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The Relationship Between Non-Suicidal Self-Injury, Suicide-Attempts and Resilience, Life Satisfaction, and Subjective Happiness in Minority Groups

Anna Siewers
Western Kentucky University, anna.siewers018@topper.wku.edu

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THE RELATIONSHIP BETWEEN NON-SUICIDAL SELF-INJURY, SUICIDE ATTEMPTS AND RESILIENCE, LIFE SATISFACTION, AND SUBJECTIVE HAPPINESS IN MINORITY GROUPS

A Capstone Experience/Thesis Project
Presented in Partial Fulfillment of the Requirements for
the Degree Bachelor of Science with
Honors College Graduate Distinction at Western Kentucky University

By
Anna K. Siewers
April 2019

CE/T Committee:
Dr. Amy Brausch, Chair
Dr. Matthew Woodward
Ms. Siera Bramschreiber
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This thesis is dedicated to all who experience suicidality in any form, especially those who are systematically erased from research and treatment spaces as a result of their fundamental identity. Their struggles deserve visibility.
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First and foremost, I would like to thank my research mentor, Dr. Amy Brausch, for the unwavering encouragement, guidance, knowledge, and expertise that she so willingly provided throughout this process. I would also like to acknowledge my lab mates in the WKU Risk Behaviors Laboratory and the faculty of the WKU Department of Psychological Sciences for continually offering support, fostering growth, and providing opportunities for me to grow to as a student and researcher.

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ABSTRACT

Non-suicidal self-injury and suicide ideation are important issues and known predictors of suicide attempts for any demographic, but specifically for minority groups who are significantly understudied and underreported in comparison to their White and Heterosexual counterparts. It has been found that among adolescents and college students, minority students are disproportionately impacted and are at greater risk for suicidal ideation and behavior. The goal of the present study was to examine the role of both ethnic and sexual minority experience in NSSI and suicide attempts, as well as potential protective factors. A sample of 2,280 undergraduate students completed a survey assessing lifetime suicide attempt and lifetime non-suicidal self-injury, along with perceived levels of resilience, life satisfaction, and subjective happiness. Results confirmed the hypotheses that ethnic and sexual minority individuals largely report higher likelihoods of suicidal and self-harm behaviors, as well as lower scores on protective factors. This disproportionate impact on minority individuals, as well as the specific role of resilience, are important distinctions to make in future research, treatment, and prevention.
VITA

EDUCATION

Western Kentucky University, Bowling Green, KY May 2019
B.S. in Psychological Science
Minor in Citizenship and Social Justice
Mahurin Honors College Graduate
Honors Capstone: The Relationship Between Non-Suicidal Self-Injury, Suicide Attempts, And Resilience, Life Satisfaction, And Subjective Happiness In Minority Groups

Bowling Green High School, Bowling Green, KY May 2015

AWARDS & HONORS

Cum Laude, WKU, May 2019
Undergraduate Research Award, WKU Department of Psychological Sciences, 2019
Undergraduate Student Poster Winner: Social Sciences and Education, WKU Student Research Conference, 2019

PROFESSIONAL MEMBERSHIPS

Psi Chi Honors Society
Order of Omega Honors Society
Rho Lambda Honors Society

INTERNATIONAL EXPERIENCE

Harlaxton College Study Abroad Program, Grantham, U.K. Jan. – Apr. 2017
Habitat for Humanity Global Village Build, Braga, Portugal Mar. 2017

PRESENTATIONS


Siewers, A. K. & Brausch, A. M. (March, 2019). Non-suicidal self-injury, suicide attempts, and resilience in sexual and ethnic minority groups. Poster presented at the Western Kentucky University Student Research Conference, Bowling Green, KY.

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The Relationship Between Non-Suicidal Self-Injury, Suicide Attempts And Resilience, Life Satisfaction, And Subjective Happiness In Minority Groups

Suicidality is a primary cause of both injury and death on a worldwide scale. In the United States, more than 8 million experience suicidal ideation each year, with approximately 1 million people attempting suicide (Crosby, Gfroerer, Han, Ortega, & Parks, 2011). But despite its gravity, suicidality has also been a deeply misunderstood concept for many years. To combat this, empirical research on the subject has grown expansively in recent decades. Professionals have noted that fully understanding this phenomenon and its implications begins with distinguishing the intent of deliberate self-harm behaviors (Reisner, Biello, Perry, Gamarel, & Mimiaga, 2014). Phenomena such as suicide ideation, planning, and attempts all express varying levels of intent to die, while non-suicidal self-injury (NSSI) connotes the intentional and purposeful destruction of one’s own body without the intent to die (Klonsky, Victor, & Saffer, 2014). Regardless, both are important issues and known predictors of suicide attempt or completion.

While making this distinction is an important step towards a fuller understanding of suicidal behavior and its implications, there is still more work to be done. Existing research indicates that many empirical studies on suicidal thoughts and behaviors are centered primarily on White, Heterosexual populations (Cha et al., 2017). By inferring the findings of a few to all demographics, researchers fail to identify the true external validity of suicide-related risk factors. Beutler, Brown, Crothers, Booker, and Seabrook (1996) indicate the following:
It is reasonable to question whether psychologists will ever obtain a clear picture of the nature and psychological implications of demographic qualities in the absence of either reports of participant demographics or large numbers of systematic investigations of those distinctions. (p. 898)

Furthermore, this exclusion perpetuates the systematic discrimination and erasure of non-White and non-heterosexual populations from academic spaces and subsequent research-based treatment. According to Cha et al. (2017), most scholarly articles regarding suicidal thoughts and behaviors either predominately featured White, non-Hispanic young adults or did not report race, ethnicity, sexual orientation, or gender identity at all. Case and Smith (2000) similarly found that only 40% of applied psychology articles reported race or ethnicity as a demographic. They stated that there are multiple demographic discrepancies in major academic research terminology, specifically surrounding the use of ‘ethnicity’ over ‘race’ and the use of ‘sex’ and ‘gender’ interchangeably (Case & Smith, 2000). These inconsistencies indicate a pervasive need for more comprehensive suicide research in minority groups.

