally unacceptable to them, it wasn't even real. This made me determined to identify strongly as a bisexual over anything else, in order to make up for their lack of recognition. I felt that I had to do this in order to keep my sexuality "real," since they were trying to will it into non-existence...And it makes me sad, because I wish I could be closer to my parents but if they refuse to let me share this kind of important emotional experience with them, they are placing a barrier between us.” (P29)
Her parents’ reaction further solidified her sexual identity, but she also highlighted the limits that her parents’ denial has placed on her relationship with them. Due to the denial (or silencing) of her sexual orientation, she was unable to develop the truly close and authentic relationship she desired with her parents (Harter et al., 1998). There is one aspect of her identity that could not be truly expressed and events associated with that identity that could not be shared with her parents, and this, she described, resulted in feelings of sadness. Similarly to Participant 29, Participant 43 also described feelings of sadness in reaction to her father’s denial of her sexual identity:

“...All in all, I was just glad that I didn't get disowned, but I was also sad because my dad didn't believe me. It was frustrating because it took me almost a year to do come out, and I was hugely nervous. However, I didn't expect my parents (my dad later told my mum - she didn't believe me either) to embrace it, so I suppose this was the best scenario and reaction I could have received from them.” (P43)

Her account reflects the expectation of a negative response from others with respect to her sexual orientation. After building up the courage to disclose her sexual identity despite her fear, she was met with denial and she is left having to accept her parents’ lack of acceptance of her sexual orientation. Reactions such as these effectively break down the ability to be open about one’s sexual orientation in this relationship, and may impact how this individual interacts with others in her world (Harter et al., 1998).

Taken together, many of participants’ self-defining narratives relating to their sexual orientation contained references to experiences of sexual prejudice. The fact that experiences of sexual prejudice are the memories that serve as self-defining memories pertaining to participants’ sexual orientation underscores the critical role these negative experiences can play in defining
this domain of the self. Indeed, experiences of sexual prejudice can prevent one from sharing one’s true thoughts, feelings, and opinions with others, as described by the participants above, which underscores the power of sociocultural factors in silencing one’s sexual orientation identity. While sexual minority identities may have more voice than they ever have in recent years (Weststrate & McLean, 2010), findings from this research suggest that the master narrative of the heterosexual life story still prevails. Due to experiences of sexual prejudice, including the explicit and implicit expression of antigay attitudes as well as denial of the existence of sexual orientations other than heterosexual, LGBQ individuals may have difficulty incorporating their sexual identity into their coherent sense of self over time given the limited opportunities to voice this aspect of the self (McLean, 2015). Indeed, poorer mental health outcomes have been associated with the experience of sexual prejudice, including self-harm and NSSI (Alexander & Clare, 2004; Almeida et al., 2009; Blosnich & Bossarte, 2012; D’Augelli et al., 2002; Dragowski, Halkitis, Grossman, & D’Augelli, 2011; House et al., 2012; Liu & Mustanski, 2011; McDermott et al., 2013; Scourfield, Roen, & McDermott, 2008; Walls et al., 2010) and silencing may be one way to explain the connection between the experience of sexual prejudice and NSSI.

**Presumption of heterosexuality.** A theme relating to silence that was extracted from participants’ self-defining memories is the presumption of heterosexuality, which can also be described as a form of heterosexism or the result of living in a heterosexist culture. This theme reflects the expectation of a heterosexual orientation (also represented by the master narrative of the heterosexual life story; McLean & Syed, 2015), which thereby silences non-heterosexual identities and also implies the sociocultural superiority of heterosexuality. This was evident in Participant 80’s self-defining memory when she described how her own presumption of heterosexuality was challenged in her life: “...I was confused, I had never thought of myself as
anything but straight...” (P80). An excerpt from Participant 26’s self-defining memory demonstrated how heterosexuality served as her “default” sexual orientation: “I was going out with a boy at the time, and I had not yet realised that I was anything but heterosexual…” (P26)

These accounts demonstrate how the sociocultural norms of heterosexism become internalized and impact the interpretation of life events. Heterosexuality is considered the “norm” and this is conveyed through our language (Land & Kitzinger, 2005; Weinberg, 2009), media (Binder & Ward, 2015; Levina, Waldo, & Fitzgerald, 2000; Quist & Weigand, 2002), and through the implicit and explicit attitudes shared by others (described above). Heterosexism is also perpetuated through lack of exposure to sexual diversity as exemplified by Participant 15’s self-defining memory in which she highlights her unawareness of non-heterosexual orientations:

“…because I didn't know that girls could be attracted other girls, I allowed myself to believe that she was a boy. I had a crush on her, the way that kids have crushes...I would sometimes look at her in class and literally pray that she really was a boy with long hair, because I wanted it to be okay that I "liked" her...when I saw her washing her hands in the girl's bathroom one day [I] realized that she was definitely a girl and that I'd been fooling myself...I thought there was something seriously wrong with me, and that I was somehow "sick." I thought that [she] would hate me if she knew I thought she was a boy and that I "liked" her. I spent the rest of that day having awful panic attacks, so bad that I was shaking uncontrollably and vomiting, and the teacher sent me to the school nurse, who sent me home. I told them I didn't know why I was crying, but I was lying to them…”

(P15)

While one cannot make presumptions about the consequences of assuming a heterosexual orientation, Participant 15 shared how shameful she felt following the realization of her same-sex
attraction and the resulting mental health difficulties she experienced. Participant 26’s self-defining narrative also demonstrated that negative emotions and consequences (i.e., unwanted sexual experiences) of the presumption of heterosexuality:

“I was going out with a boy at the time, and I had not yet realised that I was anything but heterosexual. I was at his house and all I felt was awkward. I knew what he wanted, and I knew that I didn’t want to do anything sexual with him. And I didn’t understand why. I tried to just watch a DVD with him, and he kept trying to kiss me. So I kissed him, because I felt obligated. I still feel bad about this. [P26 describes an additional unwanted sexual experience] and it was horrible. Yet I still didn't consider that I might be gay. I felt like there was something wrong with me. I felt like that for a long time.” (P26)

As Participant 26 shares, there are certainly significant risks associated with the presumption of heterosexuality. Participants in the current study described experiencing isolation, shame, and confusion as a result of the presumption of heterosexuality, which have been linked to mental health difficulties by participants in this study and to NSSI (Alexander & Clare, 2004; Claes, Lucykx, & Bijttebier, 2014; Lewis, Lumley, & Grunberg, 2015; McDermott et al., 2008; Schoenleber et al., 2014; VanDerhei et al., 2014).

