The Relationship between Self-Harm and Teen Dating Violence Among Youth in Hawaii

Charlene K. Baker¹, Susana Helm¹, Kristina Bifulco¹, and Jane Chung-Do¹

Abstract
The connection between teen dating violence (TDV) and self-harm is important to consider because of the serious consequences for teens who engage in these behaviors. Self-harm includes nonsuicidal self-injury (NSSI) and suicide behaviors such as suicide attempts or deaths. Although prior research shows that these two public health problems are related, the context in which they occur is missing, including what leads teens to engage in self-harm and the timing of self-harming behaviors within the relationship. To fill this gap, we conducted focus groups with 39 high-school-aged teens, all of whom had experienced prior relationship violence. Teens described incidents in which they and their partners engaged in NSSI and suicide attempts. Incidents often were associated with extreme alcohol and drug use and occurred during the break-up stage of the relationship. Prevention and intervention programs are needed that consider the intersections of TDV, substance use, and self-harm.

Keywords
adolescents / youth; relationships; self-harm; suicide; violence

The relationship between teen dating violence (TDV) and self-harm is important to consider, because the consequences of these experiences are significant and might continue into adulthood. To date, researchers have yet to explore the intersection of these two public health problems and the contexts in which they occur. Self-harm is a term that is used to indicate any behavior in which one intentionally injures one’s body. There are a range of behaviors that make up self-harm, including nonsuicidal self-injury (NSSI; e.g., cutting or hitting oneself), suicide behavior (e.g., suicidal ideation or attempts), and suicide deaths. Many in the field have distinguished between these behaviors because not all who engage in self-harm intend to die from their self-injury (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Muehlenkamp, 2005; Nock & Kessler, 2006); rather, adolescents might harm themselves through cutting and other self-mutilating methods as a method of coping with stressful or traumatic life events (Nock & Prinstein, 2005).

Although findings from prior studies point to a relationship between TDV and adolescent self-harm, researchers know less about the contexts in which these incidents occur. Findings from our study begin to fill this gap. We conducted a series of focus groups with high-school-aged teens, all of whom had experienced violence in a prior dating relationship. In these groups, teens reported a range of self-harming behaviors resulting from their experiences of TDV, thereby prompting a call for the development of prevention and intervention programs with youth that integrate these topics.

Literature Review

Prevalence of NSSI and Suicide Behavior Among Adolescents

Self-harm encompasses a range of behaviors and can include suicide behavior, such as suicide attempt or death by suicide, and nonsuicidal self-injury, such as cutting, burning, or hitting oneself (Swahn, Ali, et al., 2010). Researchers who have conducted studies of NSSI with community samples of high-school-aged youth reported prevalence rates between 13% and 29% (Bakken & Gunter, 2012; Brausch & Gutierrez, 2010; Guan, Fox, & Prinstein, 2012; Muehlenkamp & Gutierrez, 2007; Swahn, Ali, et al.). Some researchers have suggested that rates of NSSI are increasing (Jacobson & Gould, 2007; Olsson, Gameroff, Marcus, Greenber, & Shaffer, 2005);

¹University of Hawaii at Mānoa, Honolulu, Hawaii, USA

Corresponding Author:
Charlene K. Baker, Department of Psychology, 2530 Dole St., Sakamaki, C-400, Honolulu, HI 96822, USA.
Email: bakercha@hawaii.edu
however, in a recent review, Muehlenkamp and colleagues reported that NSSI rates have stabilized (Muehlenkamp, Claes, Havertape, & Plener, 2012).

Regarding suicide behavior, findings from data collected by the Centers for Disease Control and Prevention (CDC) showed that suicide is the third leading cause of death for youth between the ages of 10 and 24 years (CDC, 2013a). In a national study with adolescents in Grades 9 through 12, 16% reported seriously considering suicide and 8% reported a suicide attempt in the prior 12 months (CDC, 2012a). In 2009, Hawaii (where we conducted the current study) had the highest percentage of youth in the nation reporting that they had seriously considered attempting suicide, had made a suicide plan, and/or had attempted suicide (CDC, 2013b). In fact, in Hawaii, suicide is the second leading cause of injury-related death among 15- to 24-year-olds (Galanis, 2012).

Although many researchers have investigated the prevalence rates of NSSI and suicide behaviors separately, there is also overwhelming evidence that these behaviors co-occur (Hamza, Stewart, & Willoughby, 2012; Jacobson & Gould, 2007). For example, Guan and colleagues (2012) reported that adolescents who engaged in NSSI were seven times more likely to make a future suicide attempt than those who had not engaged in NSSI. Additionally, Swahn, Ali, et al. (2010) found that among youth who reported NSSI (20% of their sample), 38% had also attempted suicide in the prior year. Within a college sample, Wilcox et al. (2012) reported that one in six participants who reported NSSI had attempted suicide by early adulthood. Finally, within a clinical sample of adolescents who had been admitted to a psychiatric inpatient unit in the prior 12 months, 70% of adolescents who reported engaging in NSSI also reported a lifetime suicide attempt (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006).

Gender Differences in NSSI and Suicide Behaviors

Investigators have reported gender differences in rates of NSSI, although this finding is not uniform. Across several studies, girls reported higher rates of NSSI than boys (Bakken & Gunter, 2012; Guan et al., 2012; Laye-Gindhu & Schonert-Reichl, 2005; Sornberger, Heath, Toste, & McLouth, 2012). There were also differences in the types of NSSI methods used, with girls reporting more instances of cutting and carving skin, whereas boys reported more hitting behavior. Other researchers have shown similar rates between males and females, both with community samples comprised of youth in middle school, high school, and college, and in a clinical sample of adolescents (Hilt, Nock, Lloyd-Richardson, & Prinstein, 2008; Klonsky & Muehlenkamp, 2007; Muehlenkamp & Gutierrez, 2007; Nock et al., 2006; Whitlock, Eckenrode, & Silverman, 2006).

