School of Population Health - Discipline of Psychology

Understanding Stigma in the Context of Nonsuicidal Self-Injury

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Declaration

Originality

To the best of my knowledge and belief, this thesis contains no material previously published by any other person except where due acknowledgment is made. This thesis contains no material that has been submitted or accepted for the award of any other degree or diploma at any university.

Human Ethics

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2014). Human research ethics approval from the Curtin University Human Research Ethics Committee (HREC) was obtained for the studies presented in Chapter 3 (HRE2018-0615) and Chapter 5 (HRE2020-0267). Ethical approval was not required for the studies in Chapter 2 or Chapter 4 as neither study involved collecting data from any humans.

1st April 2022

Acknowledgments

I am honoured and privileged to have completed my PhD on Whajuk booja, unceded by the Noongar custodians of Country. I pay my respects to Elders past and present, and to all Indigenous peoples across Australia, whose strength, resilience, and creativity is an inspiration, and whose culture is ongoing and everlasting.

I extend my whole-hearted gratitude to my supervision team: Professor Penny Hasking, Professor Stephen Lewis, and Associate Professor Mark Boyes. Penny and Stephen, together you have cultivated a sense of safety and security regarding my lived experience of self-injury. The support you have offered as I explored how to navigate this in the context of my research has been invaluable. You have been an ongoing source of inspiration and strength. Mark, you have been a pillar during turbulent times and I appreciate your unrelenting concern for my wellbeing. When my hyperactive or self-defeating brain was too loud, you were a source of stability and calm. Penny, Stephen, Mark - your combined passion, expertise, and genuine care made doing a PhD as a first-generation university student possible, even enjoyable! Thank you for being present, compassionate, and most of all, for believing in me. I could not have done this without you.

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Dedication

In the final days of writing my thesis discussion and formatting this extraordinarily long document, I got a call from a close friend whose partner had just self-injured. I could hear them both on the call, my friend seeking advice, their partner sobbing, “I didn’t mean to.” I know you didn’t, honey. She was terrified. Scared she’d be yelled at by the nurses, scolded for hurting herself on purpose when other people need help; afraid of being forced into a mental health ward under suicide watch. She wasn’t suicidal. She accidentally cut deeper than she meant to. I helped them understand the process they’d experience going to the emergency department, reassuring them that it would be okay, meanwhile fearing she’d be judged, dismissed, or stitched with no pain relief.

In a way that might seem peculiar to some, I felt a deep honour in being the recipient of that call. Throughout my PhD I have become a person others feel comfortable to talk to about self-injury. I’ve heard many stories, some hard, some horrific, but always deeply moving. I wanted to avoid the “to all the people who self-injure” dedication, which has always seemed hollow to me, but I truly dedicate this work to all individuals who have self-injured. We are resilient, we are capable, we are strong, and we keep ourselves alive even in moments when we desperately don’t want to be. It is my never-ending hope that my current and continued work helps to strengthen your hope and diminish the obstacles you face.

Journal Articles

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Thesis Abstract

Non-suicidal self-injury (NSSI; self-injury) is a highly stigmatised behaviour. The intentional damage to oneself without suicidal intent, self-injury typically involves cutting, burning, and/or hitting oneself. In this way, self-injury appears to violate our innate desire to avoid pain and harm, and can therefore be difficult to understand. A lack of understanding may inform the stigmatisation of self-injury; indeed, unnuanced assumptions about self-injury (e.g., that it is ultimately attention-seeking) are relatively common. However, the composition, manifestation, and impact of self-injury stigma has yet to be thoroughly investigated. The aim of this thesis is to develop a better understanding of self-injury stigma.

The first study in this thesis involved a review of the literature and subsequent development of a theoretical framework through which self-injury stigma can be conceptualised. Developing the NSSI Stigma Framework was an important first step, as no models of stigma yet existed in the self-injury context. Drawing on work by Jones et al. (1984), Corrigan and Watson (2002), and Quinn and Chaudoir (2009), I proposed that self-injury stigma is a function of six domains that manifest across four social levels. Each domain contributes to explaining why self-injury is stigmatised: *origin*, beliefs about why a person self-injures; *concealability*; the visibility of self-injury; *course*, perceptions of how self-injury changes over time; *peril*, the perceived dangerousness of self-injury; *aesthetics*, evaluations of self-injury's appearance; and *disruptiveness*, how self-injury is thought to impact relationships. These domains of stigma emerge across the following levels: *public*, the attitudes and beliefs about self-injury held by the general public; *self*, the internalisation of public stigma (i.e., agreeing with and applying attitudes and beliefs to oneself); *enacted*, the direct and indirect experiences of prejudice and discrimination; and *anticipated*; the expectation of enacted stigma. While the NSSI Stigma Framework offers a theoretically grounded approach to the study of self-injury stigma, its applicability to lived experiences of self-injury stigma required validation, which led me to the second study in this thesis.

In study two, the applicability of NSSI Stigma Framework was examined using data obtained from a series of open-ended questions relating to stigma. I conducted a directed content analysis of 99 responses, using the Framework as the coding rubric. I found support for the Framework, with 19 of the 24 rubric cells represented by participants' experiences. Because I asked participants to describe their experiences of NSSI stigma, the enacted stigma level had the most support. While more research is required to further assess the applicability of the public, self, and anticipated levels, the NSSI Stigma Framework offers a useful guide to developing relevant research questions that further our understanding of self-injury stigma.