Indeed, the presumption of heterosexuality reflects the sociocultural silencing of the continuum of sexual orientations that exist and is consistent with the master narrative of the heterosexual life course (McLean & Syed, 2015). While there is more visibility of sexual diversity in the present day than ever before (McLean & Syed, 2015), common practices continue to alienate and stigmatize non-heterosexual orientations. For example, the widely-accepted gender-based terms that are used to describe romantic partnerships (e.g., boyfriend, wife) serve to perpetuate this assumption and may inadvertently silence those whose sexual
orientation does not align with this presumption. By using these terms, speakers are subtly communicating the superiority of heterosexuality and hence, may not be seen as an ally or one with whom someone can be open and honest about their sexual orientation. Thus, using inclusive and voice-giving terminology in everyday speech (e.g., using “partner” as a gender neutral term to refer to one’s romantic partner; Weinberg, 2009), serves to give voice to sexual diversity. By giving voice to sexual diversity through common speech, it communicates acceptance, awareness, and may serve to normalize sexual diversity; thereby, reducing the negative emotions that participants associated with the presumption of heterosexuality and subsequent mental health challenges.

**Voice.** Themes in which participants referenced moments of voice were present in self-defining memories, typically following experiences which depicted silence. Themes of voice were extracted when narratives referenced moments in which participants felt open to discuss their sexual orientation with others or felt supported in a way that encouraged them to be open with others about their sexual identity (Harter et al., 1998). This also includes references to moments in which participants described finding their own internal voice (a moment of self-acceptance or self-realization). Thus, three subthemes of voice were extracted, all of which focus on acceptance and belonging. Participants referenced moments in which they felt accepted by others, felt at ease or a sense of relief following identification with a group, and pivotal moments of self-acceptance in which participants found their own voice in a culture of silence.

**Group Membership/Identification.** Participants described moments in which they realized others were also going through an experience of sexual identity discovery. Finding others who described similar experiences appeared to give voice to participants’ sexual identity by providing language to describe and normalize their experience. Group membership or
identification appeared to counteract feelings of shame and the thought that something may be “wrong” with them. For example, Participant 3 recalled researching her experiences on the internet and the relief she felt upon discovering a label for her experience that is shared by others:

“…So I googled it, read the Wikipedia page and browsed the AVEN (Asexual Visibility and Education Network) forums. It shocked me that what I am has a name, that I wasn't weird, or broken and that there are other people like me…” (P3)

Similarly, Participant 68’s self-defining memory described the moment that she happened upon a book that described various sexual orientations:

“…It was the first time I’d ever seen any material that normalized same-sex relationships, and probably it felt both really scary and also like, "wow, this is ok for some people."” (P68)

Participants described the relief they experienced in knowing that they are not “broken” and, most importantly, not alone in their experiences. Participant 82 describes how comforting it was to know that others could be experiencing the same thing:

“…Then I told my best friend at the time who just said that she had been feeling the same way, it was so reassuring that I wasn't the only one to feel that way…” (P82)

These accounts highlight the importance of normalizing and increasing the visibility or awareness of non-heterosexual orientations. These participants described instances in which they found a collective voice and language with which to describe their experience. They became aware of alternative narratives that aligned more closely with their own personal narratives, as opposed to the ubiquitous master narrative of the heterosexuality (McLean & Syed, 2015). Once this voice was discovered through identification with others, participants described
finding comfort in the knowledge that they are not alone. Their sexual identity was normalized and legitimized.

These participants’ experiences underscore the positive effects of group identification and how group identification alone can give voice to one’s sexual identity (Meyer, 2015; Riggle et al., 2014). By connecting with a community who provides voice to this aspect of the self, one may be better able to integrate their sexual identity into their sense of self over time through narrative discourse with others (McLean, 2015; Fivush, 2004a; 2010). Indeed, feeling connected to a supportive community to which one feels a sense of belonging is associated with positive mental health outcomes. Social connectedness has been identified as a prime contributing factor to the psychological well-being of LGB youth, above and beyond that of social support alone (Detrie & Lease, 2007). In addition, affiliation with sexual identity-affirming faith groups is associated with positive mental health outcomes through reductions in internalized homophobia and increased levels of individual spirituality (Lease, Horne, & Noffsinger-Frazier, 2005). In a qualitative study of LGB youth’s use of the Internet for support and connectedness, LGB youth identified the increased ease with which they could talk about their sexual identity online as well as the increased pool of like-minded individuals online, compared to offline (Hillier, Mitchell, & Ybarra, 2011). Consistent with the findings of the present qualitative analysis, it appears that LGB youth are looking for safe spaces in which their sexual orientation can be voiced openly. Connecting with others who have had similar experiences appears to give voice to sexual identity narratives that go against the master narrative of the heterosexual life story and serves to normalize the diversity within these life stories.