These disparate findings have led some researchers to suggest that the differences in NSSI prevalence between males and females might be simply a function of some studies focusing on NSSI methods that are used primarily by females (e.g., cutting; Van Camp, Desmet, & Verhaeghe, 2011). Therefore, researchers should examine a range of behaviors, including those that put adolescents at risk for serious injury indirectly (e.g., carrying a weapon, driving after drinking, and engaging in physical fights), because these behaviors could signal underlying intent for self-harm among adolescents (Barrios, Everett, Simon, & Brener, 2000).

In contrast to the disparate findings related to gender and NSSI, when considering suicide behaviors, there are consistent gender differences. According to results from the 2011 Youth Risk Behavior Surveillance (YRBS), girls were more likely than boys to seriously consider suicide, make a suicide plan, and attempt suicide (CDC, 2012a). Investigators of international studies have corroborated these gender differences in suicide behavior (Baetens, Claes, Muehlenkamp, Grietens, & Onghena, 2011; Plener, Libal, Keller, Gegert, & Muehlenkamp, 2009; Tang et al., 2011). Of note, although girls are more likely to attempt suicide, boys are more likely to die as a result of their suicide attempt (Nock, Borges, et al., 2008), generally because of the lethality of means. In the United States, of the reported suicides in the 10- to 24-year-old age group, 81% of the deaths were males and 19% were females (CDC, 2013a).

Teen Dating Violence

Teen dating violence (TDV) includes physical, sexual, and emotional violence, including monitoring and controlling behaviors (CDC, 2012b; Mulford & Giordano, 2008). The prevalence of TDV ranges between 5% and 95%, mostly because of issues with measurement (Ackard, Neumark-Sztainer, & Hannan, 2003; Baker & Helm, 2011; Halpern, Young, Waller, Martin, & Kupper, 2004; Marquart, Nannini, Edwards, Stanley, & Wayman, 2007; Munoz-Rivas, Grana, O’Leary, & Gonzalez, 2007; Olshen, McVeigh, Wunsch-Hitzig, & Rickert, 2007; Rivera-Rivera, Allen-Leigh, Rodriguez-Ortega, Chavez-Ayala, & Lazcano-Ponce, 2007; Sears, Byers, & Price, 2007; Swahn et al., 2008). For example, researchers across several studies used data from the Youth Risk Behavior Survey, in which teens were asked to respond to only one item related to physical TDV (“During the past year, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?”). Typically, researchers have found rates ranging between 8% and 12% for this item. By contrast, researchers who have conducted
surveys of sexual violence have often found lower rates, especially for rape perpetration (e.g., 3% to 8%).

When researchers have included additional items that encompass a broader range of abusive behaviors, prevalence rates tended to be much higher. In particular, emotional violence is one of the most-often endorsed types of violence, likely because of the questions that are included in surveys. Many researchers in the field have used the Modified Conflict Tactics Scale (Cascardi, Avery-Leaf, O’Leary, & Slep, 1999), which includes the following verbal aggression questions: insulted or swore at partner; refused to talk; stomped out of the room; said something to upset or annoy the partner; and threatened physical aggression. These behaviors are likely to be common in adolescence because teens are learning to manage their emotions generally, and this can be especially difficult within the context of newly forming romantic relationships. Higher prevalence rates could also be the result of recent studies in which investigators began assessing monitoring and controlling behaviors among teens, particularly their use of technology such as cell phones and the Internet to keep track of their partners. Investigators have reported that these are common practices among teens, with rates close to 70% (Baker & Helm, 2011; Picard, 2007).

In terms of gender, both boys and girls have admitted to perpetrating violence, with Baker and Helm (2011) reporting from their study that girls perpetrated more physical violence against boys, whereas boys perpetrated more sexual violence against girls. Other researchers have suggested a distinction between severe physical violence and minor physical violence, with boys more often perpetrating severe violence and girls more likely perpetrating minor or moderate acts (e.g., slapping, throwing objects) in conjunction with emotional abuse (Foshee et al., 2009), which includes the following verbal aggression questions: insulted or swore at partner; refused to talk; stomped out of the room; said something to upset or annoy the partner; and threatened physical aggression. These behaviors are likely to be common in adolescence because teens are learning to manage their emotions generally, and this can be especially difficult within the context of newly forming romantic relationships. Higher prevalence rates could also be the result of recent studies in which investigators began assessing monitoring and controlling behaviors among teens, particularly their use of technology such as cell phones and the Internet to keep track of their partners. Investigators have reported that these are common practices among teens, with rates close to 70% (Baker & Helm, 2011; Picard, 2007).

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The Present Study

We believe that the literature described above provides a starting point for understanding the relationship between TDV and self-harm; however, it is incomplete in that the studies conducted simply showed quantitative associations between two separately measured variables. Thus, the context of this relationship is absent in the existing literature. It is not clear what was happening in the dating relationship that led teens to engage in self-harm, and when self-harming behaviors occurred within the timeline of the relationship (e.g., beginning, middle, and end). Without a better understanding of teens’ experiences of dating violence and the point at which they engaged in self-harm (including, in their own words, their reasons for doing so), researchers and practitioners will have difficulty addressing effectively the overlap of these two significant public health problems.

To begin to fill this gap, we conducted a study with high-school-aged adolescents (14 to 19 years) who had experienced dating violence in a prior relationship. We facilitated focus groups with boys and girls to gather more information about the trajectory of dating violence, as well as how social electronic media, alcohol and drug use, and peer relationships played a role in dating and experiences of dating violence. Within these discussions, teens reported a range of self-harming behaviors. Self-harm was not a specific focus of the study; thus, it was an emergent theme from the original groups. Therefore, we consider this an exploratory analysis that can begin to shed light on the context in which TDV and self-harm occur. Furthermore, given the elevated risk of suicide behaviors among teens in Hawaii (Galanis, 2012; CDC, 2013b), as well as the youths’ prior experiences of dating violence, we propose several implications for prevention and intervention programming, including the need for strategies that are targeted toward youth who might be more vulnerable to engaging in self-harm.