Suicidality in Minority Groups

To adequately frame the underreported issue of suicidal thoughts and behaviors in minority groups, a closer look at existing research and demographics must be taken. Currently, 38.7% of the United States population identifies as a racial or ethnic minority with Black/African American citizens making up 13.4% of the U.S. population and Hispanic/Latinx citizens making up 18.1% (U.S. Census Bureau, 2018). In terms of college students, 36% of Black/African American citizens aged 18-24 are enrolled in college or university compared to 39% of Hispanic/Latinx citizens, 58% of Asians, 20%
of Native American/Pacific Islanders, and 42% of those identifying as multi-ethnic (U.S. Census Bureau, 2018). Although the U.S. Census Bureau does not ask about sexual orientation, a survey of 340,000 U.S. citizens concluded that 4.5% of the population likely identifies as LGBTQ (lesbian, gay, bisexual, transgender, queer) (Gallup Inc., 2018). Among 2,037 U.S. citizens surveyed on sexual orientation, approximately 20% of those aged 18-34 reported identification as LGBTQ (GLAAD Inc., 2017).

Once an understanding of minority prevalence in the U.S. is obtained, a closer look at suicidality and NSSI in these groups can be taken. According to Cheref, Lane, Polanco-Roman, Gadol, and Miranda (2014), adolescent and college-aged racial and ethnic minorities are at greater risk for suicidal ideation and behavior than their White counterparts. In their study of 690 Black, Latino, and biracial college students, it was specifically found that the cognitive risk factors of reflective rumination and hopelessness had a significant differential impact on racial and ethnic groups and a positive association with suicidal ideation across all groups, respectively (Cheref et al., 2014). Researchers state that these findings should be aggregated with symptoms of depression in racial and ethnic minorities in order to achieve a better understanding of the assessment and treatment needs of these groups.

These results are further emphasized by research indicating that sexual minority individuals are at significantly greater risk for engaging in NSSI compared to individuals identifying as heterosexual (Batejan, Jarvi, & Swenson, 2015). In Batejan and colleagueues’ (2015) meta-analysis of fifteen existing studies comparing risk for NSSI between sexual minority and heterosexual individuals, it was found that those identifying as bisexual or as questioning/other are at higher risk for engaging in NSSI as compared to
other minorities. It was also found that sexual minority youth are at particularly higher risk for NSSI engagement as compared to sexual minority adults.

Additionally, numerous studies have identified sexual minority individuals as having increased risk for mental health problems when compared to heterosexual populations. For example, individuals identifying with a non-heterosexual orientation and those who identify outside the gender binary are disproportionately impacted in terms of suicidal thoughts and behaviors (D. Brennan, Bauer, Bradley, & Vilaythong, 2017). In this comprehensive literature review of 250 standing quantitative studies regarding sexual health in non-heterosexual males, it was established that the majority of preexisting research was centered on sexual risk, including STI and HIV prevalence or condom use. In terms of nonsexual risk-related outcomes, the emphasis was primarily on substance use, depression, or victimization (D. Brennan et al., 2017). This disparity indicates a need for empirical study on sexual minority health that looks beyond risk and focuses instead on both mental and physical health outcomes, as well as the complex relationship between minority status and its subsequent health outcomes.

This disproportion is likely due to a phenomenon explained by the minority stress theory: the higher prevalence of mental disorders or suicidal behavior in minority groups may be caused by a surplus of social stressors related to societal and institutional stigma and prejudice (Meyer, 2013). This concept has been exhibited many times, but specifically in a study examining the impact of microaggressions on sexual minority individuals in a college environment. In a sample of 568 sexual minorities, Bissonnette and Szymanski (2019) found that subtle forms of external heterosexism and internalization of negative stigma about non-heterosexuality are risk factors for poor
mental health in this population. Through an evaluation of subtle forms of sexual orientation-based discrimination, rather than blatant, Bissonette and Szymanski (2019) expanded upon preliminary understanding of the minority stress theory and how it manifests in the lives and mental health of sexual minority college students. These findings implicate that further evaluation of the impact of subtle microaggressions may serve as a newfound emphasis for sexual minority research, treatment, and prevention.

For racial and ethnic minorities who encounter cultural stressors, it is suggested that the stress and discrimination they experience undermines mental health and well-being (Rivas-Drake & Stein, 2017). In one study, cultural assets were identified as mechanisms that can serve to both reduce risk and enhance resilience in the face of acculturative stress and discrimination (Rivas-Drake & Stein, 2017). Regarding individuals identifying with a nonbinary gender, S. Brennan’s et al. (2017) study of 83 participants identifying with a gender different than their sex assigned at birth reported high rates of mental health problems as compared to cisgender populations. These transgender and gender-nonconforming groups largely exhibited gender-related stress which appeared to predict other mental health problems, like depression and anxiety (S. Brennan et al., 2017). The findings of these studies connote that stressors inflicted upon minority individuals appear to result in poorer mental health-related outcomes. It is important to note that intersecting minority statuses may imply differing experiences with distress and other outcomes of poor mental well-being. This is described through the intersectionality theory, or the understanding that both social identities and the co-occurring experiences of marginalization and privilege are interdependent and fully rely upon the other in order to exist (Crenshaw, 1989). While
members of a given singular group may experience similar discriminatory constraints or conditions, their intersecting identities (i.e. race/ethnicity, gender, sexual orientation, social class, ability, etc.) must be taken into account in order to fully comprehend the societal ramifications of their fundamental existence. This theory is echoed in a study by McConnell, Janulis, Phillips, Truong, and Birkett (2018), which examined both multiple minority stress and community resilience. Findings-wise, racial and ethnic stigmas were associated with greater stress for sexual minority men of all racial and ethnic groups. However, the connection to a sexual minority community appeared to have less importance in facilitating the relationship between stigma and stress for those with double minority status (ethnic and sexual) as opposed to those solely identifying as a sexual minority. These results suggest that minority stress and community resilience processes may differ for White and double minority men (McConnell et al., 2018). By integrating minority stress theory and intersectionality theory, McConnell et al. (2018) shows that double minorities have different experiences of stigma than White sexual minorities. Although both groups are marginalized by sexual orientation, their race and ethnicity appear to play a role in stigma and stress.

Similarly, another study by Hayes, Chun-Kennedy, Edens, and Locke (2011) found that ethnicity was not an added source of distress among sexual minority students in regard to psychological distress. However, among ethnic minority students, sexual minority status was associated with intensified psychological distress (Hayes et al. 2011). This is another example of the variation in outcome that multiple minority statuses may cause. In short, identification with intersecting minority statuses poses a complex and
multifaceted relationship with mental health and well-being, including issues with suicidality.