Acceptance from others. In addition to experiences of normalization through group identification, self-defining memories pertaining to participants’ sexual orientation often
contained references to moments in which they felt accepted by significant others in their life with respect to their sexual orientation. Some participants, like Participant 71, fondly described unexpected positive reactions of others:

“I came out to my grandmother when I was about fourteen. We were driving home in the car, and I told her I wasn’t straight. All she said was, "whatever floats your boat honey", and that was the end of it. I was so amazed that she was willing to accept me for who I was.” (P71)

Others, like Participant 103, described how difficult it was to disclose their sexual orientation, despite anticipating a supportive reaction from others:

“...My mum reacted exactly as I'd known she would, it was an absolute non-issue, she told me it was fine and left the room. My reaction was so different though. The action of voicing it, coming out for the first time, was over-whelming. I shook like a leaf and cried hot tears. I went downstairs and my parents hugged me and reassured me that my sexuality was not a problem, and yet the event still left me shaken and feeling vulnerable.” (P103)

Even among families who support sexual diversity, Participant 103 still expressed hesitation with respect to disclosing her sexual orientation. This is consistent with research findings that many LGB youth anticipate and tend to overestimate negative reactions from family members, even when approximately 35% of parents do, in fact, respond negatively (D’Augelli et al., 2008). The anticipation of negative reactions may reflect the acute awareness that LGBQ youth and young adults have of the master narrative of the heterosexual life story. The accounts from this study highlight the challenges that some participants faced upon coming out to others in their life, but
also the supportive reactions that eventually served as self-defining memories with respect to their sexual orientation. Acceptance from others can also facilitate self-acceptance:

“...I remember being very nervous, and crying a lot, because I thought everyone was going to hate me. I was just sitting there, and then finally I told him. I remember him just looking at me and saying "Yea, so what?" while shrugging his shoulders. At the time I was still very depressed and scared, but it was a very important moment for me. He helped me realize for the first time that there was nothing wrong with me, and whatever my orientation was, was OKAY...Without this experience, and acceptance, I would have never become who I am now. I am very thankful for it, and my counselor who I still see to this day.” (P102)

Each of these narratives depict feelings of acceptance by a supportive individual. By providing support and acceptance regardless of sexual orientation, participants’ sexual orientation was given voice and more opportunities to incorporate their sexual orientation into their coherent sense of self over time were provided (Fivush, 2004a; 2010).

Participants’ accounts in this study are consistent with previous research indicating the importance of supportive reactions (Rothman et al., 2012; Ryan et al., 2009), and specifically supportive familial reactions in response to “coming out” (Shilo & Savaya, 2011; Snapp et al., 2015). Family acceptance has been identified as the strongest predictor of both self-esteem and LGBT esteem compared to support received from friends or the community (Snapp et al., 2015). In addition, family acceptance has been linked to self-acceptance and general well-being (Shilo & Savaya, 2011). On the other hand, less acceptance from family members is associated with increased mental health difficulties (Ryan et al., 2010; Shilo & Savaya, 2011), including self-harm (Carastathis, 2013). Indeed, feeling accepted by those whose relationships one values is
important in giving voice to one’s sexual identity and can contribute one’s sense of self-acceptance.

**Self-acceptance.** Themes of voice were also extracted from participants’ narratives in which they described finding their own voice through moments of self-realization and self-acceptance. These narratives depicted moments in which they felt comfortable with themselves and comfortable with their sexual orientation, often despite the negative reactions or attitudes of others. Powerful language was used by participants to describe this newfound voice. Participant 59 described how she felt “at home with [herself]” while Participant 27 described experiencing a personal “epiphany.” Participant 48’s self-defining memory described a “turning point” when she “was ready to be [herself].” Participant 21 described a moment in which all of the difficulties that she had previously experienced through the process of discovering her sexual identity were trumped by the fact that she was certain about her feelings for another person:

“…I realized that this was what I wanted and that all my worries or confusion about my sexual orientation didn't matter because I was going to be happy with her and that was all that really mattered…”(P21)

This sort of self-realization has an air of contentment, satisfaction, and peace, despite previous tribulations. These moments of self-realization were occasionally facilitated by others, but the self-defining memories tended to focus on the shift that occurred within the individual. Participant 27 describes this internal shift following a colleague’s sexual orientation disclosure:

“…At that point, I realized that I didn't have to classify myself as heterosexual. We were sitting in a room on campus, in a big circle of all 45 of my coworkers, and I had an epiphany. I don't have to be what everyone stereotypes me as (heterosexual)...Now I feel free to say to myself, I am who I am, and I won't let anybody change that. ” (P27)
A sense of empowerment emerged from narratives displaying this theme of self-acceptance such that participants were able to take charge of their own identity despite the reactions of others. For example, Participant 20’s self-defining memory included a time when she stuck up for herself following a negative reaction from her mother with respect to her sexual orientation. By taking a stand and refusing to be a victim of prejudice, Participant 20 describes how this experience empowered her:

“…But those words that I said to my mom, helped in growing confidence of sticking up for the rainbow flag I gladly dawn on all my clothes today. The step in not shutting down and just taking it from her, it really helped me gain this respect for my sexualit” (P20)

Indeed, self-acceptance of one’s sexual orientation identity is key to positive adjustment in a heterosexist social context. While some narratives in the current study indicated that acceptance from others helped to facilitate participants’ own self-acceptance, the limited research on self-acceptance of one’s sexual identity is currently mixed (Carastathis, 2013; Darby-Mullins & Murdock, 2007; Vincke & Bolton, 1994). In a study of gay and lesbian men and women, parental rejection was associated with lower levels of self-acceptance (Carastathis, 2013). In contrast, family-held negative attitudes toward homosexuality was not predictive of LGB adolescents’ self-acceptance; however, it was predictive of anxiety and depression (Darby-Mullins & Murdock, 2007). Thus, it is unclear based on the current literature how self-acceptance is impacted by the acceptance of others.

