"I had a lot of anger and that's what kind of led me to cutting myself": Employing a social stress framework to explain why some homeless women self-injure

Abstract: The goal of this article is to address three research questions that are important for understanding self-injuring behaviours among homeless women: 1) do homeless women self-injure? 2) if so, do the correlates of self-injuring behaviour among homeless women in our self-injuringgroup differ in type from stressors experienced by homeless women who do not self-injure? 3) do women who have engaged in self-injuring experience a greater number of significantly stressful events than those who do not? To answer these questions, we draw on data from the fifty-five in-depth qualitative interviews conducted in Manchester and Liverpool, U.K. What our research demonstrates is that self-injury occurs and, in our sample, is linked not only to age and length of homelessness, but also to experiences of childhood trauma. Women in our sample who have engaged in self-injuring behaviours were also found to have experienced three or more significant stressors over their life course.

Keywords: self-injuring, homelessness, trauma, social stressors, sociology

The researcher is sitting in a medical office in a homeless shelter conducting an interview with a nineteen year old pregnant, homeless female. The young woman has been the victim of childhood physical and sexual abuse and, in adulthood, robbery, physical assaults and intimate partner violence. She is being asked about her use of emergency services to address the effects of victimization. After disclosing that she has been to the emergency room several times for suicide attempts, she pulls up her sleeves and reveals that she has also been engaging in another form of self-injury: cutting. Pointing to one of several scars, she says her last emergency treatment was

because she had “sliced myself down … it was deep.” The researcher spies a lone, irregular scar on another limb and asks, “Your ex did that to you?” “Yeah,” she answers.

The practise of cutting is one of a cluster of self-injuring behaviours that include scratching, carving and burning of skin to interfering with wound healing, and includes inserting pins or other objects under the skin, biting one’s self, intentionally damaging bones, banging one’s head against hard surfaces and amputation or removal of body parts, among others (Favazza, 2012). Since the 1990s, the etiology of self-injuring and its prevalence within the larger general population are better understood, and we now know that self-injuring behaviours are not linked to any particular gender, social class or ethnic group, but rather develop across and within various segments of society as coping mechanisms for individuals dealing with psychological distress (Favazza, 2012).

Given that self-injuring behaviours are seen to be a maladaptive coping response to trauma and/or other significant stressors that produce emotional and psychological distress, one segment of society in which we would expect to see reports of self-injuring is among homeless citizens – in particular homeless women. We suggest this on the ground that it has been well documented within the research literature that homeless women experience high rates of domestic violence (Browne and Bassuk, 1997), intra-familial conflict (Whitbeck, Hoyt and Ackley, 1997)**,** physical and sexual assault (Browne and Bassuk, 1997), and occupy a marginal position within society that requires them to face daily stresses associated with basic subsistence (Tyler, Melander and Almazan, 2010). And yet, previous research has neither explored nor uncovered self-injuring behaviours within this group.

The present article is based on an analysis of in-depth qualitative interviews with fifty-five homeless women in the United Kingdom. Within this exploratory study we had three aims.

The first was to discover whether any of the women in our sample had engaged in self-injuring behaviours. Of the fifty-five women, twelve self-identified as having engaged in self-injury. Given that each of the women in our sample had experienced one or more significant stressors over the course of their lives, we then sought to better understand why some women engaged in self-injury and others had not. To that end, we employed a social stress framework to comparatively analyze the life histories of the women studied. In particular, we sought to discover whether there were differences in the types of significant stressors experienced between the two groups. Then we looked at the number of significant stressors experienced over each individual's life course. Our findings and the implications of those findings are discussed in the final section.

What do we know about self-injuring?

Self-injury has been defined as the "deliberate and direct alteration or destruction of healthy body tissue without suicidal intent" (Favazza, 2012, p. 23).

There is general consensus among researchers that self-injuring is "a pathological approach to emotional regulation and distress tolerance that provides rapid but temporary relief from disturbing thoughts, feelings, and emotions" (Favazza, 2012, p. 21). This complex, heterogeneous phenomenon is associated with multiple risk factors including: childhood abuse and neglect (Gratz, Conrad and Roemer, 2002); negative parenting (Yates, Tracey and Luthar, 2008a); experiences of bullying and other forms of victimization (Heilbron and Prinstein, 2010), and; sexual minority status (Whitlock et al., 2011), among others. Self-injurers are said to be individuals with negative self-views, self-denigrating and/or hyper-critical (Duffy, 2006), whose feelings of self-hatred and/or shame form into a sense of detachment or disconnect from their bodies that permits the infliction of abuse on particular areas (Hodgson, 2004).