From existing literature, it can be determined that both ethnic and sexual minorities are at disproportionately increased risk for both NSSI and suicide attempt. As explained by the minority stress theory, existence as a minority co-occurs with societal and institutional stressors as a result of stigma, prejudice, and discrimination. These stressors may result in poorer overall mental health and well-being, along with increased likelihood to engage in suicidal and self-injury behaviors. If only White/Heterosexual experiences, causes, and outcomes are researched and understood, a significant percentage of the population is inherently misunderstood and subsequently underserved. Further suicide and NSSI research in these groups is important because it not only places focus on historically marginalized groups, but finds effective methods to prevent and treat such thoughts and behaviors.

**Protective Factors in Minority Groups**

To combat the stressors and prejudice faced by minorities in society, protective factors play a vital role in these individuals’ experience. The difference between risk and protective factors is an important distinction to make. Risk factors are conditions or variables that lessen likelihoods of positive outcomes and enhance likelihoods of negative or socially undesirable outcomes. Protective factors have an opposite effect: they increase the likelihood of positive outcomes and lower the likelihood of negative consequences from exposure to risk (Jessor, Turbin, & Costa, 2010). It has been found that enhancement of positive protective factors in sexual minorities may subsequently
decrease suicide rates within the population (Eisenberg & Resnick, 2006). Some potential protective factors include resilience, subjective happiness, and life satisfaction.

**Resilience.**

Resilience has been defined as the ability to recover from adversity (Smith et al., 2008). More specifically, it has been described as a trait on a continuum in which people high in resilience possess the ability to dynamically change and self-regulate in alignment with shifting environment and circumstances (Block & Kremen, 1996). Other studies have noted that membership in stigmatized groups may influence a number of self-protective factors, including resilience (Crocker & Major, 1989). For example, people who are low in resilience may approach changes in life with a more rigid manner and exhibit less effective self-regulation. By approaching the concept of resilience from a continuous trait-based lens instead of universal state-based lens, Block and Kremen (1996) effectively controlled for individual differences while acknowledging that not all people, or all members of a group, possess the same degree of resilience throughout their lives. This is an important distinction to make when studying oppressed or marginalized populations. Although life experience may be similar, levels of resilience, or other protective factors, are not necessarily the same.

Resilience can also potentially serve as a positive prospective predictor for NSSI or suicide attempt. In a sample of 604 undergraduate students using a survey regarding the relationship between grit, perseverance, and suicidal behavior, it was found that both higher levels of grit and higher levels of perseverance appeared to predict more frequent attempts (Anestis & Selby, 2015). Additionally, Anestis and Selby (2015) found that grit and perseverance also appeared to moderate the relationship between NSSI and suicide
attempts and increased concurrently with heightened reports of suicidality persistence. Important results were found regarding the relationship between suicidality and grit and perseverance, as it seems that individuals must have been able to persevere through difficult and frightening emotional experiences in order to have engaged in suicidal behavior. Notably, these findings seemingly contrast with other suicide-related theories that state that individual engages in suicidal behavior in order to escape aversive self-awareness or emotional distress (Anestis & Selby, 2015). However, although the study had a racially diverse sample (approximately 45% were racial/ethnic minorities), race/ethnicity was the only controlled minority group. Without acknowledging sexual orientation or nonbinary gender differences, the findings cannot fully be applied to all populations.

Another study aiming to identify the relationship between sexual minority youth diversity and resilience found that identification as a sexual minority significantly may predict higher levels of resilience than identification as heterosexual (Kember, 2018). Using Latent Profile Analysis, Kember (2018) identified a combination of individual-level protective factors in sexual minority individuals. Latent Profile Analysis is a technique that identifies profiles or groups in a sample that show similar patterns of variables, and the resulting profiles can then inform behavioral or other important outcome differences that may have been otherwise unclassified (Stanley, Kellermanns, & Zellweger, 2017). Participants were grouped into low, medium, and high resilience profiles and it was found that both age and sexual minority status significantly predicted the level of resilience profile membership (Kember, 2018). By using this technique, patterns in resilience levels and their relationship to sexual minority status is clearly seen.
However, in contrast to the study by Anestis and Selby (2015), ethnic minority status was not reportedly accounted for. While important patterns were drawn between resilience and sexual minority identification, further work is needed to fully understand the impact of this protective factor on marginalized groups.

**Life Satisfaction.**

Another important, yet further understudied protective factor, is life satisfaction. In contrast to many findings regarding resilience, alternate protective factors like life satisfaction may be exhibited at lower levels in minority groups (Kööts-Ausmees & Realo, 2016). Life satisfaction has been found to have three components: a long-term component due to relatively stable factors like personality and genetic factors; a moderate-term component due to recent life events like perceived health, unemployment, and work load; and a short-term state component that involves current state, mood, or circumstances (Kööts-Ausmees & Realo, 2016). Because of these components, life satisfaction is seen as relatively stable over time. However, dramatic or untimely circumstances and life events, like marriage, divorce, unemployment, or migration, can have a significant impact on overall life satisfaction (Luhmann, Hofmann, Eid, & Lucas, 2012). When evaluating groups that tend to experience unexpected or stressful life events, it seems that minority groups are often disproportionately impacted (Kööts-Ausmees & Realo, 2016). In a European Union-wide sample of 54,540 participants from 29 countries, survey questions regarding life satisfaction were analyzed. Participants were asked to indicate their perceived level of life satisfaction, ethnic identification, perceived discrimination, health, current employment, and perceived social support. The results indicated that ethnic minorities exhibited lower levels of overall life satisfaction than
their White counterparts (Kööts-Ausmees & Realo, 2016). This is an important finding and a sample of this size should not be discounted in protective factor research. However, only 6.7% of the total sample reported identification as an ethnic minority which discounts other minority groups. Additionally, the use of a single-item measure of life satisfaction was potentially problematic. Measurement variance cannot be assessed from a single item, making it difficult to fully assess the implications of life satisfaction in this sample (Kööts-Ausmees & Realo, 2016). Future studies should implement a multi-item and validated measure of life satisfaction in order to more fully understand the ramifications for not only minorities, but all groups.