Conceptually, self-acceptance is the product of LGBQ self-esteem, a lack of internal conflict regarding one’s sexual identity, and the degree to which one is able to reject heterosexist notions (Carastathis, 2013). Self-acceptance appears to capture the absence of internalized heterosexism and internal conflict, as well as the pride and value placed on one’s LGBQ status.
Self-acceptance with respect to one’s sexual identity may provide the confidence needed to voice one’s sexuality with pride despite the reactions of others. It may also help protect one from the deleterious effects of familial rejection (Carastathis, 2013). While research on self-acceptance of one’s sexual identity is limited, a lack of self-acceptance regarding one’s sexual orientation has been linked to alcoholism (Kus, 1988) and depression (Vincke & Barton, 1994). Taken together with the accounts of participants in this study, it appears that self-acceptance is an under-researched area of LGBQ identity development that may serve to protect participants from negative mental health outcomes associated with LGBQ status in a heterosexist society by providing an internal sense of empowerment and voice.

From a narrative theory perspective, the dynamics of voice and silence are impacted by the power granted to particular viewpoints within society (Fivush, 2004b; 2010). Perspectives that align with master narratives (e.g., the master narrative of the heterosexual life story) are more accepted by society and given voice (Fivush, 2004b; McLean & Syed, 2015). Life stories that deviate from the master narrative are less accepted and silenced because “these stories are either not heard or these perspectives are not validated” (Fivush, 2004b, p. 7). Moments of self-acceptance appear to reflect a shift in power. Rather than being silenced by others in power, an individual has reclaimed their power and feels free to express oneself despite sexual prejudices and the ubiquitous voice given to those whose life stories align with the master narrative.

**Concluding Remarks and Implications**

Part 2 provided a venue for LGBQ young adults with a history of NSSI to share their self-defining memories that may be rendered silent. Indeed, themes of voice (i.e., group identification, acceptance from others, self-acceptance) and silence (i.e., explicit references to silence, fear, shame, sexual prejudice, and the presumption of heterosexuality) were extracted
from LGBQ participants’ self-defining memories relating to their sexual orientation. Analysis of participants’ memories demonstrated the heavy impact of social interactions and the sociocultural environment on participants’ self-defining memories, the prevalence of silence as it relates to participants’ sexual orientation, and the empowerment that is experienced through voice; all of which suggest that the theory of voice and silence may have utility in describing the experiences of LGBQ young adults. While conclusions cannot be drawn about the causal connection between the experience of voice or silence and NSSI among LGBQ young adults, the self-defining memories of LGBQ young adults with a history of NSSI highlight the many ways that one’s sexual orientation can be silenced and how this silence can be overcome through instances in which they are given voice through group identification, acceptance from others, and self-acceptance.

Based on the current qualitative analysis, participants’ sexual identities were silenced through experiences of shame, fear, sexual prejudice – all of which occurred within the context of social interactions with others. In addition, the heteronormative expectations that occurred within the broader sociocultural environment also served to silence participants’ sexual orientation within this study. It is notable, but not unexpected, that the majority of self-defining memories described social interactions. It is through relationships with others that we develop our personal narrative and make sense of who we are and our experiences (Bruner, 1990; Fivush, 2004b; 2004a; 2010; Harter et al., 1998; McAdams, 2001; McLean, 2015; McLean et al., 2007). Outcomes of this analysis continue to highlight the impact of social interactions and the sociocultural environment on the development of one’s sexual identity, which is consistent with the underlying assumption that LGBQ identities develop within a heterosexist sociocultural environment that can impact the wellbeing and mental health of those who identify as LGBQ.
AN EXPLORATION OF SEXUAL ORIENTATION AND NSSI

(Szymanski et al., 2008). Indeed, there needs to be a global shift in the general attitude toward sexual minorities and in the heterosexism that pervades all systems, from the microsystem to the macrosystem (Bronfenbrenner, 1979), with the goal of creating a space where individuals’ personal narratives can be voiced, rather than silenced; where rejection is the exception, rather than the norm. While more recent research suggests that the narratives of LGBQ adults are now characterized by more voice than in years previous (Cohler & Hammack, 2007; Weststrate & McLean, 2010), evidence from the current research suggests that there is still plenty of room for growth in this domain. By increasing the general acceptance of the continuum of sexual identities and increasing the visibility of sexual minorities within the broader sociocultural environment, the shame, fear, and sexual prejudice experienced by LGBQ individuals may be reduced. By doing so, one who identifies as LGBQ or who is exploring their sexual identity may be in a better position to develop a positive sense of self, connect with others in the community, and feel as though their sexual identity is valid and has value.

While working toward this broad sociocultural shift, findings from this qualitative analysis suggest that it may be important to focus on empowerment and self-acceptance as a way to build resilience and provide voice when embedded in a system that oppresses and stigmatizes. This is consistent with recent shifts toward a Positive Clinical Psychology approach to mental health, which acknowledges the interactional nature between both risk and protective factors in predicting mental health outcomes as opposed to investigating risk factors in isolation (Wood & Tarrier, 2010). A holistic approach to investigating NSSI risk within the LGBQ population requires an in depth examination of both risk and protective factors and how these factors interact to produce a particular outcome. Indeed, there is a paucity of research exploring resiliency and protective factors when it comes to LGBQ mental health (Kwon, 2013; Riggle,
Theories of voice and silence (Harter et al., 1998; Fivush 2004a; 2010) take both of these factors into consideration and may be fruitful in exploring risk for NSSI among LGBQ populations, especially as these theories relate to narrative identity development (Fivush, 2004b; 2004a; 2010; McLean, 2015; McLean, Shucard, & Syed, 2016; McLean & Syed, 2015).

For narratives in which themes of voice were extracted, the meaning that participants made of their experiences helped shift the tone of their narrative into something positive, even if they described being silenced initially. This is consistent with Cohler & Hammack’s (2007) narrative of “struggle and success,” which highlights the struggles of developing a gay identity in a heterosexist sociocultural environment as well as the experience of success and resilience in the face of such hardships. Thus, the meaning that people make of their experiences (Park, 2010; Singer, 2004) may be particularly salient in creating the link between voice and silence and NSSI. Based on these preliminary findings, it may be fruitful to consider the role of narratives in the context of therapy to assist LGBQ youth and young adults with a history of NSSI to reconstruct the story of their life into an empowering and self-affirming story.