Such questions can be derived at specific cells within the Framework, for example, "how does concealability inform self-stigma?". Questions relating to specific domains regardless of level could also be generated, with the view to better understand how particular domains manifest. Likewise, questions at the broader levels regardless of domain can be generated. Given the incipient nature of NSSI stigma research, wide scope research questions allow us to explore the phenomenon flexibly, and potentially illuminate previously unconsidered facets. Therefore, in Study Three, I sought to explore NSSI stigma at the public level.

It is well-established that stigma is proliferated through mass media. In particular, news media are a prominent source of stigma due to perceptions that news media are representing the "truth". Thus, news media portrayals of self-injury[1] are likely key to the development and maintenance of public NSSI stigma. To investigate how news media portray self-injury, I conducted a media framing analysis of 545 news article published in Australia during 2019. Within an overarching theme of pathology, instability, and damage, six media frames were generated: *Inevitably Suicidal*, *A Tragic Outcome*, *Mentally Unwell*, *An Epidemic*, *Threatening and Dangerous*, and *A Manipulative Tactic*.

Each frame contributes to NSSI stigma in unique ways. *Inevitably Suicidal* captured a lack of distinction between suicidal and non-suicidal self-injury, which may lead to confusion about what constitutes self-injury, informing misconceptions about why people self-injure. *A Tragic Outcome* described the positioning of self-injury as an indication of impact. In stories about abuse, discrimination, detention, bulling and social, school, and work pressures, self-injury was referenced to demonstrate how impactful the experience was. The *Mentally Unwell* frame captured portrayals that synonymised self-injury with mental illness and/or portrayed self-injury as the behaviour of someone who was "unstable". Rates of self-injury were often portrayed as increasing, as indicated by the *An Epidemic* frame, whereby language such as "shocking" and "disturbing" was used to support the notion that self-injury is an epidemic. *Threatening and Dangerous* included articles that framed self-injury as an act of violence, or criminalised individuals who indicated intent to self-injure in public. The final frame, *A Manipulative Tactic*, related to portrayals of self-injury as a tool to manipulate circumstance and people for one's own gain. Taken together, these frames point to news media as a likely source of public NSSI stigma; however, the extent to which such messaging is internalised requires further investigation. Such investigation necessitates a measure of

[1]For consistency, I use the term "self-injury" here; however, in Study Three, I use the term "self-harm" because that is the common vernacular in Australia.

self-injury stigma. Therefore, the final study in this thesis was the development and validation of the Self-Injury Stigma Scales.

I developed the Self-Injury Stigma Scales in two parts. In the first part, I used the NSSI Stigma Framework to generate a large pool of items (approximately 150 per level). I then piloted these items with a sample of 316 (M^{age} = 32.1, 68% male, 40% with a history of self-injury) participants recruited via MTurk. I then conducted item reduction using bivariate correlations and exploratory factor analyses before administering the reduced item pool to 722 (M^{age} = 29.2, 27.3% male, 55.7% with a history of self-injury) participants recruited via social media, my university's participant pool, and MTurk. Due to its theoretically informed nature, I used confirmatory factor analyses to assess the structure of the Self-Injury Stigma Scales. Four factors were generated: *Origin*, *Concealability*, *Peril*, and *Disruption*. While I expected six factors to mirror the NSSI Stigma Framework, the four-factor solution was conceptually sound. I then demonstrated internal consistency, convergent and divergent validity, and measurement invariance. The Self-Injury Stigma Scales offers a comprehensive measure of self-injury stigma that can be used in future research to assess the extent and impact of self-injury stigma, and evaluate the effectiveness of NSSI stigma reduction efforts.

Taken together, the four studies presented in this thesis demonstrate self-injury stigma as a phenomenon requiring targeted investigation. Through the development and application of the NSSI Stigma Framework and the development and validation of the Self-Injury Stigma Scales, this thesis contributes to a better understanding of self-injury stigma and offers a foundation to inform future self-injury research.

Author's Note

Thesis Format

As a hybrid thesis, the following chapters comprise both published and unpublished research. In published (Chapters 2, 3, and 4) and submitted papers (Chapter 5), I use the pronoun "we", as these papers are authored by myself and others. Relevant attributions and permissions are included at the beginning of each chapter. Due to the hybrid nature of this thesis, some repetition across Chapters is inevitable; however, I have tried to limit this where possible. Furthermore, I have combined the references for all chapters into a single list following the final chapter for brevity.

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Chapter 1

Introduction to Thesis

In this chapter, I provide an introduction to the thesis topic. First, I provide an overview of non-suicidal self-injury and why it may be stigmatized. I then provide a description of stigma and summarize what is known about non-suicidal self-injury stigma. I finish this chapter with an outline of the thesis.

Non-Suicidal Self-Injury

Non-suicidal self-injury (NSSI; self-injury) is the intentional damage of one's own body enacted without suicidal intent (International Society for the Study of Self-Injury [ISSS], 2022). Usually done by cutting, hitting, and/or burning oneself, the most common motivation for self-injury is emotion regulation (Taylor et al., 2018). Accordingly, individuals who have self-injured tend to experience greater psychological distress than individuals who have never self-injured (Buelens et al., 2019). Despite being non-suicidal in nature, self-injury confers increased risk for suicidal thoughts and behaviours (Kiekens et al., 2018).