It has been suggested that self-injurious behaviours are "remarkably prevalent and woefully understudied" (Prinstein, 2008, p.1). Early studies examined the prevalence and etiology of self-injury among psychiatric patients (Phillips and Muzaffer, 1961), children with developmental disabilities (Ressman and Butterworth, 1952) and with male (Panton, 1962) and female prisoners (McKerracher et al., 1968). Study samples subsequently expanded to include adolescents (Yates et al., 2008a), college students (Heath, Toste, Nedecheva and Charlebois, 2008) and adults within the general population (Briere and Gil, 1998). As a result of the inclusion of the latter groups, a broader picture of the prevalence and diversity of self-injuring behaviours has developed. While the actual rate of self-injury among the general population remains unknown (Tyler et al.,2010), estimates for self-injuring in non-clinical samples range from 1% to 4% among adults (Briere and Gil, 1998; Klonsky, Oltmanns and Turkheimer, 2003), between 7% and 38% among college and University students (Gratz et al.,2002; Whitlock, Eckenrode and Silverman, 2006; Gollust, Eisenberg and Golberstein, 2008), between 12.5% and 24% among adolescents (Heath, Schaub, Holly and Nixon, 2008; Muehlenkamp, Claes, Havertape and Plener, 2012), and 7.5% to 28% among early adolescents and preadolescents (Hilt, Nock, Lloyd-Richardson and Prinstein, 2008; Alfonso and Dedrick, 2010). Within clinical samples, rates range from 21% (Briere and Gil, 1998)to 82% (Nock and Prinstein, 2004).

Research has also demonstrated that self-injuring follows a developmental trajectory, with onset typically occurring between the ages 13.5to 24, with the behaviours beginning to wane as individuals age (Favazza and Conterio, 1988). Both males and females are found to engage in self-injuring behaviours (Bakken and Gunter, 2012) and self-injurers can be found across the social class spectrum (Whitlock et al., 2006), from homeless runaway youth (Tyler et al., 2010) to young people from upper-middle-class homes (Yates et al.,2008a). Nor does self-

injuring appear to be exclusive to one racial, ethnic, cultural and/or sub-cultural group (Gratz et al., 2002), as self-injuring behaviours have been reported in such diverse groups as Turkish male substance abusers (Evren, Kural and Cakmak, 2006), Chinese adolescents (You, Leung, Fu and Lai, 2011) and sexual minorities in Japan (DiStefano, 2008).

A social stress framework

Recognizing the critical role that adverse life circumstances, negative status and other social stressors can play in facilitating harmful behaviours, in a recent study of self-injuring among homeless youth, Tyler et al. (2010) employed what they term a 'social stress framework' in order to better understand the complex interplay of various dynamics. Following Wheaton (1999), these scholars define stressors as "conditions of threats, demands or structural constraints that by their very occurrence or existence, call into question the operating integrity of the organism" (Tyler et al., 2010, p. 270). With their use of this definition, these researchers directly acknowledge the multi-dimensional nature of stress and stressors – it is not simply the case that an individual experiences a stressor and adopts a maladaptive behaviour in response. We also know this from resiliency studies, which clearly demonstrate that many people learn to cope with and move beyond the most traumatic of events, while others do not (Tedeschi and Calhoun, 1996).Tyler and his colleagues (2010, p. 270) suggest that "those with unique social circumstances such as homeless individuals" might engage in maladaptive coping strategies as a consequence of "additional stressors associated with their social situation."

The 'additional stressors' associated with homelessness are many and begin with the insecurities, anxieties and risks attendant on such things as basic survival. As Tyler et al. note (2010, p. 270), "the daily struggles that homeless individuals experience such as having to secure a place to stay for the night and finding food makes the situation of homelessness a unique social

circumstance." Status strains associated with being not only homeless – a stigmatized status which, in and of itself, frequently subjects its carriers to social rejection by the wider society – but also female and, in many instances, of a minority sexual status, must also be considered (Tyler et al., 2010). For example, the streets are unsafe places for both homeless women generally, who face significantly increased odds of being physically and sexually assaulted (Jasinski, Wesely, Wright and Mustaine, 2010) and for those who are members of the GLBTQ community, who are often targets of hate-crime based violence (Whitbeck, Chen, Hoytz, Tyler and Johnson, 2004). To the extent that homeless citizens often experience other traumatic events prior to and after becoming homeless –intimate partner violence (Tischler, Rademeyer and Vostanis, 2007), familial physical and sexual abuse (Whitbeck et al.,1997), fires and natural disasters (Yeater, Austin, Green and Smith, 2010), and/or the death of loved ones (Huey, Fthenos and Hyrniewicz, 2012), to name but a few – they are likely to carry symptoms of untreated trauma, which can add further emotional and psychological burdens (Huey, Fthenos and Hyrniewicz, 2012).