Methods

Recruitment Strategy

Prior to initiating participant recruitment, we received project approval from the University of Hawaii Committee on Human Studies. The first and second authors had previously conducted teen dating violence workshops with service providers from community-based organizations across the state of Hawaii. Therefore, we chose to utilize these relationships in our recruitment of teens for the study. The initial points of contact were service providers who had become TDV-prevention trainers through the workshops as part of a dissemination project funded by the Hawaii Department of Health, and who could serve as liaisons in recruiting teen participants. We contacted trainers by email and provided them with a description of the project, the timeline, participant eligibility criteria, and assent/consent forms. Subsequently, we contacted each trainer by phone to discuss the project in more detail and to answer any questions. Trainers unable to assist with participant recruitment referred us to other organizations and points of contact.

Trainers and other community liaisons introduced the project to teens in their program. Based on their familiarity with the experiences of teens in their program, they targeted recruitment to those youth who met the study’s eligibility criteria. Therefore, providers were responsible for introducing the project to teens, determining whether each teen was interested in participating, and collecting consent/assent forms.

Providers invited youth who met the following eligibility criteria to participate: (a) high school age (14 to 19 years), although they did not need to be enrolled in public school; (b) had prior dating relationships in the past year which they characterized as having been problematic, although not necessarily abusive; and (c) were not currently in a relationship involving abuse or dating violence. Providers ensured that teens understood these eligibility criteria. As an additional check, at the beginning of each focus group the facilitator confirmed that teens met eligibility criteria prior to securing participant assent/consent.

Participants

We recruited participants on a voluntary basis from a range of community-based organizations, including a peer mentoring program, an alcohol support program, a youth career center, and court-ordered temporary group homes for boys and girls. We conducted a total of eight gender-specific focus group interviews on Oahu and Hawaii Island with a total of 39 participants: four focus groups with boys (n = 21, 54%) and four focus groups with girls (n = 18, 46%). Focus group participant numbers ranged between three and eight, with an average of four per group. Youth under the age of 18 (ages 14 to 17, n = 31; 17 boys, 14 girls) obtained parental consent and completed an assent form on the day of the focus group. Participants 18 or 19 years of age (n = 8; 4 boys, 4 girls) completed a consent form on the day of the focus group. Given the complexity of race and ethnicity in Hawaii, we did not ask youth to report their race and/or ethnicity. Rather, all were identified as “local.”¹¹ We gave each participant a $10 gift card as compensation.

Data Collection Procedure

We held the focus groups at community-based organizations with girls and boys separated into private rooms.
Experienced interviewers facilitated the focus groups, with assistance from a note taker. A male facilitator, assisted by a male note taker, conducted the focus groups with boys, whereas a female facilitator, assisted by a female note taker, conducted the groups with girls. We audio-recorded each focus group and used pseudonyms to maintain participant confidentiality. We used a focus group guide with the following topics for discussion: (a) how relationships begin, progress, and end; (b) the use of social electronic media in dating and dating problems; (c) the role of peers in relationship development and dating problems; and (d) the role of substance use in dating relationships.

We introduced and maintained focus group discussion ground rules to ensure respect among participants (e.g., one person speaking at a time, maintaining respectful language, and confidentiality). Facilitators encouraged youth to participate fully in the discussion, and also informed them that they could decline to answer any question and could stop participating for any reason at any time. Facilitators also reiterated that the discussion should focus only on participants’ prior relationships.

**Data Management and Analysis**

The research team transcribed over 500 minutes of audio verbatim, with an average focus group time of 63 minutes. This process resulted in 388 pages of transcripts (ranging from 24 to 63 pages per group, averaging 43 pages per transcript). With these transcripts we then began the process of analysis. The goals of data analysis in qualitative research are to generate meaning (Miles, Huberman, & Saldana, 2014), to represent multiple constructed realities of people in natural settings (Lincoln & Guba, 1985), and to pursue discovery and insight into human experience (Kirk & Miller, 1986). To ensure that our analyses produced quality interpretations of meaning, reality, and human experience, we used criteria emphasizing reliability and validity of qualitative data that have been developed and refined over the past several decades (Eisenhart & Howe, 1992; Lincoln & Guba, 1985; Miles et al., 2014).

We used the following steps to enhance reliability and validity in our qualitative data management and analysis process, also referred to as credibility, trustworthiness, and dependability (Anastas, 2004). First, we were involved in all phases of the project, including research design, data collection, and data management and analysis; thus, we were very familiar with the dataset. We conceptualized the research questions using grounded theory, thereby ensuring that the questions were based on our previous knowledge and experience, as well as concepts that have been shown to be important in the literature (Corbin & Strauss, 2008; Ponterotto, 2010); these questions served as the foundation for the codebook.

Second, we used a computer-assisted qualitative data analysis computer software, NVivo, to ensure a systematic approach to data management and analysis, while also allowing for the emergent nature of the analysis to occur (Miles et al., 2014; Richards, 2009). Our first step was akin to conducting a content analysis. We read the transcripts several times and coded using a priori categories that matched the interview questions, including (a) how relationships begin, progress, and end; (b) the use of social electronic media in dating and dating problems; (c) the role of peers in relationship development and dating problems; and (d) the role of substance use in dating relationships. During this content analysis it became clear that teens were describing instances of self-harm with some regularity; therefore, we used grounded theory and included open, axial, and selective coding procedures to determine whether there were patterns to these disclosures (Corbin & Strauss, 2008; Ponterotto, 2010).