While self-injury is reported across identities, individuals identifying as lesbian, gay, bisexual, and/or transgender (LGBT) are more likely than their cisgender and heterosexual peers to engage in self-injury (Liu et al., 2019). In some research, the features of self-injury are similar for males and females, with females more likely than males to scratch themselves and injure on the stomach/abdomen and legs, and males more likely than females to burn themselves and injure on the chest/torso (Victor et al., 2018).

NSSI can begin at any age, however, onset is most common during adolescence between 14 and 15 years of age, and early adulthood between 20 and 24 years of age (Gandhi et al., 2018). Self-injury is relatively common, with approximately 17% of adolescents, 13% of young adults, and 5% of adults reporting a lifetime history (Swannell et al., 2014). There are some indications that rates of NSSI are increasing, particularly among adolescents (Hiscock et al., 2018); however, it is not yet clear whether such increases are attributable to changes in hospital recording of self-injurious behaviours, ambiguity in distinguishing between suicidal and nonsuicidal self-injury, or actual changes in behaviour. Furthermore, emerging evidence suggests an increase in NSSI following the onset of the COVID-19 pandemic (Zetterqvist et al., 2021).

Despite being a relatively common behaviour, individuals are unlikely to disclose their self-injury to others (Simone & Hamza, 2020). Given that people who have self-injured are vulnerable to psychological distress and suicidality, it is vital that individuals who wish to

seek support can do so; however, shame, fear of rejection or judgement, the potential for disclosure to impact opportunities (e.g., career choices), and the possibility of losing control over future disclosures are prominent barriers to NSSI disclosure (Simone & Hamza, 2020). Removing these barriers is therefore critical to improving the wellbeing of individuals with lived experience of self-injury. Understanding the origin of those barriers is a key first step, and the aforementioned barriers likely stem from a single problem: stigma.

Stigma

Goffman (1963) described stigma as the mark or attribute an individual carries that leads to social rejection. Since Goffman's early works, psychologists have endeavoured to conceptualise, understand, and reduce stigma, proposing various social psychological models to do so (Corrigan, 2014). Common to many of these models are the following constructs: stereotype, prejudice, and discrimination. Stereotypes are culturally developed knowledge structures about individuals and groups that serve to categorise people in the least cognitively taxing way (Corrigan & Kosyluk, 2014). Stereotypes are unavoidable, as they represent autonomic processes designed to increase cognitive efficiency; however, when such stereotypes are endorsed, prejudice can arise. Prejudices are the emotional responses elicited by belief in and exposure to a stereotype, and can take many forms, including anger, pity, and disgust. Prejudices can then lead to discrimination – the actions taken against a stereotyped group or individual that result in some form of social, structural, economic, or emotional disadvantage (Corrigan & Kosyluk, 2014).

Unsurprisingly, stigma has significant adverse impacts. Mental illness stigma diminishes self-esteem and self-efficacy, thwarts help-seeking and treatment adherence, interferes with coping and resilience, and is associated with fewer opportunities in relationships, housing, and employment (Sickel et al., 2014). Consequently, individuals experiencing mental health difficulties tend to conceal such difficulties to avoid stigmatisation, leading to ineffective treatments, isolation, and worsening of symptoms (Isaksson et al., 2018). Similar impacts may be related to self-injury stigma.

Self-Injury Stigma

The stigmatisation of self-injury is a topic of emerging scholarly attention. In line with a broader shift in the field toward better understanding the lived experiences of NSSI (e.g., Lewis & Hasking, 2021; Long, 2018; Victor et al., 2022), there is increasing recognition of how stigma negatively impacts individuals who have self-injured. Much of our understanding of self-injury stigma is drawn from qualitative work, which has provided insight into experiences of NSSI stigma, demonstrating that it is a significant barrier to support seeking

and negatively impacts wellbeing (e.g., Hodgson, 2004; Kendall et al., 2021; Long, 2018; Long, 2021; Mitten et al., 2016). Limited quantitative research has been done to investigate the predictors, correlates, and outcomes of self-injury stigma, possibly due to the absence of NSSI-specific models and measure of stigma.

In the absence of an existing model specific to self-injury stigma, researchers have drawn on Corrigan et al.'s (2003) Attribution Model of mental illness stigma to investigate NSSI stigma. This model proposes that stigma is driven by attributions of responsibility, suggesting that prejudice and discrimination are a function of perceptions and assumptions about why an individual has engaged in a behaviour (the cause) and whether they can control that behaviour (the controllability). If the cause is attributed to the individual engaging in the behaviour and that behaviour is seen to be controllable by the individual, then the responsibility for the behaviour will be attributed to the individual. When attributions of responsibility are made, prejudice and discrimination are more likely (Corrigan et al., 2003). Therefore, beliefs about why an individual has self-injured are important to understanding NSSI stigma.