Tyler and colleagues hypothesize the link between self-injuring and homelessness as follows. Self-injury is commonly understood within the literature and in clinical practice as an 'affect regulator'; individuals experience negative emotions that feel intolerable to them and use self-injuring variously as a means of gaining a sense of control over feelings (Suyemoto, 1998), disconnecting from unpleasant feelings (Nock and Prinstein, 2004) or reconnecting when one has become detached or numb in response to overwhelming feelings (Nock and Prinstein, 2005). As Nock (2010, p. 345) states in his review of the literature, "the presence of negative thoughts and feelings immediately prior to engaging in self-injury has been reported consistently across studies and supports the widely held belief that self-injury is performed in most cases as a means

of self-soothing or of helpseeking [in dealing with negative emotions].”These threatening feelings might come directly after a stressful event, or as a result of memory recall or reminders of some past trauma that has not been resolved or overcome (Tyler et al., 2010). To the extent that homeless individuals experience not only significant levels of personal trauma, but also structural and other stressors, they are at high risk of engaging in self-injuring behaviours.

And yet, not all homeless citizens engage in self-injuring (Tyler et al., 2010). Does this fact weaken support for the social stress framework? Or might it be the case that we need to begin to develop a more nuanced understanding of the role that various social stressors play in the development and continuation of self-injuring behaviours?

Method of inquiry

Our purpose in this article is to address three research questions that we see as important for beginning to understand self-injuring behaviours among homeless women:

1. Do homeless women self-injure?
2. If so, do the types of stresses experienced by self-injuring homeless women differ in type from stressors experienced by homeless women who do not self-injure?
3. Do women who have engaged in self-injuring experience a greater number of significantly stressful events than those who do not?

To answer these questions, we draw on data from the fifty-five in-depth qualitative interviews conducted in Manchester (n=24) and Liverpool (n=31).

This article is informed by data collected for an on-going study of the healthcare needs of homeless women who have been victims of violence. The purpose of the larger study is to develop a better understanding of their health and mental health needs post-victimization, their

ability to access services and the quality of services offered. To examine these issues, one phase of our research entailed conducting interviews with women in the United Kingdom. The cities of Manchester and Liverpool were selected as each is a major metropolitan area with a sizeable homeless population.

To locate research participants for this study, we developed a non-probability sample consisting of the maximum number of service agencies that work with homeless women in each city. Each organization was asked if they would agree to participate in our research by providing access to their clients. In total, thirteen agencies – including hostels, day centres, and mixed-use facilities – agreed to assist our research.

The fifty-five women who agreed to be interviewed were self-selecting – that is, they were informed about our study by staff members and chose whether they wished to participate[1]. Eligibility requirements were that interviewees had to be a minimum age of 18, currently accessing services offered by a participating homeless service provider, and appeared capable of understanding the nature of their consent[2]. With each participant, we explained the goal of the study, went over the informed consent forms[3], and reviewed the types of questions we would be posing and why. Once assured that individuals were fully informed about what would be taking place, consent forms were signed and interviews begun. Interviews typically ranged in length from 45 minutes to an hour and were recorded with participants' consent.

Interviews were conducted using an interview guide covering six key areas: a) demographic information; b) experiences of victimization and other trauma over the life course; c) physical, emotional and mental effects of trauma; d) experiences of accessing healthcare

[1]Because of funding issues, compensation for participation could not be offered.

[2]For example, we would not have proceeded if a woman appeared to be intoxicated.

[3]This project received IRB approval from our University.

providers; e) willingness to use healthcare services (physician, hospitals, mental health counselors), and; f) facilitators and barriers to accessing health services. In relation to the data used within the present study, we draw specifically on answers provided to demographic questions posed and to our queries concerning the physical, emotional and mental effects of victimization. It was during this portion of the interview when participants were likely to discuss self-injuring behaviours.

Our approach to coding and interpreting the data collected was to employ Glaser and Strauss' (1967) grounded theory method. Interviews were transcribed and then coded using open coding. In particular, we followed Glaser's (1978) concept-indicator model, looking first for key concepts and then for words and phrases that functioned as indicators of that concept. For example, to code for 'self-harm', we looked for words and phrases such as 'cutting,' 'injuring' 'slicing', 'burning' and other related terms. To determine which concepts to code for – that is, those we found to be of theoretical and empirical interest – we drew on notes taken during post-interview team debriefing sessions. Once initial coding was complete, we evaluated our preliminary results and began the process of developing a suitable theoretical framework to help deepen our understanding of what the data was telling us about the relationship between stressors across the life course and self-injuring behaviours. It was at this point that we determined that a social stressor framework would serve as the best theoretical and methodological approach to elucidating connections drawn. We then returned to the transcripts and recoded them using selective coding, an approach that drew not only on concepts and sub-concepts previously identified, but also on key concepts arising from focused readings of the relevant literature on the social stressor theoretical framework and its application to understanding traumas experienced by homeless citizens (see, for example, Tyler et al. 2010).Further focused coding allowed us to

refine our ideas and to assess the extent to which our data fit with not only the framework employed, but also with the existing research literature.

Sample characteristics

Of the fifty-five women represented within this study, twelve self-identified as self-injurers.