The first and second authors inductively identified patterns in the narratives during open coding (e.g., non-suicidal self-injury, suicidality). Using the literature to inform our conceptualizations of self-harm, we included broadly defined categories that would begin to capture these emergent patterns. We then elucidated the patterns further through axial and selective coding, in which we sought to clarify the participants’ statements related to self-harm as well as their connections with other phenomena of interest from our a priori categories (e.g., TDV, alcohol and drug use). Building on the initial codebook that included our a priori categories, we added new codes for nonsuicidal self-injury, suicide threats, death by suicide, and risk factors for self-harm. We also added codes distinguishing between participant disclosure of self-harm, participant disclosure of their partner’s self-harm, and “other” (when the participant described an incident in his or her community or with peers).

Finally, we coded transcripts using the revised codebook and added to the digital database (QSR International, 2012). The a priori and emergent categories were not mutually exclusive, meaning that we coded data within multiple categories, as appropriate to the content of the narrative. Narrative segments that were not identically coded by research team members (final coding was conducted by two coders independently and then checked by the first author) were discussed until consensus was reached. Then, the first author selected excerpts that exemplified both the a priori and emergent categories for inclusion in the article, as well as pseudonyms for these excerpts so as to maintain participants’ anonymity.

**Results**

Before turning to the results for self-harm, it is first important to understand the context of the dating relationships for participants in the sample. Teens across all
groups described relationships filled with distrust, anxiety, and discord, in many cases from the outset of the relationship. One boys’ group described how social electronic media, such as Facebook, created distrust in the relationship. This occurred when someone (e.g., another boy) texted his partner or posted something about her on Facebook. The distrust grew quickly, resulting in the boy trying to control who his partner talked to and what she did with her friends:

Facilitator (F): So, can you just say more about what that looks like? Okay, so you’re in a relationship and then something happens. What happens? With Facebook? Or Texting?
Kai: Yeah, rumors.
Jake: And, basically you get so controlling, yeah? And then, to the point where you don’t even want somebody talking to your girl.

Jake went on to describe how this controlling behavior created additional problems in the relationship, but that he could not stop because he was afraid of losing his girlfriend. But in the same breath he said he knew “that when you hold them tight, it just makes things worse.” Another boys’ group also discussed (hypothetically) how rumors created problems of trust, leading to the boy becoming so increasingly agitated with his partner as he was trying to sort out truth from the rumors that he would end up slapping her in the face.

Girls also described acts of violence against their partners, and similar to boys, the violence was typically perpetrated within a context of distrust and suspected cheating. In some of these cases the violence was mutual:

Amanda: There’s a lot of yelling.
Amelia: Um, like when they cheat on you.
Amanda: No, when it’s just not going well.
Elle: My past relationship, I found out that he was cheating.
We used to fight with each other. Like trouble kind.
That’s how I got the pretty scar on my face.
F: So then, would you fight, and then after the fight be like, “Okay, we’re done”? Or you would make up?
Elle: Both. We would make up sometimes and the other times we would break up and then get back together.

By contrast, in another group, girls lamented that they felt so stressed by being in a bad (and emotionally abusive) relationship that they lashed out physically against their partners:

Ana: And, I was like punching him and doing all these things. And then I just was like, “What am I doing?” like “You just made me this person.” And, then it, like really sucks how they look at you, like, “Wow, you’re so psycho, bitch.” But it’s like, “You made me like this.”

It was within this context of distrust, discord, and violence that five of the eight groups (three boys’ groups, two girls’ groups) discussed self-harm. These were spontaneous discussions not prompted by the facilitator. The majority of teens’ comments were related to NSSI or threats of suicide. In contrast, death by suicide was mentioned infrequently, and when teens did mention it they were referring to incidents that had happened between adult couples in their community. Finally, teens shared behaviors that are considered risk factors for NSSI and suicide behaviors. We include this discussion because an understanding of these factors might provide opportunities for intervention before self-harm occurs.

Nonsuicidal Self-Injury

Girls discussed NSSI more often than boys; in particular, one girl—Jen—described her relationship with her previous boyfriend. She shared that she met him on the school bus and she liked him, but right from the start of their relationship he had been “super controlling.” She described how he “chucked [threw] her cell phone out of the bus window” because he thought he heard a boy talking. It turned out that it was her father who had called. She then went on to describe a time when he punched himself:

I was scared to be in a relationship, ‘cause my boyfriend had anger issues. And he was like, whenever he got mad he used to punch himself. And I used to get scared ‘cause my dad used to punch me when I was younger, so I was always traumatized. I was like, “Oh my God! You’re gonna punch me.” That’s why I just like balled [curled] up in front of him. Like, “Okay, I’m just going to stay here and just like rock back and forth.”

Jen also disclosed her own self-harming behavior that occurred in the context of a new relationship, although she described it as being linked to her experiences with this previous boyfriend. Her description illustrates that NSSI was a way of coping with her new relationship, which also turned out to be an abusive one:

Jen: And I was like, “Are you serious?” I was like, “Our one-year anniversary and you come here at eleven at night, and my house, my parents are sleeping, and you’re high off your ass.”
F: And what happened after that?
Jen: I cut myself [laughs]. And, then, I don’t know. Like, ‘cause my previous relationship with that other psycho boy? He like drove me to like wanting to cut myself and stuff.
Madeline: That’s how we get when we’re upset. Boys, they run to their friends and they run to alcohol and drugs. But girls, we run straight to like, razorblades. [All participants agree.]
It is important to note that this instance came after the relationship had been established for some time (it was their one-year anniversary). In fact, girls in this group all commented on how difficult it was to break up with their boyfriends, even though the relationships were emotionally and physically abusive.