**Subjective Happiness.**

A third potential prospective factor is subjective happiness, or perceived levels of one’s own happiness by their own terms and in comparison to others. In a study by de Vroome and Hooghe (2015), the difference in subjective happiness (or well-being) between citizens identifying as an ethnic minority and citizens identifying as White or Caucasian was examined. Through an analysis of data from 20 countries with approximately 1,500 ethnic minority respondents, it was found that subjective happiness was reported at lower levels for minority participants (de Vroome & Hooghe, 2015). This difference was likely due to the relatively disadvantaged socioeconomic and discriminatory position that ethnic minorities occupy in current society.

Similar findings were echoed in Powdthaveea and Wooden’s (2015) comparative analysis of reported levels of subjective happiness in sexual minorities in both Australia and the United Kingdom. Using data from two nationally representative surveys, sexual identity and its influence on life satisfaction was studied both directly and indirectly
through a structural-equation model, rather than a single-equation model, and the following channels were evaluated: income, employment, health, marriage and de facto relationships, children, friendship networks, and education (Powdthaveea & Wooden, 2015). It was found that participants identifying as lesbian, gay, or bisexual were significantly less satisfied with their lives than heterosexual participants. Another important finding was that identification as a sexual minority appeared to be associated with generally lower levels of well-being through life satisfaction-predicting factors (either social, economic, or personal) (Powdthaveea & Wooden, 2015). A major strength of this study was its use of structural equation-based estimation model, as this allowed researchers to separate direct associations between identification as a sexual minority and life satisfaction from any other indirect effects that may have resulted from other individual characteristics. It was also the first study of its kind to empirically identify specific channels for improvement of participants’ life satisfaction, resulting in a direct “real world” application that many studies fail to successfully link directly.

Existing literature indicates higher rates of suicide and NSSI in minorities, which coincides with a paucity of suicide and NSSI research centered on these very groups. This discrepancy signifies a need to draw the two together. There are studies investigating NSSI, suicidal ideation, suicide attempt, and protective factors in minority youth, such as findings from Taliaferro and Muehlenkamp (2017) who found that those identifying as a sexual minority were significantly more likely to report NSSI and suicidality, as well variation in effects of protective connectedness factors across sexual orientation groups. However, there is no existing minority suicide research examining the specific role of resilience, life satisfaction, and subjective happiness. Additionally,
existing suicide literature focuses primarily on risk factors, rather than protective factors. By examining mental health-related issues through only one lens, advances in treatment and prevention are inherently limited and more effective solutions are potentially yet to be uncovered. Focusing on the intersection of minority status, NSSI and suicidal thoughts and behaviors, and protective factors alongside risk factors opens the door for novel research findings which, in turn, lay the groundwork for better treatment and prevention for these groups.

**The Current Study**

The goal of the present study was to examine the role of minority experience in NSSI and suicide attempts, as well as the potential protective factors of resilience, life satisfaction, and subjective happiness. While there is existing information regarding minority experience with each of these variables individually, there is not yet any published work that addresses both lifetime NSSI, suicide attempts, and the protective factors of resilience, life satisfaction, and subjective happiness. Because of this, the current study is an important and timely piece of literature as it coincides with broader colloquial interest in such influences, as well as growth of minority populations as a whole.

It was hypothesized that individuals identifying as an ethnic minority or a sexual minority would be more likely to report lifetime NSSI or suicide attempts than those identifying as White or heterosexual. It was also hypothesized that ethnic minorities and sexual minorities would report lower levels of resilience, life satisfaction, and subjective happiness compared to those who identify as White or heterosexual.
Method

Participants

Participants in this study were 3,320 undergraduate students from a mid-sized university in the southcentral region of the United States. Although all participants completed demographic questions, only 69% completed all parts of the survey (n = 2,280). Therefore, due to response incompleteness, 1,040 participants were removed from final analyses and 2,280 respondents were evaluated. The participants in this sample had a mean age of 19.03 years (SD = 1.478).

Of all participants in the sample, 16.5% (n = 548) identified as a racial/ethnic minority: 9.3% as Black/African American (n = 308), 2% as Hispanic/Latinx (n = 67), 0.3% as Native American (n = 9), 2.3% as multi-ethnic (n = 77), 1.6% as Asian (n = 53), and 1% as other (n = 34).

In terms of sexual orientation, 11.6% (n = 405) of all participants in the sample identified as a sexual minority: 2.5% as gay/lesbian/homosexual (n = 83), 5.6% as bisexual (n = 187), 1.3% as pansexual (n = 44), 1.3% as questioning (n = 42), and 0.9% as other (n = 30).

Procedures

Respondents were recruited via an online university study board and each completed an online self-report survey. The survey was posted to the university’s Study Board site and students who were enrolled in psychology or psychological sciences courses received class credit upon completion of the survey. In addition, linked access to the online survey was distributed to all undergraduate university students via university
email (see Appendix A, B). Respondents who completed the survey via emailed linked access did not receive class credit.

The university Institutional Review Board evaluated ethical and methodical concerns and granted approval for this study (see Appendix C). Prior to beginning the survey, participants completed informed consent documents. Throughout the survey, if they answered “yes” to any questions regarding lifetime suicide attempt or NSSI, they were prompted to read the following item: “As researchers in this area, we care about your safety. Please know there is support available like the national suicide lifeline at 1-800-253-TALK. You can also use the Crisis Text Line. Just text START to 741741. To return to the survey click ‘yes, I’ve read this’ below.” After completion of the survey, they reviewed an online debriefing document. The document included linked access and phone numbers to the university-operated counseling and testing center, Texting Crisis Support Line, National Suicide Prevention Lifeline, and contact information for the university professor who oversaw the study (see Appendix D).

In order to maintain anonymity, participants indicated whether or not they were willing to be contacted for further participation in a subsequent longitudinal study on suicidal and self-injurious behaviors. If the participant answered ‘yes’, the survey’s skip-logic programming prompted an opportunity to provide a name, phone number, and email address used for follow-up contact. The participants were informed that their identifying information would be kept private through separation from the remainder of their answers. The survey read that contact information would be stored in a password-protected database only accessible to the study’s researchers. If the participant answered
‘no’, the survey continued to basic demographic questions and required no identifying information (see Appendix E).