Overall, approaching the analysis of LGBQ participants’ self-defining memories from Harter and colleagues’ (1998) theoretical framework of voice and silence, while also considering conceptualizations of voice and silence from a narrative approach to identity development (Fivush; 2004a; 2004b; 2010), provided a holistic way to describe both negative and positive memories associated with one’s sexual orientation. By combining these two approaches, it is apparent that voice includes, but is not limited to, being able to express one’s thoughts, feelings, and opinions with others (Harter et al., 1998). Voice and silence are determined by the power of the majority and are highly impacted by the sociocultural environment in which one’s narrative
identity takes shape (Fivush, 2004a; 2004b; 2010; McLean, 2015; McLean & Syed, 2015). Voice appeared to emerge within these narratives when there was a shift in power (whether power was reclaimed by the individual or when power was bestowed by another; Fivush, 2004b). Silence, on the other hand, appears to be very much imposed by the heterosexist sociocultural environment, which is consistent with the master narrative framework of identity development (McLean & Syed, 2015). Findings from the current analysis suggest that minority voices can still be silenced, even when one openly voices their thoughts and opinions with others. Thus, Harter and colleagues’ (1998) conceptualization of voice and silence, while related, is distinct from Fivush’s (2004a; 2004b; 2010) conceptualization of voice and silence as it relates to narrative identity development in the sense that Fivush’s conceptualization captures the more subtle and cultural causes of silence (e.g., through the impact of the listener and sociocultural environment). Approaching the data in this way provides a starting point in which one can begin to study NSSI from this framework by incorporating both risk and protective factors and how these may interact to produce positive and negative mental health outcomes, including NSSI. Findings from this research highlight that experiences of voice relating to self-defining memories pertaining to one’s sexual orientation have to do with reclaiming or shifting the power that is often assigned to narratives that fit the canonical life story (McLean & Syed, 2015; Fivush, 2004b).

**Limitations and Future Directions**

Self-defining memories were collected online to preserve participants’ privacy and to enhance their sense of security in sharing potentially sensitive information. Given the ethical constraints, one limitation of this study was the inability to clarify participants’ meaning or check with participants to ensure the accuracy of the themes extracted from their individual narratives.
In addition, participants were limited to a certain number of characters when providing their text responses, which resulted in three of the narratives being cut short. It may be fruitful to use face-to-face interviews in the future to glean participants’ self-defining memories so as to allow for clarification when meaning is unclear and follow-up to ensure the extracted themes accurately reflect participants’ experiences. It would also be helpful to ask participants specifically about their personal experiences of both voice and silence.

By virtue of using qualitative research methods, the coding was impacted by the lens through which the coder viewed the data. Thus, this research was conducted by a heterosexual graduate student in clinical psychology in an attempt to understand disparities between NSSI rates among heterosexual and LGBQ individuals. The qualitative analysis was completed using an inductive approach informed by the theoretical framework of voice and silence (Harter et al., 1998) while also considering how voice and silence impacts narrative identity development (Fivush 2004b, 2010; McLean, 2015). Analysis from these perspectives may have limited the scope of themes that were extracted from the data; however, using an inductive approach helped narrow the focus of the analysis and is consistent with the goals of this research. In future explorations of voice and silence, it will be important to include members of the LGBQ community in development and analysis phases of the research to ensure that analyses truly reflect experiences of those within the LGBQ community. In addition, it may be useful to explore self-defining memories pertaining to sexual orientation from a broader scope in the future.

The main purpose of Part 2 was to explore how experiences of voice and silence may characterize the self-defining memories provided by LGBQ participants with a history of NSSI in order to gain a more in depth understanding of how the theory of voice and silence may relate
to this population so as to inform future research endeavors. This study provided a venue for those who may be silenced to share their story, which is the goal of qualitative research (i.e., to describe individual experiences rather than make broad conclusions about populations; Braun & Clarke, 2013). Indeed, Part 2 does not, and was not intended to, draw conclusions about the causal relationship between voice and silence and NSSI within the LGBQ community. In the future, it will be useful to explicitly inquire about the potential connection between sexual identity formation and NSSI. Indeed, this has been done in the past and youth indicated that their self-harm was the result of heterosexism and the consequential fear, shame, and self-loathing it caused (McDermott et al., 2013), which is consistent with the themes of silence extracted from participants self-defining memories in this analysis. In the future, it may be useful to explore how the themes extracted from participants’ self-defining memories (e.g., concealment, fear, shame, sexual prejudice, the presumption of heterosexuality, self-acceptance, acceptance from others, group identification) are or are not related to NSSI. It may also be useful to explore LGBQ young adults’ self-defining memories pertaining to their sexual orientation in relation to their NSSI journey to recovery. It may be that participants who no longer self-injure, but have self-injured in the past, are those whose self-defining memories contain references to voice and may mirror Cohler & Hammack’s (2007) narrative of “struggle and success”.