**Threats of Suicide**

Teens generally discussed threats of suicide in relation to the break-up stage of a relationship. In most cases the participants described their partner (or a friend’s partner) who had threatened suicide. One boys’ group discussed the difficulty of getting out of a relationship, and that often couples break up and get back together repeatedly. However, one boy contrasted this scenario by saying that the difficulty of getting out of a relationship, and that of the girl’s attempts to get back together with him. As part of the drama that unfolded during this particular break up, the boy shared that his now ex-girlfriend threatened suicide:

Duke: I’m sorry. I’m not weak-minded like that. I broke up with one girl right after the break up. With her eight months. Was all good. We’re done. Get the fuck out of my house.

F: And that was that?

Duke: [Agrees] Yeah. Oh, but she still like, came around. Try make buddy, but don’t talk to her. Don’t give her the benefit of doubt.

F: So it’s a clean break? At least from your perspective? It was clean?

Duke: Yeah. Well for her, she all messed up. Yeah, how you going answer one girl [who says], “Oh, I’m going to kill myself, ’cause we broke up.” Ha! That gonna want me to stay with you? No! Fuck that! See ya! Call me stupid?

One girls’ group also discussed a partner’s threat of suicide, and similar to the boys’ group, this threat was related to breaking up, or in this case, as a way to prevent a break up:

Madeline: But he used to like rage out at random points and like say, “I wanna go kill myself! And, if you leave me I’m gonna kill myself!” And then we fought after.

F: Did it ever move to this spot?

Madeline: He tried to, but, he didn’t succeed.

In the second excerpt it is not clear (nor was it probed in the focus group) when the attempt occurred, during or after the break up, nor whether it was a method her partner used to control her and prevent her from ending the relationship. In this particular case, there were several references throughout the focus group of this partner having mental health problems that were likely a result of drug use. According to Madeline, he “did every kind of drug possible.” She described him as “nice, at times but he, like, was bipolar or something.” As a result, there seemed to be volatility in the relationship from the beginning.

In addition to descriptions of partners’ threats of suicide, one participant in a boys’ group disclosed his own suicide attempt. In response to the facilitator asking the group how they recognized problematic relationships and when to get out of a problematic relationship, boys referred to a lack of trust and respect, treating each other like “shit,” crossing boundaries, having “no reason to stay,” and turning to drugs and self-harm. Self-harm included, as Ken stated, “Some people just go suicidal,” even though “suicide is the crazy part,” according to Frank:

F: Treat you differently. So, you can kind of sense it. You can kind of sense that something’s gone. How then do you manage that? Do you confront them?

Ken: Some people just go suicidal.

Frank: Suicide is like the crazy part.

F: You sense that lack of trust or lack of respect. What do you do?

Frank: Like I ended up in the fricking mental hospital thing for like a week. I got so bad. You guys ever heard of that drug, TCI [also referred to as 2C-I]? Never heard of it? Yeah, it’s pretty much like acid and ecstasy, like together. I took it one night. I don’t know, but I went crazy. Like, I was tripping out on a sweet roll and I called her and I was like, “You know what? I’m done with this shit.” And, she was like, “Oh, what are you talking about?” “Done with your bullshit.” And, like straight up: “I don’t want to deal with your shit anymore. Don’t want to deal with life anymore.” And she was like, “Oh, what are you talking about, blah, blah, blah.” It’s like, I’m just gonna go kill myself and just see what the fuck happens. And then like, I think I tried to overdose. Like, I took a couple more, ’cause they come in like capsules, and like I just went super trippy. I told everyone I was gonna kill myself. I told my friend, ’cause my friend was tripping with me, too. And, he was just like, “Dog, don’t do it, dog, don’t do it.” Nah, too late. Already took the load. I was like, “Fuck that, I’m gonna do it. I’m gonna do it.” And then, if it wasn’t for my friend inducing me to vomit, then I think I would’ve guaranteed overdose. And, like my mom sent me to the hospital just ’cause she felt like I wasn’t safe on my own. And once I got out of there, I contacted my chick or my ex-girlfriend or whatever, and she was like, “Oh, where were you? Like, I was worried.” And in my head I was like, “Oh, wow. Like it takes you, it takes an action like that for you to like actually worry about what’s going on between us.” It’s pretty crazy.
relationship. The respondent was frustrated at being in a noncaring relationship and seemed to realize that the relationship should end, but could not end it. Instead, he took drugs as a way to cope, which ultimately turned into a suicide attempt.

**Death by Suicide**

In contrast to their discussion of NSSI and suicide threats, teens mentioned death by suicide only in relation to stories they had heard about adult couples in their community or about teens who were highlighted in national news stories or on social media. One boys’ group described two incidents of death by suicide, with one being a murder–suicide:

F: Okay, so someone ends it [the relationship], right? But it doesn’t end. So what happens? You [referring to one of the boys] provided an example of a girl calling you back and saying, “I’m going to kill myself.” Is that a common occurrence?

Duke: Pretty common. One guy killed his own lady and then hang himself.

Kyler: A couple of them like that. One guy shot himself right in the head with one twelve-gauge round. And his lady right there.

**Associated Risk Factors**

Participants also mentioned risk factors that are associated with NSSI and suicide behaviors. In particular, a consistent theme throughout all focus groups was teens’ use of alcohol and drugs. Lisa and her boyfriend started out as friends. After “talking” on Facebook for 3 months they began dating, but Lisa described the relationship as being “overprotective” because her boyfriend would not let her go out without him. She shared, “He couldn’t tell me he loved me, but he had time to slap me, for no reason.” Even though she was miserable with him, she could not break up: “I couldn’t. I wasn’t strong enough to leave him, and to see him with someone else would kill me.” He then accused her of cheating and ended the relationship abruptly. As a way to cope with the abusive relationship and the break up, Lisa increased her intake of alcohol and drugs dramatically, even though she admitted that this was not healthy:

Like, with my ex-boyfriend, there is this certain point where I couldn’t take it anymore. So, I would drink every night and get so messed up. Like, it wasn’t even okay. And then I got prescribed um, prescription? So then I would, like literally overdose on my prescription. So when I was just with my friends, like I would never really ever hang out with my friends. And when I did, I was so quiet because I was just [softly] so like high. I was so high. I was so quiet and they’ll just be like, “What’s wrong with you?” Like you’re usually like all loud and irritating. What’s wrong with you?” [Laughs]. And, I’m just like [high voice], “I don’t know dude. I’m just over it.” And, like um, I don’t know, I did so much drugs when I was with him, ’cause he just drove me so insane. I couldn’t even handle it. Even though he was on [a different island], I was just like, losing my mind, pulling out my hair, breaking my phone. Drinking so much alcohol. It wasn’t even okay. And like, he just broke me. And then when he broke up with me, that’s when it just went [louder] more worse. It just, I don’t know.