**Measures**

**Suicide Behaviors Questionnaire – Revised (SBQ-R).**

Osman’s et al. (2001) SBQ-R is meant to measure four elements of suicidality: lifetime suicide ideation and/or suicide attempt, frequency of suicidal ideation over the past twelve months, threat of suicide attempt, and self-reported likelihood of suicidal behavior in the future. For the purposes of this study, only the first element (lifetime suicidal ideation and/or suicide attempt) was evaluated. Participants were asked “have you ever thought about or attempted to kill yourself?” They then selected one of six options: “no,” “it was just a brief passing thought,” “I had had a plan at least one to kill myself but did not try to do it,” “I have had a plan at least once to kill myself and really wanted to die,” “I have attempted to kill myself, but did not want to die,” and “I have attempted to kill myself and really wanted to die.”

This measure was scored on a four-point scale and answers were grouped into four groups: No Suicide subgroup, Suicidal Ideation subgroup, Suicide Plan subgroup, and Suicide Attempt subgroup. If participants selected “no,” they were placed in the No Suicide subgroup and coded as 1. If they selected “it was just a brief passing thought,” they were placed in the Suicidal Ideation subgroup and coded as 2. If they selected “I had had a plan at least one to kill myself but did not try to do it” or “I have had a plan at least once to kill myself and really wanted to die,” they were placed in the Suicide Plan subgroup and coded as 3. If they selected “I have attempted to kill myself, but did not want to die” or “I have attempted to kill myself, and really wanted to die,” they were
placed in the Suicide Attempt subgroup and coded as 4. If participants indicated that they had made a suicide attempt, they were prompted to answer an additional question regarding attempt in the past year. The question read, “have you made a suicide attempt in the past year?” Participants selected “no,” “yes, once,” “yes, twice,” or “yes, three or more times.” The SBQ-R was selected for use in this study as it has been found to have strong validity and reliability of self-report measures (Osman et al., 2001).

**Self-Injurious Thoughts and Behaviors Interview, Self-Injury Subscale.**

The NSSI Module from Nock, Holmberg, Photos, and Michel’s (2007) Self-Injurious Thoughts and Behaviors Interview (SITBI-NSSI) assessed thoughts and behaviors related to self-injury. The survey prompted participants to only endorse behaviors they had done intentionally and without suicidal intent. The survey first asked, “have you ever purposefully hurt yourself without wanting to die? (for example, cutting or burning).” If participants responded “no,” skip-logic technology prompted them to move on to the next section. If they answered “yes,” they were prompted to answer a series of five questions: how many times they had engaged in self-harm in the past year, how many times they had engaged in self-harm in their lifetime, if they would consider themselves to be “recovered” from self-injury if they had not engaged in the past year, how old they were when they first engaged in self-injury, and if they had ever received medical treatment for injuries caused by self-injury. For the current study, only responses to the first question were used for final analyses (yes or no to lifetime NSSI). The SITBI-NSSI measure was selected for use as it was found to have strong interrater and test-retest reliability, along with concurrent validity (Nock et al., 2007).
**Connor-Davidson Resilience Scale – Brief (CD-RISC-10).**

Connor and Davidson’s (2003) measure was used to gauge resilience through ten statements. Participants indicated the degree to which they agreed with each statement using a seven-point Likert scale from strongly disagree = 1 to strongly agree = 7. Such phrasing included statements like “I can deal with whatever comes my way” and “I try to see the humorous (funny) side of things when I am faced with problems.”

Each of the ten items on the CD-RISC-10 is scored with a minimum of 0 and maximum of 4. Total mean scores range from a minimum of 0 to a maximum of 4. A total resilience score was calculated from the mean score of all ten items, and higher scores indicated higher resilience. The measure was chosen because it has been found to have average reliability and it allows for identification of a wide range of resilience-evaluating behaviors (González et al., 2015). In the current sample, reliability for this scale was good (α = .90).

**Subjective Happiness Scale.**

Lyubomirsky and Lepper’s (1999) Subjective Happiness Scale was used to assess a subjective account of a participant’s overall happiness. The scale included four statements, all used to assess subjective happiness either by the participant’s own standards or in relation to others. Each statement was evaluated on a five-point Likert scale. The first question read, “in general, I consider myself,” and participants indicated their level of considered happiness from not a very happy person = 1 to a very happy person = 5. The next question read, “compared to most of my peers, I consider myself,” and they indicated their level of happiness as compared with their peers from less happy = 1 to more happy = 5. The next question read, “some people are generally very happy.
They enjoy life regardless of what is going on, getting the most out of everything. To what extent does this describe you?” Participants indicated their level of perceived extent of description from not at all = 1 to a great deal = 5. The last question read “some people are generally not very happy. Although they are not depressed, they never seem as happy as they might be. To what extent does this describe you?” Participants indicated their level of perceived extent of description from not at all = 1 to a great deal = 5.

The measure was primarily scored through reverse coding. A total subjective happiness score was calculated from the mean computed from responses to all four statements, and higher scores indicated lower subjective happiness. According to Lyubomirsky and Lepper (1999), the Subjective Happiness Scale was found to have high internal consistency, reliability, and validity, hence its inclusion in this study. In the current sample, reliability for this scale was good (α = .83).

**Satisfaction with Life Scale (SWLS).**

Diener, Emmons, Larsen, and Griffin’s (1985) measure sought to account for the life satisfaction component of the participants’ overall perceived well-being. In the survey, a series of five statements were issued and participants were prompted to indicate the degree to which they agreed with the statement using a seven-point Likert scale from strongly disagree = 1 to strongly agree = 7. The statements read as follows: “in most ways, my life is close to ideal,” “the conditions of my life are excellent,” “I am satisfied with my life,” “if I could live my life over, I would change almost nothing,” and “I am able to adapt when changes occur.”

Scores were based on the sum of answers from all five statements, meaning that scores ranged from 5 to 35. Scores between 5 and 9 indicated that the participant was
extremely dissatisfied with life, and scores between 31 and 35 indicated that the participant was extremely satisfied with life. According to Pavot and Diener (2008), the scale was found to be a reliable and valid measure of life satisfaction. In the current sample, reliability for this scale was good ($\alpha = .88$).
Results

It was hypothesized that individuals identifying as an ethnic minority or a sexual minority would be more likely to report lifetime NSSI or suicide attempts than those identifying as White or heterosexual. It was also hypothesized that ethnic minorities and sexual minorities would report lower levels of resilience, subjective happiness, and life satisfaction as compared to those who identify as White or heterosexual.