This has been demonstrated in experimental studies (Burke et al., 2019; Law et al., 2009; Lloyd et al., 2018), whereby vignettes depicting a fictional character who has self-injured for various reasons are presented to participants. Characters who self-injured for controllable reasons (e.g., drug misuse) were rated less favourably than characters who had self-injured for uncontrollable reasons (e.g., history of abuse). Apart from attributions of responsibility, however, little is known about why self-injury stigma occurs. Indeed, there are aspects of self-injury that are likely not fully captured by mental illness sigma models. While self-injury likely incurs mental illness stigma due to its empirical (Keikens et al., 2018) and assumed (Newton & Bale, 2012) associations with mental illness, self-injury is also a behaviour that is enacted by the individual themselves, and often leaves marks in the form of wounds and scars.

Research by Piccirillo et al. (2020) and Kendall et al. (2021) demonstrates the importance of scarring in NSSI stigma. Piccirillo et al. examined participants' implicit and explicit evaluations of self-injury scars compared to scars from "non-intentional disfigurement" or tattoos, finding that self-injury scars were rated most negatively, both implicitly and explicitly. Kendall et al. examined 60 blog entries posted by individuals who had a history of self-injury and found that NSSI scarring has expansive implications. Most notably, participants were concerned their self-injury scars would preclude them from job opportunities and invite stigma. These concerns motivated scar concealment, interfering with

daily life, such as avoiding holidays or wearing uncomfortable clothing. Clearly, the visible aspect of self-injury is crucial to understanding self-injury stigma. Yet, we still know little about how, why, and where self-injury stigma manifests. In this thesis, I contribute to the field's understanding of self-injury stigma in two ways. First, I propose and assess a theoretical framework of self-injury stigma; second, I develop and validate a measure of self-injury stigma.

Aims and Outline of the Thesis

The central objective of the present work was to develop an understanding of non-suicidal self-injury stigma. In the following six chapters, I advance this understanding by proposing and applying an integrated framework of self-injury stigma before developing and validating a comprehensive measure of self-injury stigma. The contents of each chapter are detailed below.

Chapter 2

In Chapter 2, I present the first study, *Application of a conceptual framework of non-suicidal self-injury stigma*, which provides an empirically derived theory for how to identify, explore, and explain self-injury stigma. Drawing together stigma models proposed by Jones et al. (1984), Corrigan and Watson (2002), and Quinn and Chaudoir (2009), I developed a holistic framework that considers how self-injury stigma manifests across multiple social contexts, and the domains that underly why self-injury is stigmatised.

Chapter 3

In Chapter 3, I present the second study, *Crazy, weak, and incompetent: A directed content analysis of self-injury stigma experiences*, where I assess the applicability of the NSSI Stigma Framework. Using the Framework as a rubric, I conducted a directed content analysis of responses from 99 participants to a series of online, open-ended questions about their experiences of stigma. This study provided preliminary empirical support for the NSSI Stigma Framework.

Chapter 4

Chapter 4 comprises the third study, *News media framing of self-harm in Australia*. This study represents an example of how the self-injury stigma framework can be used to generate and answer a relevant research question. I sought to understand how the news media portray self-injury by conducting a media framing analysis on 545 news articles published in 2019. I found that self-injury framing was largely negative, with common stereotype perpetuation and use of stigmatising language. This study provided insight into how self-

injury stigma may manifest at the public stigma level proposed in the NSSI Stigma Framework.

Chapter 5

The fourth study is presented in Chapter 5. Comprising two parts, this study involved the development and validation of the Self-Injury Stigma Scales, which are a set of four 18-itme scales (public, self, anticipated, and enacted stigma), each comprising four factors (origin, concealability, peril, disruption). In part one of the study, I developed a large pool of potential items using the NSSI Stigma Framework as a guide. Using correlational and exploratory factor analyses, I reduced the item pool before piloting it to a new sample in part two of the study. I then conducted psychometric evaluations. Using a series of confirmatory factor analyses, I established the factor structure and examined measurement invariance. I then assessed reliability and convergent and divergent validity. The results demonstrated that the Self-Injury Stigma Scales are psychometrically sound.

Chapter 6

The final chapter concludes the thesis with a discussion of the contributions of the present work and their implications for future research.

Chapter 2

Stigma and NSSI: Application of a Conceptual Framework

As alluded to in the introduction, self-injury stigma comprises the interaction of mental illness-related, behavioural, and physical stigma elements. Therefore, existing theories of stigma may not adequately capture self-injury stigma and therefore limit our understanding of the phenomenon. The aim of the first study was to develop a theoretical framework of NSSI stigma that incorporated the elements unique to self-injury stigma. To do so, I conducted a literature review of self-injury stigma research and integrated multiple conceptualisations of stigma to form an integrated model of NSSI stigma.

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Attributions

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Abstract

Nonsuicidal self-injury (NSSI) is a stigmatized behaviour that involves intentionally damaging one's own body, usually by cutting or burning the skin. Despite evidence that NSSI is stigmatized, the processes underlying NSSI stigma and associated outcomes are poorly understood. Given associations between NSSI and mental illness, NSSI may incur mental illness–related stigma. Additionally, NSSI is self-inflicted, which violates societal expectations of self-preservation, resulting in stigmatization. Finally, NSSI leaves physical marks in the form of wounds and scars that are subject to stigmatization. These behavioural and physical aspects of NSSI mean that a mental illness stigma lens may not holistically capture the experience and process of NSSI stigma. Understanding the manifestation and experience of NSSI stigma is a critical step toward stigma reduction. Given the incipient nature of research in this area, we have a unique opportunity to provide a theoretically grounded foundation to stimulate future work. In this article, we draw on theoretical perspectives to demonstrate the complexity of NSSI stigma and identify possible constructs that may underlie the development and experience of NSSI stigma. We then provide a theoretically and empirically informed framework to guide future work in this area.