**Final Thoughts**

This study is a preliminary investigation of how the theory of voice and silence (Harter et al., 1998) may help to explain why higher rates of NSSI are reported within the LGBQ community. Results from Part 1 continue to underscore that sexual orientation does not increase one’s risk for NSSI, but negative experiences associated with sexual minority status in a
heterosexist sociocultural environment may increase one’s risk for NSSI (Herek & Garnets, 2007; McDermott et al., 2013). LGBQ individuals may have social experiences that may thwart the expression of oneself in relationships with others which may heighten one’s emotion dysregulation (i.e., a lack of awareness, clarity, and acceptance of one’s emotional responses, access to few effective emotion regulation strategies, impulsivity when experiencing distress) and increase one’s risk for NSSI. Thus, it will be important to explore the connection between the experience of silence in relationships with others and emotion dysregulation in future research. Part 2 demonstrated how experiences of voice and silence are presented within the self-defining memories provided by LGBQ participants with a history of NSSI. Findings from the qualitative analysis also highlighted the prevalence of voice and silence within participants self-defining memories pertaining to their sexual orientation and suggest that the theory of voice and silence may be helpful in understanding the experiences of LGBQ young adults with a history of NSSI. Clinically, this research underscores the importance of accepting and validating social environments in mitigating NSSI risk, providing safe and accepting spaces in which to explore one’s sexual identity, and points to the potential utility of narratives in the context of therapy to assist LGBQ youth and young adults with a history of NSSI to reconstruct the story of their life into an empowering and self-affirming story.
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doi:10.1007/978-0-387-89825-4_4


doi:10.1080/09658210903153923


doi:10.1080/15374410802359734


Table 1

*Sexual Orientation based on Measures of Sexual Attraction and Sexual Behaviour*

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Sexual Attraction&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Sexual Behaviour&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Straight</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Mostly straight</td>
<td>3</td>
<td>2.8</td>
</tr>
<tr>
<td>Bisexual</td>
<td>50</td>
<td>46.7</td>
</tr>
<tr>
<td>Mostly gay/lesbian</td>
<td>30</td>
<td>28.0</td>
</tr>
<tr>
<td>Gay/Lesbian</td>
<td>19</td>
<td>17.8</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2.8</td>
</tr>
<tr>
<td>Asexual</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td>No sexual experiences in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>past 5 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Percentage is based on the total sample (n = 107) with and without a history of NSSI.

<sup>a</sup>Sexual attraction is based on the respondent’s biological sex and the gender of those whom the respondent is sexually attracted or aroused by.

<sup>b</sup>Sexual behaviour is based on the respondent’s biological sex and the biological sex of those the respondent has engaged in sexual behaviour with during five years prior to participation.
### Table 2

*Spearman’s Rho Correlations between Age, Level of Voice (LOV), Emotion Dysregulation (DERS), Outness, Support, and NSSI Outcomes*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Age</th>
<th>LOV – General</th>
<th>LOV – Sexuality</th>
<th>DERS</th>
<th>Outness</th>
<th>Support</th>
<th># NSSI Methods</th>
<th>NSSI Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>---</td>
<td>-.05</td>
<td>-.02</td>
<td>-.03</td>
<td>.13</td>
<td>-.16</td>
<td>.06</td>
<td>.08</td>
</tr>
<tr>
<td>LOV – General</td>
<td>-.05</td>
<td>---</td>
<td>.66**</td>
<td>-.50**</td>
<td>.35**</td>
<td>.32**</td>
<td>-.33**</td>
<td>-.34**</td>
</tr>
<tr>
<td>LOV – Sexuality</td>
<td>-.02</td>
<td>.66**</td>
<td>---</td>
<td>-.32**</td>
<td>.63**</td>
<td>.25*</td>
<td>-.24*</td>
<td>-.24*</td>
</tr>
<tr>
<td>DERS</td>
<td>-.03</td>
<td>-.50**</td>
<td>-.32**</td>
<td>---</td>
<td>-.20*</td>
<td>-.35**</td>
<td>.54**</td>
<td>.62**</td>
</tr>
<tr>
<td>Outness</td>
<td>.13</td>
<td>.35**</td>
<td>.63**</td>
<td>-.20*</td>
<td>---</td>
<td>.15</td>
<td>-.16</td>
<td>-.14</td>
</tr>
<tr>
<td>Social Support</td>
<td>-.16</td>
<td>.32**</td>
<td>.25*</td>
<td>-.35**</td>
<td>.15</td>
<td>---</td>
<td>-.19</td>
<td>-.26**</td>
</tr>
<tr>
<td># NSSI Methods</td>
<td>.06</td>
<td>-.33**</td>
<td>-.24*</td>
<td>.54**</td>
<td>-.16</td>
<td>-.19</td>
<td>---</td>
<td>.82**</td>
</tr>
<tr>
<td>NSSI Frequency</td>
<td>.08</td>
<td>-.34**</td>
<td>-.24*</td>
<td>.62**</td>
<td>-.14</td>
<td>-.26**</td>
<td>.82**</td>
<td>---</td>
</tr>
</tbody>
</table>

* M = 20.93, SD = 2.25

**p < .01. **p < .05.
Table 3

Hierarchical Binary Logistic Regression Statistics with Lifetime NSSI Frequency Status Predicted from Level of Outness, Social Support, Emotion Dysregulation, and Level of Voice.