- Table 1. Demographic characteristics of self-injuring versus Non-self-injuring groups -

Given that self-injuring behaviours are typically found among individuals between the ages of 13 and 24 (Favazza and Conterio, 1988), it is of little surprise that two-thirds of the women who had engaged in self-injuring in our sample were between the ages of 18 and 24. However, four of the women who revealed self-injuring practises fell into the 36-50 age group. Whereas one of the latter had stopped self-harming, the other three were still actively engaged in self-injury (ages 36, 39 and 47 respectively). In this respect, our data differs from other studies that have shown a waning effect after the age of 24 (Favazza and Conterio, 1988). In relation to women in the non-self-injuring group, women in this group tended to be older (aged 25 and above). While the higher ages in this group might explain differences in why some women were not currently engaged in self-injuring behaviours, it does little to explain why they did not report engaging in self-injuring at younger ages. Thus, age in and of itself does not appear to tell us much about the differences between these two groups.

Whereas two of the self-injuring women had been homeless for less than a year (3 months and just short of a year respectively), the majority of this group reported having been homeless for a period of one to three years. In total, ten of the twelve women in the self-injuring group had been homeless for over a year, compared to twenty-five of those in the non-self-

injuring group. It would thus appear that women who engage in self-injuring behaviours remain homeless for longer periods than those who do not, probably as a result of a multitude of complex social and personal factors. Of particular interest is the fact that self-injuring women aged 36 to 50 tended to have been homeless for longer periods of time (average length: 3.375 years) than those self-injurers aged 18 to 30 (average length: 2.42 years). The increased length of homelessness and/or the occurrence of homelessness later in life – which is often tied closely to stressful precipitating events – might partially explain the durability of self-injuring behaviours among women in the older age group.

Risk factors: social stressors in the lives of homeless women

Each of the women in this study had experienced at least one significant social stressor: homelessness. Further, most had become homeless through processes that were in and of themselves stressful. In this section we examine other significantly stressful events in the lives of the women interviewed. To develop a better understanding of these stressors, we grouped the most commonly reported events by when they occurred in a respondent's life (childhood and adolescence versus adulthood). As seen in Table 2 below, we have also noted the number of reports made for each type by those within the self-injuring and non-self-injuring groups, and provided the overall percentages within each group in order to provide a basis for modest comparison.

- Table 2. Significant stressors reported -

The figures in Table 2 reveal that self-injurers were more likely to report significant stressors in childhood and adolescence. Indeed, self-injurers had higher scores in each category of stressor reported in childhood. These differences are particularly notable in relation to childhood physical and sexual abuse. With respect to the former, self-injuring women were more

than twice as likely to have been a victim of childhood physical abuse. For example, one young woman from Afghanistan said of herself, "I used to take beatings from my mom and my family." She saw her self-harming as an act aimed at hurting not herself, but her mother who had beat her:

> I had a lot of anger and that's what kind of led me to cutting myself. It was my mom. I have a lot of anger in me and I can't let it out on her, so I used to hurt myself, thinking that it would affect her.

Her self-injuring behaviours began with feelings of agitation that lead to periods where she would "just start itching myself". Intense scratching then progressed to cutting, as she sought greater relief from anxiety and anger. In respect of the link between childhood physical abuse and self-injuring found, we note that the self-injurers in our sample are not dissimilar from those found within other sub-populations: researchers have consistently found childhood physical abuse to be strongly correlated with cutting and other self-injurious behaviours (Yates, Carlson, and Egeland, 2008; Lang and Sharma-Patel 2010).

Within the literature it has also been repeatedly demonstrated that the trauma produced from childhood sexual abuse "can have profound [negative] effects on the developing child's sense of safety, feelings about self and others, relationships with others, cognitions (beliefs), and general sense of well-being" (Hudson, Wright, Battacharya, and Sinha, 2010, p. 1259). Not surprisingly then, we found that self-injuring women were also significantly more likely to have experienced sexual abuse, usually by a guardian or family member. A fourty-six year old Manchester woman said of her early life, "I was abused as a child … my stepdad … it was sexual abuse." Elaborating on the nature of this abuse, she explained, "Between the ages of 9 and 14, he passed me around between him and his friends." Some women, such as an eighteen year old hostel resident interviewed in Liverpool, were both physically and sexually victimized in childhood and/or adolescence: "Me mom and dad were drunk all the time. I was sexually abused

and domestic violence." This young woman further revealed that she had been treated medically for both self-harming and taking deliberate pill overdoses. An eighteen year old Manchester woman saw her self-injuring as a direct manifestation of anger over sexual abuse she experienced as a child. She explained: "Most of my anger is more directed at the situation I'm in. So, growing up, I was one really angry person. I self-harmed and attempted suicide a couple of times." A forty-seven year old Liverpool woman had been homeless for approximately two and a half years when we met her. Her experiences of violent victimization began in childhood, "Physical. Emotional. Sexual. From me dad." Later in the interview, when asked whether she had ever sustained any physical injuries that required treatment as a result of the victimization she had suffered, she simply replied, "Cutting." To illustrate her point, she then revealed two bandaged arms to the interviewer.