Introduction

Nonsuicidal self-injury (NSSI) is damage caused to one's body without suicidal intent (International Society for the Study of Self-Injury, 2022), and is a relatively common behaviour, with prevalence rates of 17.2% for adolescents, 12.5% for young adults, and 5.5% for adults (Swannell et al., 2014). NSSI is most often used as a way to manage painful and/or unwanted emotions, and typically takes the form of cutting, burning, or hitting oneself (Cipriano et al., 2017). While not always coinciding with a mental illness diagnosis, NSSI may be related to mental health difficulties and is associated with heightened psychological distress (Bentley et al., 2015). Although enacted without intent to die, NSSI confers significant risk for immediate physical harm and later suicidal thoughts and behaviour (Kiekens et al., 2018).

Despite advancements in understanding the behaviour, NSSI is highly stigmatised and often misunderstood. Common misconceptions include that it is an attention-seeking or manipulative behaviour (Lewis et al., 2014; Lloyd et al., 2018; Sandy, 2013; Scourfield et al., 2011), circumscribed to teenagers (Hughes et al., 2017; Oldershaw et al., 2008) or girls (Lewis et al., 2014), that it is suicidal (Kumar et al., 2004), or superficial and transitory (Mitten et al., 2016; Oldershaw et al., 2008). These misconceptions generate stereotypes about NSSI that may result in prejudice and discrimination in the form of negative judgements (Long, 2018), reduced access to services (Anonymous, 2016), or removal of autonomy (Parker, 2018). People who self-injure may internalise NSSI stereotypes, resulting in diminished self-esteem and a reluctance to seek support (Chandler, 2014; Long, 2018), despite the potential benefits of doing so (Hasking et al., 2015). These experiences are consistent with stigma, and while the process and experience of stigma are well-documented in other fields (e.g., HIV, mental illness; Jackson-Best & Edwards, 2018), surprisingly little is known about how stigma develops and occurs in the context of NSSI.

NSSI stigma likely comprises an interaction of behavioural, physical and mental illness stigma. Self-injury is a behaviour often associated with mental illness that may leave physical evidence in the form of wounds and scars. Because NSSI is self-inflicted, it violates society's understanding of self-preservation and may be stigmatised for being a socially "deviant" behaviour (Adler & Adler, 2007). Additionally, due to associations between NSSI and mental illness, it is likely that NSSI attracts mental illness stigma. Finally, NSSI often results in wounds or scars that can be long-lasting and visible to others (Lewis, 2016; Lewis & Mehrabkhani, 2016), which adds an additional layer of complexity to the stigma experience

for people with lived experience. Therefore, a holistic understanding of the process and experience of NSSI stigma must be approached with these three components in mind.

In the following paper, we provide a brief description of stigma, drawing on established theoretical perspectives. We then explore how NSSI stigma may be evident at a broad public level and at an individual level, including experiences of self-directed, anticipated, and enacted stigma. Using Jones and colleagues' (1984) model, we then identify constructs that may underlie the development of NSSI stigma. Finally, we propose a theoretically informed framework that considers the unique interplay of behavioural, physical, and mental illness stigma. This framework can be used guide future theoretical developments and empirical work in this area.

NSSI Stigma

Conditions, behaviours, personal characteristics, and other marks deemed to be socially unacceptable are frequently subject to stigmatisation (Goffman, 1963). Stigmatisation occurs through a process of labelling, stereotyping, separation, and discrimination (Link et al., 2004). A person is first identified on the basis of a mark and labelled accordingly. A set of usually negative characteristics known as stereotypes are then applied to the individual (e.g., "dangerous", "unpredictable") and symbolic separation is made possible, whereby a labelled person becomes an "other." An emotional response is subsequently elicited (e.g., fear, pity), which contributes to discrimination. Discriminatory behaviours may be overt (e.g., rejection of job application) or subtle (e.g., reduced funding for the relevant condition) and may operate through external forces or arise within the self.

As a phenomenon that emerges within social interactions, stigma is inexorably embedded within social structures such as gender, class, and ethnicity (Scambler, 2006). Understanding stigma must therefore be informed by an acknowledgement of the power and privilege associated with these social structures, as well as a critical evaluation of the social institutions that allow, perpetuate, or even encourage stigma (Scambler, 2004). A multi-level approach to conceptualising stigma in any given context may help to direct attention to these macro issues while simultaneously appreciating lived experience.

At the broadest level, public stigma emerges in the stereotypes about a given mark and gives rise to a range of stigmatising experiences, including prejudice and discrimination (Corrigan & Watson, 2002). These experiences of prejudice and discrimination are referred to as enacted stigma and may manifest in experiences such as being denied access to a service due to mental illness (Scambler, 1998). The expectation of such experiences may result in anticipated stigma (Quinn & Chaudoir, 2009), and the internalisation of stereotypes can result

in self-stigma (Corrigan & Watson, 2002). In the context of NSSI, there is a small but developing body of work demonstrating that NSSI stigma is present across public, self, enacted, and anticipated levels (Breen et al., 2013; Burke et al., 2019; Lloyd et al., 2018; Mitten et al., 2016; Piccirillo et al., 2020; Rosenrot & Lewis, 2018).