**Discussion**

Results from the current study provide a preliminary look at the relationship between TDV and self-harm. Researchers have highlighted this relationship but have not provided the context of how the two experiences are related. To begin, teens in this study described a range of violence experiences in their relationships, including emotional and physical violence. Although some teens reported slapping or punching their partners—or being a victim of these acts—the majority of participants described instances of emotional violence, including yelling at each other, ignoring each other, and monitoring and controlling behaviors.

Our findings show that self-harm occurred within a context of distrust, discord, and violence, and it seemed most often associated with the break-up stage of the relationship. Within these relationships, teens openly described their own experiences of NSSI and threats of suicide (often out of frustration with their partner), as well as their partner’s self-harming behaviors. Other investigators have outlined similar risk factors for engaging in NSSI or suicide behaviors, including emotional reactivity and experiencing stressful life events (Liu & Miller, 2014; Nock, Wedig, Holmberg, & Hooley, 2008).

In addition to the importance of exploring teens’ actual disclosures of self-harm, the tone of these disclosures should be noted. Teens reported NSSI and suicide behaviors in a matter-of-fact way. That is not to say that they did not have any emotion when describing their experiences; indeed, they were angry and frustrated at both themselves and their partners. It was as if they still were processing these behaviors but at the same time were able to talk about them openly to the facilitator and others in the group. Because we recruited many of the participants from community-based or court-ordered programs, it could be that these disclosures had already occurred as part of their participation in these programs. In some cases participants knew each other, and therefore they might have felt more comfortable talking about their experiences with others in their focus group. Also, it could be that because of other experiences (some disclosed having been a victim of child abuse or other stressful family experiences; having been in juvenile detention),...
each of these incidents were seen as just another stressful event in their lives.

Although their disclosure of self-harm seemed pragmatic in that there was little emotion attached to the disclosure, teens often finished their statements by saying that “it was crazy” or “psycho” (either their own actions or their partner’s actions). In the majority of these cases there did not seem to be an intention to die as a result of these self-injurious behaviors. As an example, one participant shared an instance when she cut herself out of frustration with her boyfriend. This action, and others like it, is consistent with findings from other researchers who have suggested that many teens who engage in NSSI do not report suicide intent (Lloyd-Richardson et al., 2007; Muehlenkamp, 2005), but rather use self-harm as a method of coping with a stressful life event (Nock & Prinstein, 2005).

It also seemed, in some instances, that the injury occurred as a result of an impulsive act; in fact, other researchers have found a similar relationship between impulsivity and self-harm among adolescents (Bridge, Goldstein, & Brent, 2006; McKewon et al., 1998). Additionally, our findings show that self-harm transcended the original partner for one of the girls, with the self-harming behavior continuing into her next relationship. Successively engaging in self-harm from one partner to the next is important to address, because it signals an alarming trend in how some teens respond to stressful relationship experiences.

In addressing this trend we must also consider other risk factors for self-harm. For example, it is important to note that teens’ descriptions of self-harm were related to their use of alcohol and drugs, as well as their experiences of dating violence, which is consistent with findings from other studies that highlight the role of substance use in dating violence and self-harm (Nock et al., 2006; Silverman et al., 2001; Swahn, Ali, et al., 2010). The teens in this study described extreme substance use, and both boys and girls reported that they had used alcohol and drugs excessively during their relationships and at the end as they tried to cope with the break up. Investigators have found that using drugs and alcohol to cope with relationship dissolution is common among those who lack secure attachments (Davis, Shaver, & Vernon, 2003); therefore, a combination of substance use and being in a problematic dating relationship could create a constellation of risk that increases the likelihood that teens will engage in self-harm.

In addition to substance use, the teens might have been struggling with mental health issues, because they reported being depressed or having partners that were “all messed up”; in fact, one participant felt that her boyfriend’s drug use and mental instability contributed to his suicide attempt. Although it was beyond the scope of the current study to corroborate these statements with a specific diagnosis, other researchers have stated unequivocally that mental illness is an important risk factor for self-harm, with depression being one of the strongest predictors of suicide behaviors (Andover, Morris, Wren, & Bruzzone, 2012; Ayyash-Abdo, 2002; Chan et al., 2008; Dougherty et al., 2009; Jacobson, Muehlenkamp, Miller, & Turner, 2008; Moscicki, 2001; Muehlenkamp & Gutierrez, 2007).

Finally, not only can experiencing continual interpersonal conflicts pose an increased risk for teens’ suicide behavior (Brent et al., 2010), but self-harming behaviors can be used as a strategy to get the attention they desire from their partners (Rodham, Hawton, & Evans, 2004). Within the current study, we found several instances when partners threatened self-harm as a way to keep their partners in the relationship. This dangerous tendency can be reinforced by what youth see around them in their communities, which was emphasized by the participants who spoke about adults in problematic relationships dying by suicide. In fact, researchers have shown that repeated exposure to suicidal behaviors of others increases the adolescent’s risk for suicide (Bearman & Moody, 2004; de Leo & Heller, 2008).