Family conflict has long been recognized as a salient risk factor for emotional and psychological disturbances among children and adolescents and, in turn, to self-injuring (Asgeirsdottir, Sigsusdottir, Sigfusdottir, Gudjhonnsoon and Sigurdsson, 2011). Women who self-identified as self-injurers in this study reported higher rates of family conflict and familial breakdowns in their histories. One young Manchester woman left home at sixteen. Of her family life, she said:

> My mom is a drug user, so she is very money-oriented. She wanted me to quit college and get a job so I could give her my money … We ended up arguing a lot over that, and I ended up leaving home. I've never lived with my dad or had a really good relationship with him. He just comes and goes.

In the following exchange, a twenty-year old homeless woman in Manchester reveals that she self-learned cutting as a coping mechanism to deal with feelings of anxiety and depression resulting from on-going disputes with her father ("Me and me Dad started arguing a lot"):

> Respondent: I started before moving here. And then I stopped.

Interviewer: Where did you get the idea to do that?

Respondent: I do not know. It just popped into me head.

Interviewer: It made you feel better?

Respondent: Yes.

Death of a loved one is one of most stressful events that humans experience, and loss of someone in childhood to whom the individual has formed a close, intimate bond can have severe negative emotional and psychological consequences. Such effects include the development of a sense of helplessness or, conversely, the belief that one must maintain constant vigilance and control over situations in order to prevent bad things from happening (Haine, Ayers, Sandler and Wolchick, 2008). The latter can consequently lead to negative self-evaluations, as well as feelings of shame and guilt, when the individual is unable to control external factors (Haine et al., 2008). Such was the case with one young Angolan woman, whose brother had "died from Malaria" "back home." His death, she said, resulted in a depression that lead to self-harming: "When my brother died I had a bad situation where I used to harm myself. I used to cut … it was because of my brother." Depression over her brother's death was compounded by helplessness over the subsequent death of her father and her inability to travel back to Angola for this second funeral. Of that period in her life, she simply said, "I had a hard time."

When examining reports of stressors occurring in adulthood, a notable shift emerged. Self-injuring women reported more experiences of physical assault committed by a non-intimate partner. This finding can be understood as a result of the fact that women in the self-injuring group had been homeless for longer periods of time than women in the non-injuring group, and thus were more likely to have been in vulnerable situations. For example, one woman was physically assaulted while she was rough sleeping:

> I was robbed twice, once violently. I was bashed over the head with a metal bar while I was asleep. They took my rucksack with all my stuff in it. I ended up in hospital. I don't really remember too much about it. It left me with a stutter.

Another woman, who had bartered sex for a place to stay, was assaulted by "one gentleman in Longside", who "tried cutting me throat when I was sleeping."

Interestingly, our interview data also reveals that women in the non-self-injuring group reported higher rates of significant stressors experienced in adulthood. Among such stressors included victimization from intimate partner violence (IPV), loss of custody of their children, experiences of imprisonment and the death of a partner or child. Despite the commonly reported co-occurrence of childhood sexual abuse and sexual assault in adulthood (Follette, Polusny, Bechtle and Naugle, 1996), women in the non-self-injuring group also reported slightly more experiences of adult sexual assault than self-injurers.

Cumulative effects?

A sizeable body of research has shown that intensity and frequency of exposure to violent victimization can have serious adverse consequences on the emotional and psychological well-being of homeless women (Goodman and Dutton, 1996; Hudson et al., 2010). Thus, in order to further our understanding of how social stressors might be linked to the development of self-injuring behaviours within our sample, we also examined the extent to which participants stated they had experienced one or more of the stressors reported (see Table 3 below). What we found is that nine of the twelve women who had engaged in self-injuring reported experiencing three or more significant stressors over the course of their life. When we compared this result to that of the non-self-injuring group, we found a notable difference. In the non-self-injuring group, only sixteen of the forty-three women had reported three or more social stressors. In essence, among

the women sampled those who had previously or were currently engaging in self-injuring were notably more likely to have been subject to multiple traumatic events and/or significant stressors.

- Table 3. Number of significant stressors reported by group -

We note that women in the self-injuring group who reported childhood physical and sexual abuse were more likely to also report violent victimization in adulthood, particularly physical assault by a non-intimate partner. Some of the women with childhood abuse histories reported intimate partner violence, two of whom additionally reported sexual assaults in adulthood. Their experiences are not uncommon: previous research has found childhood abuse to be a significant predictor of not only homelessness among adult women, but also of violent victimization in adulthood (Fitzpatrick, LA Gory and Ritchey, 1993; Hudson et al., 2010).

Perhaps the most illustrative example of cumulative significant stressors in the lives of the self-injuring women in our study is offered by the experiences of a thirty-six year old Liverpool woman, whom we met in a drop-in centre where she was hiding from an abusive partner. When this woman, who also had a history of childhood physical and sexual abuse, was asked if she had ever experienced violence while rough sleeping, she replied, “everything. People walk up to me and assault me.” This particular individual had also been sexually assaulted in adulthood: “I have been raped a few times, by strangers and people I know. This is what I am used to.” She was also despondent over the loss of a sibling, “Me brother died on the railroad line. He got pinned down and they found him two miles down the track. And I have to live with that.”