Lifetime Suicide Attempts and NSSI

Of the participants identifying as White/Caucasian, 6.7% (n = 153) reported lifetime suicide attempt, while 8.1% (n = 44) of those identifying as an ethnic minority reported lifetime suicide attempt. Chi-square analyses showed that lifetime suicide attempt likelihood was not significantly higher in ethnic minority groups as a whole than in the White/Caucasian group ($\chi^2 (1, N = 2818) = 1.218, p = .270$). However, for differences between individual ethnic groups, chi-square analyses showed that lifetime suicide attempt likelihood in Hispanic/Latinx and Native American groups was significantly higher than in all other ethnic groups ($\chi^2 (6, N = 2818) = 17.310, p = .008$) (see Table 1).

For White/Caucasian participants, 25.8% (n = 588) reported lifetime NSSI, while of the ethnic minority participants, 26.3% (n = 139) reported lifetime NSSI. Chi-square analyses showed that lifetime NSSI likelihood was not significantly higher in ethnic minority groups as a whole than in the White/Caucasian group ($\chi^2 (1, N = 2824) = 0.51, p = .821$). However, for differences between individual ethnic groups, chi-square analyses showed that all ethnic minority groups, except for Black/African Americans, exhibited
higher lifetime NSSI likelihood than the White/Caucasian group ($\chi^2 (6, N = 2824) = 20.167, p = .003$) (see Table 1).

Of participants identifying as Heterosexual/Straight, 5.3% (n = 128) reported lifetime suicide attempt, while of the sexual minority participants, 16.9% (n = 68) reported lifetime suicide attempt. Chi-square analyses showed that lifetime suicide attempt likelihood was significantly higher in sexual minority groups as a whole than for Heterosexual/Straight participants ($\chi^2 (1, N = 2806) = 70.8222, p < .001$). Additionally, chi-square analyses showed that lifetime suicide attempt likelihood was significantly higher for each individual sexual minority group than in the Heterosexual/Straight group ($\chi^2 (5, N = 2787) = 92.639, p < .001$) (see Table 2).

For Heterosexual/Straight participants, 20.8% (n = 500) reported lifetime NSSI, while of sexual minority participants, 55.6% (n = 225) reported lifetime NSSI. Chi-square analyses showed that lifetime NSSI likelihood was significantly higher in sexual minority groups as a whole than in the Heterosexual/Straight participants ($\chi^2 (1, N = 2812) = 219.187, p < .001$). Additionally, chi-square analyses showed that lifetime NSSI likelihood was significantly higher for each individual sexual minority group than the Heterosexual/Straight group ($\chi^2 (5, N = 2763) = 230.206, p < .001$) (see Table 2).

**Protective Factors**

ANOVA results revealed that the White/Caucasian group had significantly different protective factor scores than the ethnic minority group in resilience [$F(1, 2765) = 6.660, p = 0.01$], significantly higher scores than ethnic minority group in life satisfaction [$F(1, 2776) = 27.510, p < .001$], and scores for subjective happiness were not significant [$F(1, 2818) = .107, p = .744$] (see Table 3).
ANOVA results revealed that Heterosexuals had significantly higher scores than the sexual minority group on all protective factors: resilience \( F(1, 2755) = 83.337, p = .001 \), life satisfaction \( F(1, 2765) = 165.574, p = .001 \), and subjective happiness \( F(1, 2806) = 165.616, p = .001 \) (see Table 4).
Table 1. Lifetime Suicide Attempts and NSSI in Ethnic Minority Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Reported lifetime SA (%)</th>
<th>Reported lifetime NSSI (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n)</td>
<td>No (n)</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>6.7 (153)</td>
<td>93.3 (2120)</td>
</tr>
<tr>
<td>Black/African American</td>
<td>5.6 (17)</td>
<td>94.4 (289)</td>
</tr>
<tr>
<td>Hispanic/Latinx</td>
<td>17.9 (12)</td>
<td>82.1 (55)</td>
</tr>
<tr>
<td>Native American</td>
<td>22.2 (2)</td>
<td>77.8 (7)</td>
</tr>
<tr>
<td>Multi-Ethnic</td>
<td>7.8 (6)</td>
<td>92.2 (71)</td>
</tr>
<tr>
<td>Asian</td>
<td>9.4 (5)</td>
<td>90.6 (48)</td>
</tr>
<tr>
<td>Other</td>
<td>6.1 (2)</td>
<td>93.9 (31)</td>
</tr>
</tbody>
</table>
**Table 2. Lifetime Suicide Attempts and NSSI in Sexual Minority Groups**

<table>
<thead>
<tr>
<th>Group</th>
<th>Reported lifetime SA (%)</th>
<th>Reported lifetime NSSI (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n)</td>
<td>No (n)</td>
</tr>
<tr>
<td>Heterosexual/Straight</td>
<td>5.3 (128)</td>
<td>94.7 (2275)</td>
</tr>
<tr>
<td>Gay/Lesbian/Homosexual</td>
<td>14.6 (12)</td>
<td>85.7 (70)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>14.5 (37)</td>
<td>85.5 (159)</td>
</tr>
<tr>
<td>Pansexual</td>
<td>31.8 (14)</td>
<td>68.2 (30)</td>
</tr>
<tr>
<td>Questioning</td>
<td>19 (8)</td>
<td>81 (34)</td>
</tr>
<tr>
<td>Other</td>
<td>20 (6)</td>
<td>80 (24)</td>
</tr>
</tbody>
</table>
Table 3. ANOVA and Descriptive Statistics for Resilience, Life Satisfaction, and Subjective Happiness Between Ethnic Minority Groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilence</td>
<td>White/Caucasian</td>
<td>2240</td>
<td>48.98</td>
<td>10.82</td>
<td>6.660</td>
<td>≤.010</td>
</tr>
<tr>
<td></td>
<td>Ethnic Minority</td>
<td>527</td>
<td>50.35</td>
<td>11.36</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2767</td>
<td>49.25</td>
<td>10.94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>White/Caucasian</td>
<td>2244</td>
<td>22.96</td>
<td>6.78</td>
<td>27.510</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>Ethnic Minority</td>
<td>534</td>
<td>21.26</td>
<td>6.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2778</td>
<td>22.64</td>
<td>6.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective Happiness</td>
<td>White/Caucasian</td>
<td>2275</td>
<td>13.6</td>
<td>3.39</td>
<td>.107</td>
<td>.744</td>
</tr>
<tr>
<td></td>
<td>Ethnic Minority</td>
<td>545</td>
<td>13.55</td>
<td>3.46</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2820</td>
<td>13.59</td>
<td>3.41</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4. ANOVA and Descriptive Statistics for Resilience, Life Satisfaction, and Subjective Happiness Between Sexual Minority Groups