We now consider several implications of this study. In the development of prevention programming, researchers need to consider critical points in the relationship. The dissolution of a relationship is especially problematic, and has been linked to self-harm among adolescents (Harvard Injury Control Research Center & Suicide Prevention Resource Center, 2007). This finding is consistent with other research findings that show the difficulty teens have in getting out of abusive relationships, or simply ending relationships they no longer enjoy.

Also, because some youth are unclear about what is healthy dating as opposed to an unhealthy or abusive dating relationship, they might endure poor relationships rather than dissolve them (Baker & Helm, 2010). In fact, researchers have reported that teens remain in abusive relationships for multiple reasons, including self-blame, feelings of shame, feeling alienated or alone, being fearful of worsening their situation by upsetting their abusive partner, not recognizing the abusive behavior, and seeing violent acts as indications of love and caring (Amar & Alexy, 2005; Chung, 2007; Johnson, et al, 2005; Jouriles, Garrido, Rosenfield, & McDonald, 2009). Moreover, researchers have found that adolescents stayed in relationships because they believed that they gained more than they lost by being in a relationship—even a violent one (Choice & Lamke, 1999; Few & Rosen, 2005). However, much of the research on staying in abusive relationships has been conducted with female victims. We have shown that boys also struggle with how to get out of abusive relationships.
Furthermore, several researchers have shown that in adolescent relationships there often is not just one perpetrator; rather, the violence can be mutual (O’Leary et al., 2008; Swahn, Alemdar, et al., 2010). Thus, there are health consequences for boys and girls during the break-up stage if the dissolution is not handled well by one or both partners. Therefore, we recommend that one focus of an intervention should be on helping teens traverse the initiation and dissolution of relationships more generally, as these feelings of stress and anxiety at the break-up stage are likely to be present regardless of whether or not the relationship was an abusive one.

In addition to fostering teens’ resilience in the face of a break up, we believe it is equally important for prevention and intervention programs to address the complexity of teen’s lives, thus improving the ecological aspects of resiliency, not just at the individual level but also at the outer levels of the social ecology (Lerner et al., 2013). With this in mind, we recommend a multipronged approach whereby programs are comprehensive in both the topics they include for addressing the complexity and the audiences toward which the programs are targeted.

With regard to topics, currently, health programming often highlights one topic and presents it in isolation. As examples, there are TDV prevention programs, substance use prevention programs, and suicide prevention programs, each with separate curricula; such distinct programs fail to raise awareness among teens of how risks are interrelated. Yet anecdotally, suicide prevention program practitioners mention that TDV is brought up by teens in their groups. To our knowledge, there has been no attempt to formally address these two problems simultaneously. Furthermore, there appears to be limited overlap between TDV and substance use programming, both of which, according to this study’s findings, serve as risk factors for adolescent self-harm. One recent review supports the need for comprehensive programs, but rather than integrating topics as described above, the authors proposed that programs target multiple background and situational factors (e.g., experiences of child abuse; drinking alcohol) because of their overlap with TDV (Vagi et al., 2013).

In addition to being comprehensive in the topics covered, we recommend that program messages be extended not only to teens, but also to parents and practitioners who work with youth in different settings. Depending on the audience, the specific content will vary. Starting with adolescents, there might need to be differential programming depending on whether adolescents have been exposed to other risk factors (alcohol use, prior relationship violence, child abuse). Rather than offering prevention messages targeted for universal populations, we believe that program content should resonate with teens’ lived experiences. Results reported here strongly support the need for selective and indicated prevention interventions given the overlap between dating violence, substance use, and self-harm (e.g., Ackard et al., 2003; Belshaw et al., 2012; National Research Council & Institute of Medicine, 2009; Swahn, Ali, et al., 2010; Zaha et al., 2013).

Continuing along these lines, we recommend that program content be tailored to the age of the adolescent. For example, across studies it has been shown that NSSI tends to have its onset in early adolescence, and in particular between the ages of 13 and 15 years. Researchers have also shown that self-harming behaviors diminish in late adolescence (Glenn & Klonsky, 2009; Moran et al., 2012; Nock & Prinstein, 2004). Conversely, suicide behaviors typically have their onset in late adolescence (Nock et al., 2008). Suicide attempts and deaths by suicide increase as adolescents move from pre-adolescence to late adolescence (Mulye et al., 2009). Therefore, just as there are critical points in the relationship that must be considered (i.e., the break up), there are critical points in adolescent development when prevention messages are especially salient. Outside of this window, these messages might be less effective in reducing unhealthy behaviors among teens.

Supportive relationships with parents, adult family members, and adults at school are important for youth, especially those at risk for self-harm (Pisani et al., 2013). Researchers have shown that lack of parental support and nurturance is the strongest predictor of adolescent suicide risk (Brausch & Gutierrez, 2010; Fotti, Katz, Afifi, & Cox, 2006). Therefore, we recommend that interventions increase parental awareness of adolescent risk for NSSI and suicide behaviors, and promote involvement by teaching parents skills for communicating with adolescents. Although empirical evidence demonstrating the efficacy of parental prevention education programs is limited, results from one study show promise for an empowerment-based parental education program that sought to reduce youth suicide risk factors (Toubourou & Gregg, 2002).

Moving outward to systems and settings designed to promote adolescent well-being, another audience to include are the different practitioners who work with youth. In particular, one set of practitioners who would benefit from training on these topics are physicians. As an example of the impact of such training, in a review of suicide prevention programs, researchers showed that training physicians to recognize and treat depression has been successful in reducing suicide rates (Mann et al., 2005). Given the established link between self-harm and trauma (with more frequent NSSI behaviors associated with higher levels of adversities and trauma symptoms), researchers have suggested that there is also an explicit need for physicians and other health care personnel to...
inquire about an adolescent’s trauma history, which can include relationship violence (Zetterqvist, Lundh, & Svedin, 2013). In light of these findings, we recommend expanding professional development to include dating violence, self-harm and suicidality, and substance use. Furthermore, early identification and referral of youth at risk for suicide are fundamental aspects of suicide prevention, and similar practices are used in substance abuse prevention. Both emphasize screening, brief intervention, referral, and treatment (Substance Use and Mental Health Services Administration, 2011). Therefore, by improving the capacity of professionals to think about and address these intersecting health risks among the youth with whom they work, we believe that the ecological aspects of resiliency will be enhanced beyond the individual-youth level of resilience to include the family and the systems level as well.