Discussion

The purpose of this exploratory study was to answer three research questions that we see as important for the task of better understanding homeless women's self-injuring behaviours and thus developing further insight into their mental health needs: 1. do homeless women self-injure? 2. if so, do the types of stresses experienced by self-injuring homeless women differ in type from stressors experienced by homeless women who do not self-injure? and; 3. do women who have engaged in self-injuring experience a greater number of significantly stressful events than those who do not? To aid in better understanding the answers to the second and third questions posed, we employed a social stress framework to guide our analysis.

In relation to the first question, we found that twelve of the fifty-five women sampled reported self-injuring behaviours – that is, more than a fifth of the women who participated in this study.

Through comparative analysis of the experiences of women in the self-injuring and non-self-injuring groups it was also revealed that women who self-injured had higher reporting rates in every category of stressor occurring in childhood/adolescence. Only in relation to three forms of trauma occurring in adulthood did we observe more reports from non-injuring women: sexual assault, intimate partner violence and loss of child custody. In essence, it appears that while both groups had experienced significant social stressors during their lifetimes, those within the self-injuring group first experienced significant trauma in childhood and adolescence, which indicates that the period in which stressors occur over the life course may play a crucial role in the development of self-injuring behaviours among homeless women. In this result, our findings replicate earlier studies with other population segments, which similarly suggest that childhood

maltreatment "is the most salient environmental risk factor for self-injury identified to date"(Lang and Sharma-Patel, 2012, p. 26).

As the research literature suggests that frequency of exposure to significant stressors can produce adverse effects on individual well-being (Hudson et al., 2010), we also sought to explore whether there were any observable differences in relation to the number of significantly stressful events experienced by self-injuring and non-injuring women over their individual lifetimes – in other words, can frequency of stressors produce a cumulative effect leading to a perceived need to self-injure? Women in our sample who had engaged in self-injuring behaviours were more likely than women in the non-self-injuring group to report having experienced three or more significant stressors over their life course. This result suggests the possibility that self-injuring in this segment of the population is linked to a cumulative traumatic effect, a proposition that we feel bears further investigation.

In sum, what our use of a social stress framework illuminates is the fact that while each of the women in our sample had faced one or more significant social stressors – from homelessness to intimate partner violence to the loss of a loved one – the timing, type and frequency of traumatic experiences play significant roles in whether a homeless woman will adopt self-injuring behaviours. In this regard, homeless women appear to be no different from individuals in other segments of the general population who engage in self-injuring practises (Gratz 2006; Gratz and Chapman 2007).

To be clear: this study is not without limitations. One limitation is that our focus on victimization within the larger study likely excluded some women who self-injure, but who had not been victimized. Thus, we are likely lacking a broader range of traumas experienced. Further, we recognize that our conclusions are based on a small sample of respondents and thus are

hardly representative of *all* homeless women. However, our aim is more modest in scope in that we intend this article to serve as an exploratory study meant to draw attention to an under-studied aspect of social life, one with clear cut policy and practical implications for members of a fairly marginalized sub-population. To that end, we hope this work will spur continuing research efforts in this area.

References

Asgeirsdottir, B., Sigfusdottir, I., Gudjonsson, G., and Sigurdsson, J. (2011) Associations between sexual abuse and family conflict/violence, self-injurious behavior, and substance use: the mediating role of depressed mood and anger. *Child Abuse & Neglect*, 35 (3):210-219.

Bakken, N., and Gunter, W. (2012) Self-Cutting and suicidal ideation amongadolescents: Gender differences in the causes and correlates of self-injury.*Deviant Behavior*, 33, 339–356.

Briere J., and Gil, E. (1998) Self-mutilation in clinical and general population samples: prevalence, correlates, andfunctions. *American Journal of Orthopsychiatry.*68, 609–20.

Browne, A., and Bassuk, S. (1997). Intimate violence in the lives of homeless and poor housed women: Prevalence and patterns in an ethnically diverse sample. *American Journal of Orthopsychiatry*, 67(2), 261-278.

DiStefano, A. (2008) Suicidality and self-harm amongsexual minorities in japan.*Qualitative Health Research*, 18(10), 1429-1441.

Duffy, D. (2006). Self-injury.*Psychiatry*, 5(8), 263: 265.

Favazza, A., and Conterio, K. (1988) The plight of chronic self-mutilators .*Community Mental Health Journal*, 24(1),22-30.

Fitzpatrick, K., La Gory, M. and Ritchey, F. (1993)Criminal victimization among the homeless. *Justice Quarterly*, 10(3): 353–68.

Follette, V., Polusny, M., Bechtle, A. and Naugle, A. (1996) Cumulative trauma: The impact of child sexual abuse, adult sexual assault, and spouse abuse. *Journal of Traumatic Stress*, 9(1): 25-35.