<table>
<thead>
<tr>
<th>Block</th>
<th>B</th>
<th>SE</th>
<th>Wald</th>
<th>p</th>
<th>Exp(B)</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outness</td>
<td>-.47</td>
<td>.30</td>
<td>2.46</td>
<td>.12</td>
<td>.62</td>
</tr>
<tr>
<td></td>
<td>Social Support</td>
<td>-.16</td>
<td>.32</td>
<td>.24</td>
<td>.62</td>
<td>.85</td>
</tr>
<tr>
<td></td>
<td>χ² (2) = 3.44, p = .18; Nagelkerke R² = .06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Block 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outness</td>
<td>-.14</td>
<td>.33</td>
<td>.18</td>
<td>.67</td>
<td>.87</td>
</tr>
<tr>
<td></td>
<td>Social Support</td>
<td>.44</td>
<td>.39</td>
<td>1.28</td>
<td>.26</td>
<td>1.56</td>
</tr>
<tr>
<td></td>
<td>DERS</td>
<td>1.88</td>
<td>.49</td>
<td>14.57</td>
<td>&lt; .001</td>
<td>6.53</td>
</tr>
<tr>
<td></td>
<td>χ² (1) = 23.58, p &lt; .001; Nagelkerke R² = .43</td>
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<tr>
<td>LEVEL OF VOICE - GENERAL (Gen LOV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Block 3</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outness</td>
<td>-.07</td>
<td>.35</td>
<td>.04</td>
<td>.84</td>
<td>.93</td>
</tr>
<tr>
<td></td>
<td>Social Support</td>
<td>.55</td>
<td>.43</td>
<td>1.66</td>
<td>.20</td>
<td>1.73</td>
</tr>
<tr>
<td></td>
<td>DERS</td>
<td>1.78</td>
<td>.50</td>
<td>12.70</td>
<td>&lt; .001</td>
<td>5.94</td>
</tr>
<tr>
<td></td>
<td>Gen LOV</td>
<td>-.77</td>
<td>1.03</td>
<td>.56</td>
<td>.45</td>
<td>.46</td>
</tr>
<tr>
<td></td>
<td>χ² (1) = .58, p = .45; Nagelkerke R² = .44</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEVEL OF VOICE – SEXUAL ORIENTATION (Sex LOV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Block 3</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outness</td>
<td>.19</td>
<td>.43</td>
<td>.19</td>
<td>.66</td>
<td>1.21</td>
</tr>
<tr>
<td></td>
<td>Social Support</td>
<td>.58</td>
<td>.43</td>
<td>1.89</td>
<td>.17</td>
<td>1.79</td>
</tr>
<tr>
<td></td>
<td>DERS</td>
<td>1.90</td>
<td>.51</td>
<td>14.14</td>
<td>&lt; .001</td>
<td>6.69</td>
</tr>
<tr>
<td></td>
<td>Sex LOV</td>
<td>-1.17</td>
<td>.95</td>
<td>1.49</td>
<td>.22</td>
<td>.31</td>
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<tr>
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<td>χ² (1) = 1.57, p = .21; Nagelkerke R² = .45</td>
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Table 4

Hierarchical Binary Logistic Regression Statistics with NSSI Method Status Predicted from Level of Outness, Social Support, Emotion Dysregulation, and Level of Voice.

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<td>.45 – .12</td>
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<td>Wald</td>
<td>p</td>
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<td>.23</td>
<td>.63</td>
<td>1.16</td>
<td>.64 – .09</td>
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<tr>
<td>DERS</td>
<td>1.10</td>
<td>.34</td>
<td>10.43</td>
<td>.001</td>
<td>3.00</td>
<td>1.54 – 5.58</td>
<td></td>
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<td></td>
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<td></td>
<td>$\chi^2 (1) = 12.58, p &lt; .001; \text{Nagelkerke } R^2 = .26$</td>
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LEVEL OF VOICE - GENERAL (Gen LOV)

<table>
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<tr>
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<td></td>
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<td>Wald</td>
<td>p</td>
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<td>95% C.I.</td>
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<td>.88</td>
<td>.35</td>
<td>.78</td>
<td>.47 – .13</td>
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<td>.30</td>
<td>.59</td>
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<td>.64 – 2.19</td>
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<td>.003</td>
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<td>1.44 – 5.81</td>
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<td>.73</td>
<td>.79</td>
<td>.21 – 2.97</td>
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<td>$\chi^2 (1) = .12, p = .73; \text{Nagelkerke } R^2 = .26$</td>
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LEVEL OF VOICE – SEXUAL ORIENTATION (Sex LOV)

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<td></td>
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<td>.20</td>
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<td>.64 – 2.09</td>
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<td>.001</td>
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<td>1.53 – 6.02</td>
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<td>.32 – 3.85</td>
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Table 5

*Model Coefficients for the Prediction of Lifetime NSSI Frequency by General Level of Voice (GenLOV) in Relationships through Emotion Dysregulation (DERS)*

<table>
<thead>
<tr>
<th>Antecedent</th>
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<th></th>
<th></th>
<th></th>
<th>Coeff.</th>
<th>SE</th>
<th>p</th>
<th>Y (NSSI Frequency)</th>
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<th>SE</th>
<th>p</th>
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<tr>
<td>X (GenLOV)</td>
<td>a</td>
<td>-22.92</td>
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<td>c'</td>
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<td>.522</td>
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<td>M (DERS)</td>
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<td>---</td>
<td></td>
<td>b</td>
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<td></td>
<td>$F(3, 96) = 13.64, p &lt; .001$</td>
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<td></td>
<td></td>
<td>$F(4, 95) = 5.72, p &lt; .001$</td>
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Table 6

*Model Coefficients for the Prediction of the Number of NSSI Methods by General Level of Voice (GenLOV) in Relationships through Emotion Dysregulation (DERS)*

<table>
<thead>
<tr>
<th>Antecedent</th>
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<th>p</th>
<th>Y (NSSI Methods)</th>
<th>Coeff.</th>
<th>SE</th>
<th>p</th>
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<td>&lt; .001</td>
<td>c'</td>
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<td>.57</td>
<td>.326</td>
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<td>.992</td>
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<td>.015</td>
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</table>

\[ R^2 = .29 \]

\[ F(3, 97) = 13.26, p < .001 \]

\[ R^2 = .32 \]

\[ F(4, 96) = 11.06, p < .001 \]
Table 7

*Model Coefficients for the Prediction of Lifetime NSSI Frequency by Level of Voice specifically pertaining to Sexual Orientation (SexLOV) in Relationships through Emotion Dysregulation (DERS)*

<table>
<thead>
<tr>
<th>Antecedent</th>
<th>Coeff.</th>
<th>SE</th>
<th>p</th>
<th>Coeff.</th>
<th>SE</th>
<th>p</th>
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<tr>
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<td>M (DERS)</td>
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<td>b</td>
<td>13.16</td>
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<td>-22.35</td>
<td>90.59</td>
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\[
R^2 = .20 \\
F(3, 96) = 7.92, p < .001
\]

\[
R^2 = .19 \\
F(4, 95) = 5.72, p < .001
\]
Table 8

Model Coefficients for the Prediction of the Number of NSSI Methods by Level of Voice specifically pertaining to Sexual Orientation (SexLOV) in Relationships through Emotion Dysregulation (DERS)