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilience</td>
<td>Heterosexual/Straight</td>
<td>2363</td>
<td>50.01</td>
<td>10.71</td>
<td>83.34</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>Sexual Minority</td>
<td>394</td>
<td>44.665</td>
<td>11.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2757</td>
<td>49.25</td>
<td>10.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>Heterosexual/Straight</td>
<td>2369</td>
<td>23.31</td>
<td>6.78</td>
<td>165.57</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>Sexual Minority</td>
<td>398</td>
<td>18.68</td>
<td>6.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2767</td>
<td>22.64</td>
<td>6.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective Happiness</td>
<td>Heterosexual/Straight</td>
<td>2404</td>
<td>13.92</td>
<td>3.31</td>
<td>165.62</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>Sexual Minority</td>
<td>404</td>
<td>11.63</td>
<td>3.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2808</td>
<td>13.59</td>
<td>3.41</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Discussion

The primary purpose of this study was to examine the relationship between both NSSI and suicide attempts and the protective factors of resilience, life satisfaction, and subjective happiness in both ethnic and sexual minority groups. Results found that ethnic minorities did not report significantly different likelihoods of lifetime suicide attempt than those identifying as White/Caucasian. However, results did confirm the hypothesis that ethnic minorities would report higher likelihoods of lifetime NSSI than those identifying as White/Caucasian, with the exception of those identifying as Black/African American who reported lower likelihoods of lifetime NSSI. In terms of protective factors, results confirmed the hypothesis that ethnic minorities would report lower levels of life satisfaction than White/Caucasian groups, with the exception of resilience which was reported at higher levels, and subjective happiness which was found to not have a significant difference.

For sexual minorities, results supported the hypothesis that they would report higher likelihoods of lifetime suicide attempt or NSSI than those identifying as Heterosexual/Straight. In terms of protective factors, results confirmed the hypothesis that sexual minorities would report lower levels of resilience, life satisfaction, and subjective happiness when compared to Heterosexual/Straight participants. These results echo previous research in that NSSI and suicide is more prevalent in minority groups, but initiate novel findings in regard to ethnic minority group differences in past experience with NSSI, as well as preliminary study of resilience, life satisfaction, and subjective happiness in these groups. It is likely that the findings in the current study did not completely confirm all hypotheses due to little preexisting literature regarding this
specific intersection of minority status, NSSI and suicide, and the aforementioned protective factors.

However, the relationship shown in the findings indicates that minority status plays an important role in both suicidal and self-injurious outcomes, as well as perceived protective factors. Notably, the effects of resiliency are nuanced and can potentially be redefined when evaluated through lenses of differing minority statuses. This is consistent with Block and Krennen’s (1996) finding that resilience is trait-based, rather than state-based; if conceptualized through such a lens, the results of the present study could indicate that individual differences, rather than situational factors, explain the variation in ethnic minorities’ reported resilience as compared to that of White participants.

Among suicide attempts and NSSI in ethnic minority groups, Native Americans and Hispanic/Latinx groups were found to have disproportionately higher likelihoods of lifetime attempt or engagement. This is consistent with larger findings, indicating that these groups may be disproportionately at risk (Perez-Rodriguez, 2008). Although only nine participants in the present study self-identified as Native American, their reported likelihood of suicide attempt was approximately three-times higher than White/Caucasians and their reported likelihood of NSSI was twice higher. While the sample size of those identifying as Native American was disproportionately smaller, high likelihoods among only nine participants may indicate that this group is at even higher risk than previously understood. Another important finding in terms of lifetime suicide attempt and NSSI was that Black/African American participants indicated lower likelihood to have engaged in both behaviors when compared all other groups, including White/Caucasians. This could potentially be due to social environment factors, such as
family functioning and social support (Compton, 2005). It is possible that these protective factors, along with strong identification within an ethnic group, act as moderators in terms of suicidality and self-injurious behaviors. Further work, specifically within the Black/African American community, is needed to understand the differences that caused this group to report lower likelihoods in suicidal experience, seeing as other ethnic minority groups reported higher likelihoods when compared to White/Caucasian participants.

This study operated upon several limitations. Firstly, it solely relied on entirely self-reported measures, along with use of online data collection. Secondly, there was no intersectional approach taken into account in regard to multiple minority statuses. Participants were grouped solely as an ethnic minority or sexual minority and there were no specific analyses conducted for those identifying as both. This left the findings and larger implications of the study fundamentally closed off to the impact that intersectional minority status may have on suicidal and self-injurious behaviors, as well as protective factors. As noted by Crenshaw (1989), an intersectional approach must be taken in order to fully explore the interdependent experiences of marginalization and privilege that come with multiple minority identities. Thirdly, there was a disproportionately larger sample of White/Caucasian and Heterosexual/Straight participants as compared to minority groups. However, these proportions may be relatively consistent with the demographic makeup of the United States. It is estimated that 76.6% of the U.S. population is White/Caucasian, 13.4% is Black/African American and 18.1% is Hispanic/Latinx (U.S. Census Bureau, 2018). These percentages are relatively comparable with the demographics in the present study (80.6% are White/Caucasian,
9.3% are Black/African American, 2% are Hispanic/Latinx). Finally, due to low sample size, gender (transgender, gender fluid, gender questioning) minorities were not evaluated in final analyses.

Future research should expand upon the present findings in a number of ways. Most notably, the large sample size in this dataset adequately lends itself to further analyses, and future studies could utilize its responses for more specific evaluation of intersecting identities, or prevalence and severity of past NSSI and suicidal behavior. More broadly, the specific role of resilience as a protective factor against both suicidal behaviors and minority experience can be evaluated. Overall, individual sexual minority groups exhibited higher likelihoods of lifetime suicide attempt and NSSI when compared to the Heterosexual/Straight group. There was greater variability between individual ethnic minority groups when compared to White/Caucasian group in terms of the likelihood of lifetime suicide attempt and NSSI. Further work can be done to understand this difference and what factors play a role in the disproportion.