Gollust, S., Eisenberg, D., and Golberstein, E. (2008) Prevalence and correlates of self-injury among university students. *Journal of American College Health,* 56(5),491-498.

Goodman, L. and Dutton, M. (1996) Therelationship between victimization and cognitive schemata among episodically homeless, seriously mentally ill women. *Violence and Victims*, 11(2): 159-174.

Gratz, K. (2006) Risk factors for deliberate self-harm among female college students: the role and interaction of childhood maltreatment, emotional inexpressivity, and affect intensity/reactivity. *American Journal of Orthopsychiatry*, 76(2): 238-250.

Gratz, K. and Chapman, A. (2007) The role of emotional responding and childhood maltreatment in the development and maintenance of deliberate self-harm among male undergraduates. *Psychology of Men & Masculinity*, 8(1): 1–14.

Gratz, K., Conrad, S., and Roemer, L. (2002) Risk Factors for deliberate self-harm among college students. *American Journal of Orthopsychiatry*, 72(1),128–140.

Haw, C., Hawton, K., Casey, D. (2006) Deliberateself-harm patients of no fixed abode a study of characteristics and subsequent deaths in patients presenting to a general hospital. *Social Psychiatry and Psychiatric Epidemiology*, 41,918–925.

Heath, N., Schaub, K., Holly, S. and Nixon, M. (2008). Self-Injury today:Review of populationand clinical studies in adolescents, in Nixon, M. and Heath, N. (Eds.), *Self-injury in Youth: The Essential Guide to Assessment and Intervention* (pp. 9-28). New York:Routledge.

Heath, N., Toste, J., Nedecheva, T., and Charlebois, A. (2008) Anexamination of nonsuicidal self-injury among college students. *Journal of Mental Health Counseling*, 30(2),137-156.

Heilbron, N. and Prinstein, M. (2010) Adolescent peer victimization, peer status, suicidal ideation, and nonsuicidal self-injury: examining concurrent and longitudinal associations. *Merrill-Palmer Quarterly,* 56(3),388-419.

Hilt, L., Nock, M., Lloyd-Richardson, E. and Prinstein, M. (2008) Longitudinal study of nonsuicidal self-injury among young adolescents: Rates, correlates, and preliminary test of an interpersonal model. *Journal of Early Adolescence*, 28(3),455-469.

Hodgson, S. (2004) Cutting through the silence: A sociological constructionof self-injury. *Sociological Inquiry*, 74(2),162–179.

Huey, L., Fthenos, G., and Hryniewicz, D. 2012. "'I Need Help and I Know I Need Help. Why Won't Nobody Listen to Me? Homeless Women's Experiences with Accessing and Consuming Mental Health Services." *Society & Mental Health*, 2(2), 120- 134.

Jasinski, J., J. Wesely, J. Wright and E. Mustaine. (2010) *Hard Lives, Mean Streets: Violence in the Lives of Homeless Women*. Hanover, Mass.: Northeastern University Press.

Klonsky, D., Oltmanns, T. and Turkheimer, E. (2003) Deliberate self-harm in a nonclinical population: Prevalence and psychological correlates. *The American Journal of Psychiatry,* 160(8), 1501-1508.

Lang, C., and Sharma-Patel, K. (2011) The relation between childhood maltreatment and self-injury: A review of the literature on conceptualization and intervention. *Trauma, Violence, Abuse*, 12(1), 23-37.

Mckerracher, D. ,Loughnane, T., and Watson,R. (1968) Self-mutilation in female psychopaths. *British Journal of Psychiatry,* 114,829-832.

Muehlenkamp, J., Claes, L., Havertape, L., and Plener, P. (2012) International prevalence of adolescent nonsuicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health,* 6(10),1-9.

Nock, M. (2010) Self-injury. *Annual Review of Clinical Psychology*, 6, 339-363.

Nock, M. and Prinstein, M. (2005). Contextual features and behavioral functions of self-mutilation among adolescents. *Journal of Abnormal Psychology, 114,*140–146.

Nock, M. and Prinstein, M. (2004) A functional approach to the assessment of self-mutilative behavior. *Journal of Consulting and Clinical Psychology*, 72(5),885–890.

Panton, J. (1962) The identification of predispositional factors in self-mutilation with a state prisonpopulation. *Journal of Clinical Psychology,* 18, 63-67.

Phillips, R. and Muzaffer, A. (1961) Some aspects ofself-mutilation in the general population of a large psychiatric hospital. *Psychiatric Quarterly,*35, 421-423.

Prinstein, M. (2008) Introduction to the special section on suicide and nonsuicidal self-injury: A review of unique challenges and important directions for self-injuryscience.*Journal of Consulting and Clinical Psychology*, 76(1), 1-8.

Ressman, A.and Butterworth, T. (1952) Localized acquired hypertrichosis. *Archives of Dermatology and Syphillis,* 65, 418-423.