<table>
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<th>Antecedent</th>
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<th>Coeff.</th>
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<td>c'</td>
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<td>.53</td>
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\[ R^2 = .19 \]
\[ F(3, 97) = 7.48, p < .001 \]

\[ R^2 = .31 \]
\[ F(4, 96) = 10.87, p < .001 \]
Appendix A

Brief Demographics Questionnaire

1. Please indicate your sex:
   a. Male
   b. Female

2. Please indicate your age (in years): __________

3. Please indicate your ethnicity: __________

4. Please indicate your religious background (if applicable): __________

5. How strongly do you identify with your religious background?
   Not at all 1 -------------2--------------3---------------4-----------------5---------------6----------------7 Very much so

6. Where did you hear about this study?
Appendix B

Assessment of Sexual Orientation

1. Sexual Attraction

Are you sexually attracted to or aroused by:

a. Only men
b. Mostly men
c. More to men but significantly to women
d. About equally men and women
e. More to women but significantly to men
f. Mostly women
g. Only women
h. Neither men nor women

2. Self-labelled Sexual Orientation

There are many ways that people describe their sexual orientation. How would you currently describe your sexual orientation? ________________________

3. Sexual Behaviour

Within the past 5 years, how would you describe the biological sex of those you have had sexual experiences with?

a. Only men
b. Mostly men
c. More with men, but significantly with women

d. Both men and women equally

e. More with women, but significantly with men

f. Mostly women

g. Only women

h. Neither men nor women
Appendix C

Inventory of Statements about Self-Injury (ISAS; Klonsky & Glenn, 2009)

Section 1. Behaviours

This questionnaire asks about a variety of self-harm behaviors. Please only endorse a
behavior if you have done it intentionally (i.e., on purpose) and without suicidal intent
(i.e., not for suicidal reasons).

1. Please estimate the number of times in your life you have intentionally (i.e., on
purpose) performed each type of non-suicidal self-harm (e.g., 0, 10, 100, 500):

Cutting _____ Severe Scratching _____
Biting _____ Banging or Hitting Self _____
Burning _____ Interfering w/ Wound Healing _____
(e.g., picking scabs)
Carving _____ Rubbing Skin Against Rough Surface _____
Pinching _____ Sticking Self w/ Needles _____
Pulling Hair _____ Swallowing Dangerous Substances _____
Other _______________, _____

******************************************************************************

Important: If you have performed one or more of the behaviors listed above, please
complete the final part of this questionnaire. If you have not performed any of the
behaviors listed above, you are done with this particular questionnaire and should continue
to the next.

******************************************************************************
2. If you feel that you have a *main* form of self-harm, please circle the behavior(s) on the first page above that you consider to be your main form of self-harm.

3. **At what age did you:**

   First harm yourself? ____________ Most recently harm yourself? ____________

   (approximate date – month/date/year)

4. **Do you experience physical pain during self-harm?**

   Please circle a choice: YES SOMETIMES NO

5. **When you self-harm, are you alone?**

   Please circle a choice: YES SOMETIMES NO

6. **Typically, how much time elapses from the time you have the urge to self-harm until you act on the urge?**

   Please circle a choice:

   < 1 hour 1 - 3 hours 3 - 6 hours 6 - 12 hours 12 - 24 hours > 1 day

7. **Do/did you want to stop self-harming?**

   Please circle a choice: YES NO
Appendix D

Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004)

**Nonacceptance of Emotional Responses Subscale** (6 items)

29) When I’m upset, I feel guilty for feeling that way.

25) When I’m upset, I feel ashamed with myself for feeling that way.

15) When I’m upset, I become embarrassed for feeling that way.

14) When I’m upset, I become angry with myself for feeling that way.

33) When I’m upset, I become irritated with myself for feeling that way.

27) When I’m upset, I feel like I am weak.

**Difficulties Engaging in Goal-Directed Behaviour Subscale** (5 items)

30) When I’m upset, I have difficulty concentrating.

22) When I’m upset, I have difficulty focusing on other things.

16) When I’m upset, I have difficulty getting work done.

38) When I’m upset, I have difficulty thinking about anything else.

24) When I’m upset, I can still get things done. (r)

**Impulse Control Difficulties Subscale** (6 items)

37) When I’m upset, I lose control over my behaviors.

31) When I’m upset, I have difficulty controlling my behaviors.

17) When I’m upset, I become out of control.

23) When I’m upset, I feel out of control.

4) I experience my emotions as overwhelming and out of control.

28) When I’m upset, I feel like I can remain in control of my behaviors. (r)

**Lack of Emotional Awareness Subscale** (6 items)
7) I am attentive to my feelings. (r)

3) I pay attention to how I feel. (r)

12) When I’m upset, I acknowledge my emotions. (r)

21) When I’m upset, I believe that my feelings are valid and important. (r)

9) I care about what I am feeling. (r)

39) When I’m upset, I take time to figure out what I’m really feeling. (r)

**Limited Access to Emotion Regulation Strategies Subscale** (8 items)

20) When I’m upset, I believe that I’ll end up feeling very depressed.

19) When I’m upset, I believe that I will remain that way for a long time.

35) When I’m upset, I believe that wallowing in it is all I can do.

40) When I’m upset, it takes me a long time to feel better.

32) When I’m upset, I believe that there is nothing I can do to make myself feel better.

26) When I’m upset, I know that I can find a way to eventually feel better. (r)

41) When I’m upset, my emotions feel overwhelming.

34) When I’m upset, I start to feel very bad about myself.

**Lack of Emotional Clarity Subscale** (5 items)

6) I have difficulty making sense out of my feelings.

5) I have no idea how I am feeling.

10) I am confused about how I feel.

8) I know exactly how I am feeling. (r)

1) I am clear about my feelings. (r)