Public NSSI Stigma

Public NSSI stigma is reflected in the attitudes of some healthcare workers, teachers, parents, and members of the general public. Negative attitudes toward NSSI have been reported by medical staff, particularly within emergency departments (Karman et al., 2015; Saunders et al., 2012), with nurses sometimes perceiving people who self-injure as “time-wasters” and less deserving of care than other patients (Cook et al., 2004; Gibb et al., 2010; Sandy & Shaw, 2012). Similar views are also expressed by some psychologists (Gagnon & Hasking, 2012), teachers (Berger et al., 2014; Berger et al., 2015; Heath et al., 2011), and vocational rehabilitation providers (Lund et al., 2018). Attitudes such as these may impact care provision and/or rapport, and potentially result in a reduced likelihood that an individual will seek support for self-injury in the future. People with lived experience may internalise these attitudes, possibly leading to self-stigma (Long, 2018).

Some parents of adolescents who have self-injured report negative reactions to NSSI, describing emotions of horror, shock, and devastation to finding out their child has self-injured (Hughes et al., 2017; Kelada et al., 2016; Oldershaw et al., 2008). Parents may express beliefs that NSSI is manipulative and transitory, a behaviour that adolescents use to get their own way, and/or one that they will simply outgrow (Hughes et al., 2017; Oldershaw et al., 2008). While these reactions and attitudes may reflect concern for their child’s wellbeing, they can also reflect judgment and prejudice, which may lead to poor interactions and the child feeling unsupported (Wadman et al., 2017). Peers of young people who have self-injured may also express negative attitudes, describing their peers as “attention-seeking”, or believing that they waste doctors’ time (Klineberg et al., 2013, p. 7). In a qualitative investigation of public attitudes to self-harm (which, unlike NSSI, encapsulates both suicidal and non-suicidal actions; Kapur & Gask, 2009) participants largely expressed sympathy toward people who self-injure, however, when describing societal attitudes toward self-injury, participants suggested that society perceives people who self-injure negatively (e.g., as “nut jobs”) and that society endorses common misconceptions about NSSI (e.g., goth/emo stereotypes, behaviour isolated to teenagers). The latter attitudes may be a more accurate representation of participants’ views toward self-injury, given that people tend to downplay negative attitudes when asked directly (Scocco et al., 2012).

Recent quantitative work has also demonstrated stigma toward NSSI. Lloyd et al. (2018) found that participants were likely to express negative emotional reactions (e.g., anger) toward people who have self-injured, especially if the participant attributed blame toward the individual. Additionally, participants tended to perceive NSSI as manipulative, particularly if the person who had self-injured discloses their self-injury (Lloyd et al., 2018). NSSI stigma has been further evidenced in recent experimental research. Burke et al. (2019) compared implicit and explicit attitudes toward NSSI scarring, nonintentional scarring, and tattoos using self-report measures and an Implicit Association Test. A significant negative bias toward people with self-injury scars was found across both implicit and explicit measures, suggesting that these scars may be more stigmatised than other types of scars (Burke et al., 2019). Participants were also more likely to rate people with self-injury scars as bad, rejection-worthy, and dangerous, and less likely to accept people with self-injury scars as a friend, roommate, or romantic partner. Taken together, these works demonstrate empirical evidence of public NSSI stigma.

Finally, stigma is a socially communicated phenomenon informed by multiple complex representations of perceived normalcy (Bos et al., 2013). Public NSSI stigma is likely embedded within a shared ideology that is subtly proliferated across multiple modes of communication, such as direct social interactions, inadvertent observations, and mass media (Stangor & Crandall, 2000). There is evidence to suggest that mass media plays a significant role in the propagation of negative attitudes toward people with mental illness (Chan & Yanos, 2018), and the same may be true in the context of NSSI (Newton & Bale, 2012). More work is needed to understand how public NSSI stigma is generated and maintained across multiple modes of communication.

Self NSSI Stigma

Self-stigma is the awareness of, agreement with, and application of stigma to self that results in harm (e.g., diminished self-esteem; Corrigan & Rao, 2012). Self-stigma is evident in the context of NSSI through the narratives of those with lived experience. People with a history of self-injury describe feelings of guilt, shame, and embarrassment (Chandler, 2014; Lesniak, 2010; Long, 2018), and may perceive the self as disgusting, stupid, and abnormal (Chandler, 2014; Fortune et al., 2008; Straiton et al., 2013; Wadman et al., 2017). Confusion and self-doubt are also commonly experienced, whereby people who have self-injured worry that NSSI stereotypes (e.g., attention-seeking) are true for them and mean they do not deserve help (Long et al., 2015). These experiences may contribute to diminished self-esteem. People who have a history of self-injury report lower self-esteem than people without (Forrester et

al., 2017), and self-stigma often coincides with poor self-esteem (Corrigan, Larson, et al., 2009); however, the role of self-stigma in this association has yet to be explicitly explored.