Suyemoto, K. (1998). The functions of self-mutilation.*Clinical Psychology Review,* 18, 531–554.

Tedeschi, R. and Calhoun, L. (1996). The posttraumatic growth inventory: measuring the positive legacy of trauma. *Journal of Traumatic Stress,* 9, 455–471.

Tischler, V., Rademeyer, A. and Vostanis, P. (2007). Mothers experiencing homelessness: mental health, support and social care needs. *Health and Social Care in the Community,* 15(3): 246–53.

Tyler, K., Melander, L. and Almazan, E. (2010).Self injurious behavior among homeless young adults: a socialstress analysis. *Social Science and Medicine,* 70(2): 269–276.

Tyler, K., Whitbeck, L., Hoyt, D., and Johnson, K. (2003).Self-Mutilation and homeless youth: the role of familyabuse, street experiences, and mental disorders. *Journal of Research on Adolescence*, 13(4), 457–474.

Wheaton B. (1999) The nature of stressors, in Horwitz A. and Scheid, T. (eds.). *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems*. New York: Cambridge University Press. Pp. 176–197.

Whitbeck, L., D. Hoyt, D. and K. Ackley. (1997). Abusive family backgrounds and later victimization among runaway and homeless adolescents. *Journal of Research on Adolescence,* 7(3): 375-392.

Whitbeck, L. and Johnson, K. (2009) Self-mutilating behaviors from adolescence to young adulthood, in L. Whitbeck (ed.) *Mental Health and Emerging Adulthood Among Homeless Young People*. New York: Taylor & Francis. Pp. 145-156.

Whitlock, J., Eckenrode, J., and Silverman, D. (2006). Self-injurious behaviorsin a college population. *Pediatrics,* 117:1939–1948.

Whitlock, J., Muehlenkamp, J., Purington, A., Eckenrode, J., Barreira, P., Abrams, G., Marchell, T., Kress, V., Girard, K., Chin, C., Knox, K. (2011) Nonsuicidal self-injury in a college population:general trends and sex differences. *Journal of American College Health,* 59(8): 691-698.

Yates, T., Tracy, A., and Suniya, S. (2008a) Nonsuicidal self-injury among privileged youths: Longitudinal andcross-sectional approaches to developmental process.*Journal of Consulting and Clinical Psychology*, 76(1): 52–62.

Yates, T., Carlson, E. and Egeland, B. (2008b) A prospective study of child maltreatment and self-injurious behavior in a communitysample. *Development and Psychopathology*, 20: 651-671.

Yeater, E., Austin, J., Green, M. and Smith, J. 2010. Coping mediates the relationship between posttraumatic stressdisorder (PTSD) symptoms and alcohol use in homeless, ethnicallydiverse women: A preliminary study. *Psychological Trauma: Theory, Research, Practice, and Polic*y, 2(4),307–310.

You, J., Leung, F., Fu, K. and Lai, C. (2011) The prevalence of nonsuicidal self-injury and different subgroupsof self-injurers inChinese adolescents. *Archives of Suicide Research*, 15,75–86.

Tables

Table1[4]. Demographic characteristics of self-injuring versus non-self-injuring groups

Demographic information	SI n	SI %	Non-SI n	Non-SI %	Total n	Total %
Age						
18-24	8	15	18	33	26	47
25-35	0	0	11	20	11	20
36-50	4	7	14	25	18	33
Totals per group	12	22	43	78	55	100
Length of homelessness						
1 day to 6 months	1	2	9	16	10	18
6 months to 1 year	1	2	9	16	10	18
1 year to 3 years	7	13	13	24	20	37
Over 3 years	3	5	12	22	15	27
Totals per group	12	22	43	78	55	100

Table2[5]. Significant stressors reported (n=total number within group; %= percentage of individuals within the specific group who reported this experience).

Type	**SI n**	**SI %**	**non-SI n**	**non-SI %**
Childhood/adolescence				
Child abuse – physical	9	75	13	30
Child abuse – sexual	7	58	16	37
Family conflict/break-up	2	17	2	5
Death of a loved one (ie parent, sibling)	2	17	3	7
Adulthood				
Physical assault (non-intimate partner)	9	75	14	33
Intimate partner violence	6	50	24	56
Sexual assault	2	17	9	21
Imprisonment	0	0	3	7
Death of a loved one (ie partner, child)	0	0	3	7
Loss of child custody	0	0	9	21

[4] Percentages rounded up or down as applicable.

[5] Percentages rounded up or down as applicable.

Table 3[6]. Number of significant stressors reported by group (n=total number within group; %= percentage of individuals within the specific group who reported zero to seven or more stressors).

Stressors reported	SI n	SI %	Non-SI n	Non-SI %
None	1	8	7	16
One only	1	8	12	28
Two	1	8	8	19
Three	4	34	4	9
Four	3	25	6	14
Five	2	17	3	7
Six	0	0	1	2
Seven or more	0	0	2	5
Total n	12	100	43	100

[6] Percentages rounded up or down as applicable.