We identified several limitations of this study. First, the sample was not representative of a universal population of teens; rather, we recruited teens based on their prior experiences of dating violence. Also, teens were engaged in community-based services such as alcohol support programs and court-ordered temporary group homes for boys and girls. Recruiting from these programs resulted in a skewed sample that included youth who reported a greater number of risk factors that have been associated with self-harm than would be typical if recruitment occurred in schools or after-school programs. That being said, we chose to include youth who had prior relationship problems to gain a deeper understanding of the context of these relationships because it was a salient topic for them.

Second, we described the relationship between TDV and self-harm as emergent because this was not the original goal of the study. Therefore, facilitators did not fully explore the topic during the focus groups. As a result, it is likely that we did not capture some of the details of teens’ experiences. Notably, we found that NSSI and suicide behaviors, and associated risk factors, were brought up spontaneously by 5 of the 8 groups. We recommend that in the future researchers make inquiry on the intersection of TDV and self-harm a primary goal. We suggest that one way to accomplish this goal is to sample adolescents who have experienced self-harm as the criterion for inclusion and then explore the factors related to self-harm, including dating violence.

Third, the majority of teens in the focus groups were between 14 and 17 years old, thereby making it difficult to compare teens’ experiences throughout adolescence. Prior research findings indicate that risk for NSSI and suicide behaviors differs from early to late adolescence; therefore, we recommend that researchers conduct focus groups with youth at each developmental stage, including early adolescence (ages 10 to 14), as well as older youth and young adults (aged 18 to 24 years).

Fourth, we could not explore aspects of gender in data analysis, such as whether there were any differences in the context of TDV and self-harm between boys and girls. At first glance, this did not seem to be the case because both boys and girls reported NSSI and suicide behaviors, as well as similarities in associated risk factors (e.g., depressed mood, substance use). However, because these relationships were not explored systematically in the focus groups, we cannot say for certain that boys and girls had similar or unique experiences.

Finally, although we were able to identify a time point in the relationship when teens might be at higher risk for self-harm (at the break-up stage), there are other aspects about the violence that are in need of further investigation. For example, we know that teens in the current study were experiencing and perpetrating both physical and emotional violence. We also found that emotional violence was endorsed more often than physical (as has been shown in prior research). But what remains unclear, and in need of additional inquiry, is how the frequency and severity of violence might influence self-harm among teens.

Conclusion

Findings from this study add to the literature by providing a glimpse into the context of teen relationships in which violence and self-harm co-occur. Rather than simply establishing the relationship between the two statistically, as has been done in past research, we answer the question of how the two are related, and at what point in the relationship self-harm occurs. We show that teens’ engagement in NSSI and suicide behaviors often occurs at the end of the relationship. Teens described how difficult it was to get out of a problematic relationship, and in particular, how their partners used threats of self-harm as a way to keep them in the relationship. They also described their reliance on alcohol and drugs, in general, and as a way to cope with unhealthy relationships and relationship dissolution. Often, self-harm occurred in the context of this substance use.

Given these findings, researchers and practitioners need to develop universal prevention programming that considers the overlap of these public health problems. Universal prevention programs are important; however, these results clearly show that intervention programs must also target select populations of teens who already have experienced TDV as well as a host of other stressful life experiences that put them at higher risk for self-harm. We need to extend these interventions to parents as well as practitioners who work with youth in different settings. By developing interventions that consider the intersection of dating violence, self-harm, and substance use, we will be in a better position to provide teens with the tools.
they need as they enter into and manage intimate relationships.

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Note
1. Other authors have discussed the complicated nature of culture and ethnicity in Hawaii. According to O’Donnell and Williams (2013), rather than specific ethnic or racial backgrounds such as Hawaiian, Filipino, Japanese, Chinese, or White, people in Hawaii identify themselves as “local.” An individual’s culture is not based on his or her ethnic/racial background but on the local culture that was formed in Hawaii from the interactions between and intermarriage among the many different groups. Hawaiian Pidgin is the language of local culture and the marker of local identity; therefore, given the complexities of the many ethnic/racial combinations and the reality that all were local, no attempt was made to obtain the frequency of each background (for the history and characteristics of “local,” see Okamura, 1994; Reineke, 1969).

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Author Biographies

Charlene K. Baker, PhD, is an associate professor in the Department of Psychology at the University of Hawaii at Mānoa in Honolulu, Hawaii, USA.

Susana Helm, PhD, is an associate professor in the Department of Psychiatry at the University of Hawaii at Mānoa in Honolulu, Hawaii, USA, where she is the principal investigator for the Teen Dating Violence Prevention Research and Dissemination project and the evaluator for Hawaii’s Caring Communities Initiative, a statewide youth suicide prevention program.

Kristina Bifulco, MA, is a graduate assistant in the Department of Psychiatry at the University of Hawaii at Mānoa in Honolulu, Hawaii, USA, where she works for Hawaii’s Caring Communities Initiative for Youth Suicide Prevention: Mobilizing Communities At-Risk.

Jane Chung-Do, DrPH, is an assistant professor in the Department of Public Health Sciences and Department of Psychiatry at the University of Hawaii at Mānoa in Honolulu, Hawaii, USA, where she is the director of Hawaii’s Caring Communities Initiative for Youth Suicide Prevention: Mobilizing Communities At-Risk.