Enacted NSSI Stigma

Across multiple settings, people who have a history of self-injury have described both overt and subtle stigma experiences. At hospitals, people have described being reprimanded for the cost of dressings or refused analgesia (Anonymous, 2016). People have faced "freak out" reactions (Long, 2018), been doubted (Lindgren et al., 2004), or labelled as a "freak" or "crazy" (Mitten et al., 2016). People have also faced disparaging comments, such as being described as attention-seeking and stupid (Brown & Kimball, 2012; Klineberg et al., 2013). At school, people have described loss of autonomy (Parker, 2018) or having their disclosure choices removed from them, with their NSSI shared to others without permission (Klineberg et al., 2013). People have also described experiencing unnecessary pity, being treated like they had a disability (Klineberg et al., 2013), or as though they were now "damaged" (Mitten et al., 2016). Experiences of enacted stigma are identified as damaging and reduce future support-seeking (Long, 2018). It is also likely that these experiences have impacts beyond what research has thus far investigated in the context of NSSI (e.g., self-esteem, self-efficacy).

Anticipated NSSI Stigma

Because stereotypes are socially learned scripts, people are aware of them regardless of their relevance to self (Quinn & Chaudoir, 2009). Therefore, when a stereotype becomes relevant to the self (i.e., after a person has engaged in self-injury), an individual may subsequently anticipate negative experiences. Consistent with anticipated stigma, people with a history of NSSI avoid disclosure or support-seeking for fear of judgement or other adverse reactions (Fortune et al., 2008; Hodgson, 2004; Klineberg et al., 2013; Long, 2018; Lund et al., 2018; Rosenrot & Lewis, 2018; Wadman et al., 2017). Anticipated stigma is also evident in efforts to conceal wounds and scars, and attempts to explain them as non-self-injurious (Chandler, 2014; Hodgson, 2004; Long, 2018). Concerns of experiencing stigma, and preoccupation with avoiding stigma have a detrimental effect on an individual's quality of life (Corrigan, Kerr, et al., 2005). Given the perceived need to actively avoid stigmatisation, anticipated stigma may be a more significant barrier to support-seeking than public stigma in the context of NSSI.

The Constructs Underlying NSSI Stigma

Stigma is associated with multiple negative outcomes, including diminished self-esteem and self-efficacy (Corrigan & Rao, 2012; Lannin et al., 2016), reduced help-seeking (Clement

et al., 2015), poor treatment outcomes (Oexle et al., 2018), social isolation (Link et al., 1989), and reduced opportunities across a number of life domains including relationships, employment, and education (Lasalvia et al., 2013). Similar outcomes have been observed for people who have a history of self-injury (Victor & Klonsky, 2014), however, before exploring the impacts of NSSI stigma, we must first understand how and why NSSI is stigmatised, and what characterises stigmatising experiences for people who self-injure. Jones and colleagues (1984) proposed six stigma constructs that underlie the stigmatisation of a mark: origin, concealability, course, peril, disruptiveness, and aesthetics. This model has conceptual value for elucidating which aspects of NSSI are stigmatised and can inform our understanding of the cognitive and emotional processes that may underpin public, enacted, self, and anticipated stigma. In the following section we describe each construct in the context of NSSI to demonstrate the complexities of NSSI stigma.

Origin

Origin relates to how a mark came to exist and is closely tied to controllability. When a mark is perceived as onset-controllable (avoidable or acquired through one's own actions) the person is perceived to be responsible for that mark and is subsequently more stigmatised than if they possessed a mark perceived as uncontrollable (Weiner et al., 1988). For that reason, physical illnesses that are perceived to be behaviourally generated (e.g., lung cancer perceived to be caused by smoking) incur greater stigma than those that are not within a person's control (e.g., Alzheimer's disease; Crandall & Moriarty, 1995). It is likely that origin is a particularly relevant construct in the stigmatisation of NSSI due to its volitional nature. Like other socially rejected behaviours (e.g., drug use; Corrigan, Kuwabara, et al., 2009), NSSI incurs stigma due to perceptions of responsibility - an individual who has brought a circumstance upon themselves is considered undeserving of help (Weiner, 1995). Perceptions of origin seem to directly relate to service provision, especially in a medical setting. People describe being dismissed as low-priority due to the volitional nature of their injuries, even when severe (Brown & Kimball, 2012).

Stereotypes of attention-seeking and manipulation may stem directly from misunderstandings of NSSI origin (Borrill et al., 2012). People tend to perceive self-injury as directly the fault of the person engaging in it (Newton & Bale, 2012). While NSSI is ultimately volitional, a lack of understanding about why people self-injure may inform the tendency to assign blame that allows judgement and discrimination. Indeed, people tend to be less stigmatising when provided with an explanation for NSSI (Borrill et al., 2012; Law et al., 2009; Newton & Bale, 2012; Nielsen & Townsend, 2018). Despite a tendency to perceive

NSSI as having a person-centred origin, people may also believe NSSI to originate from mental illness. In Newton and Bale's (2012) interviews with members of the general public, people expressed mixed opinions on the relevance of mental illness to self-injury. People seemed to reject the notion that NSSI is a mental illness, but endorsed the idea that emotional difficulties must be present (Newton & Bale, 2012). Participants were also inclined to use mental illness narratives in a derogatory manner. For example, one person stated "...it's gotta be something mentally wrong with somebody to do it [self-injure]" (Newton & Bale, 2012, p. 111). Nonetheless, it was evident that sympathy may increase toward people who have self-injured if there was evidence of mental illness; participants seemed to hold an individual less responsible for their self-injury if they could attribute the reason to mental illness.