Despite recent efforts and progress to understand more about the mental-wellbeing experience of minority individuals, the comprehensive and equitable examination of the relationship between suicidality, self-injurious behaviors, and protective factors in these groups is still in its beginning stages. The increase of racial and ethnic diversity in the United States over time, along with the gradual work towards full understanding and acceptance of both ethnic and sexual minorities, are important indicators that future research should make a conscious shift in this direction. Creating awareness of the influence that minority status holds between levels of resilience, subjective happiness, and life satisfaction may better inform suicide prevention and
treatment within these groups. Without taking into account the ways in which societal and institutional prejudice manifest in mental health, a significant portion of the population is misunderstood and, therefore, mistreated. By identifying both general and specific risk and protective factors in these groups, researchers, clinicians, and lawmakers can turn their efforts towards the development of effective and sustainable prevention and treatment.
References


health in a midwestern U.S. transgender and gender-nonconforming population. 


APPENDIX A.

Email Invitation Script

Hello fellow Hilltopper!

You are being contacted because you have previously participated in a study for the Risk Behaviors Lab and may be eligible for an additional research project. I am hoping that you will be willing to help me out with a brief survey (15 min) that I am using to identify students who may be a good fit for a study I am working on that examines how different behaviors and thoughts influence each other over time. If you are eligible for this study, you will be compensated for your time (@ rate).

If you are willing to help me out, please click the link below which will take you to the first page of the survey where you can get more information. Your participation is voluntary. The survey should take approximately 15 minutes and your responses will be confidential.

[LINK TO SURVEY HERE]

Thank you for your help!

Amy Brausch, PhD
Associate Professor of Psychological Sciences
Reminder Email Invitation Script

Hello!

This is a friendly reminder, inviting you to participate in the brief survey (15 min) to help identify students who might be a good fit for a research project examining how different behaviors and thoughts influence each other over time. Participation is voluntary, so if you already did so, just ignore this email.

If you haven’t participated, and are willing, please click the link below to get more information and to access the survey. Time is running out as the survey will no longer be available after [DATE].

Thanks for helping!

Amy Brausch, PhD
Associate Professor of Psychological Sciences
INFORMED CONSENT DOCUMENT

APPENDIX C.

Project Title: Screening Survey
Investigator: Dr. Amy Brausch, GRH 3029, 270-745-4407, amy.brausch@wku.edu

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your signed agreement to participate in this project. You must be 18 years old or older to participate in this research study.

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have. You should keep a copy of this form for your records.

1. Nature and Purpose of the Project: You have been asked to participate because answers you provided in a previous study indicated that you might be eligible for an additional study by the Risk Behaviors Lab. The responses provided on this brief survey will be used to identify students who may be a good fit for a larger research project called Longitudinal Study of Self-Injury in College Students which will examine how different behaviors (like self-harm) and thoughts influence each other over time.

2. Explanation of Procedures: If you decide to participate in this screening survey, you will be asked to answer questions about your level of happiness, resilience, self-harm thoughts and behaviors, satisfaction with life, and basic demographics. In addition, you will be asked if you are willing to participate in a future study and if yes, will be asked to provide contact information. This future study will ask students to come into a private room and complete different computerized tasks and questionnaires at four different times over an 18-month time frame.

3. Discomfort and Risks: We do not anticipate any risk beyond the inconvenience of time and the potential for an emotional reaction to questions about self-harm.

4. Benefits: The potential benefits of your participation are that you may feel positively about helping with a research project.

5. Confidentiality: Your participation is voluntary and your responses will be confidential. Whether or not you participate will not affect your standing in the University. If you choose to participate, your responses will be assigned a random code number so that nobody can know how you responded, other than Dr. Brausch and her research assistants, who will not share that information with anyone on or off campus. At the end of the study, any personally identifying information will be deleted from the database so that your individual answers cannot be linked to you.

6. Refusal/Withdrawal: Refusal to participate in this study will have no effect on any future services you may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

Your continued cooperation with the following research implies your consent.

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY THE WESTERN KENTUCKY UNIVERSITY INSTITUTIONAL REVIEW BOARD

Paul Mooney, Human Protections Administrator
TELEPHONE: (270) 745-2129

WKU IRB# 17-031
Approval - 7/6/2018
End Date - 5/31/2019
Expedited
Original - 8/17/2016
APPENDIX D.

Debriefing Page

College is a lot of fun, exciting, and full of new experiences. It can also be stressful and feel overwhelming. Here are some FREE resources for you or a friend if you want some extra emotional support.

WKU Counseling and Testing Center (Potter Hall, Rm 409) – Open M-F 8:00-4:30pm
Phone: (270)745-3159; www.wku.edu/heretohelp

Texting Crisis Support Line: text START to 741 741 (available 24/7)

National Suicide Prevention Lifeline: 1-800-273-TALK;
www.suicidepreventionlifeline.org

You may also contact Dr. Brausch directly with any questions or concerns:
Email: amy.brausch@wku.edu
Phone: (270)745-4407
APPENDIX E.

Demographic Information

1. How old are you?
   - 18
   - 19
   - 20
   - 21
   - 22
   - 23
   - 24
   - 25
   - 26
   - 27 or older

2. What is your current year in school?
   - Freshmen
   - Sophomore
   - Junior
   - Senior
   - Graduate student

3. What gender do you identify with?
   - Male
   - Female
   - Transgender, Male-to-Female
   - Transgender, Female-to-Male
   - Transgender, do not identify as male or female
   - Gender fluid
   - Not sure
   - Decline to state
   - Other

4. Do you consider yourself to be:
   - Heterosexual/straight
   - Gay/lesbian/homosexual
   - Bisexual
   - Pansexual
   - Not sure
   - Decline to state
   - Other
5. Sexual Orientation: How would you place yourself on a scale of 1 to 7, where 1 is exclusively heterosexual and 7 is exclusively homosexual? I am attracted to:
   o 1) Other sex only
   o 2) Other sex mostly
   o 3) Other sex somewhat more
   o 4) Both sexes
   o 5) Same sex somewhat more
   o 6) Same sex mostly
   o 7) Same sex only
   o Not sure
   o Decline to state

6. What race/ethnicity do you identify with?
   o White/Caucasian
   o Black/African-American
   o Hispanic/Latino(a)
   o Native American
   o Multi-Ethnic
   o Asian
   o Other

7. Are you an international student?
   o Yes
   o No