The origin construct is complicated in the context of NSSI due to the interaction of behavioural and mental components. NSSI is enacted directly toward the self and may therefore be perceived as controllable, and it has connotations of mental illness that may or may not alter perceptions of responsibility. Based on the findings outlined, people seem to have limited understanding of why a person may self-injure and as a result, default to a cognitively simpler explanation - the person who self-injured is to blame and therefore does not deserve help.

Concealability

Concealability refers to the degree to which a mark may be hidden, with some marks completely unconcealable, others concealable sometimes or partially, and some completely concealable. An unconcealable mark is one that is visibly or audibly obvious to others and might include marks such as wheelchair use and skin colour, whereas concealable marks are those that can be withheld or hidden, such as mental illness or HIV status (Quinn & Earnshaw, 2013). Some marks are easier to conceal than others; a person who exclusively uses a wheelchair cannot hide this mark as easily as a person who sometimes uses a walking aid. Similarly, a physical stigma, such as wheelchair use, is more difficult to conceal than a symbolic stigma like mental illness (Corrigan, Kuwabara, et al., 2009). An unconcealable mark may be more readily susceptible to stigma, as it is observable (Quinn & Earnshaw, 2013); however, a concealable mark may be stigmatised due to a perception that it is not a "genuine" illness (Jutel & Conrad, 2011). In the context of NSSI, this means that marks caused by self-injury may be subject to stigma because they are visible, however, the connotations of mental illness that coincide with self-injury may incur stigma associated with it being perceived as an illegitimate concern.

NSSI often leaves marks in the form of bruising, burns, scratches or cuts that can result in scarring (Lewis, 2016; Lewis & Mehrabkhani, 2016). Many people with a history of self-injury report at least one permanent scar (Burke et al., 2016), and scarring caused by cutting the skin tends to be easily recognisable (Ho et al., 2018). The concealability of scars may vary person to person, depending on variables such as location on the body and severity of the injury, which may give rise to different stigma experiences. A person may be at greater risk of experiencing stigma if their scarring is located in a highly visible area (e.g., forearms) compared to a more easily concealed location (e.g., upper thighs), or if the scarring is severe (e.g., raised) or populous (Lewis, 2016; Lewis & Mehrabkhani, 2016).

A person may be more likely to be labelled an attention-seeker if they have more visible scarring due to assumptions that location is related to attention-seeking intentions (Crouch & Wright, 2004; Scourfield et al., 2011) and an expectation that unless NSSI is kept hidden, it is attention-seeking (Klineberg et al., 2013; Scourfield et al., 2011). In addition to the likelihood that objective visibility relates to public and enacted NSSI stigma (e.g., Klineberg et al., 2013), the perception of visibility for a person who has self-injured is likely important for consideration of self-stigma (Burke et al., 2017; Lewis & Mehrabkhani, 2016). Indeed, subjective ratings of scar severity are associated with psychosocial distress for a range of scar types, including those from self-injury (Brown et al., 2010).

Concealability in the context of NSSI is further complicated by the conflation between NSSI and mental illness. While mental health difficulties are, for the most part, invisible, self-injury is often not, and while self-injury may be concealable, it could act as a visible marker for mental illness (Burke et al., 2017). A person who self-injures is therefore at risk of experiencing mental illness stigma (even if they do not have a mental illness) due to the potential perception that self-injury is a "physical manifestation of mental illness" (Burke et al., 2017, p. 546). Interestingly, while mental illness may incur stigmatisation due to its lack of visibility (seen as "less real" due to its invisibility; Jutel & Conrad, 2011, p. 13), self-injury as a marker for mental illness may not improve perceptions of mental illness. Instead, self-injury is likely doubly stigmatised, both for being indicative of a mental health difficulty and for being an onset-controllable behaviour. Thus, NSSI stigma is complicated by the simultaneously visible/hideable nature of self-injury, and its association with mental illness.

Course

Course refers to how a mark is perceived to change over time. A person may be held responsible for the course of their condition through the process of offset-attribution (stigmatisation for not taking necessary action to alleviate their condition; Weiner, 1995).

However, the course of self-injury is unlikely to be a linear process, and cessation may be indefinite or temporary (Kelada et al., 2018; Lewis et al., 2019). In the context of NSSI, the volitional nature of the behaviour is likely to generate strong offset-attributions that may lead to stigmatising responses towards people who have not stopped self-injuring. This can be seen in some nursing contexts in which nurses experience greater frustration toward patients who have sought medical assistance on multiple occasions for self-injury (Sandy & Shaw, 2012).

The relevance of course to NSSI stigma may differ depending on whether a person has ceased self-injury. To be self-injuring may carry the stigma of being somebody who hurts themselves intentionally and the stigma of having scars from such injuries. A person who no longer self-injures may be able to shed the stigma of current self-injury yet carry the self-stigma of having done so, and the potential ongoing stigma of NSSI scarring. As such, the experience of stigma does not necessarily dissipate once an individual stops self-injuring. Indeed, this expectation is evident in concerns that NSSI may impact future career prospects (Long, 2018), particularly given self-injury scars are more stigmatised than other scars (Burke et al., 2019), and may signal stereotypes regardless of whether the individual still engages in self-injury. An additional complication, which has implications for ongoing enacted and self-stigma, is that the often permanent nature of scars could also, perhaps inaccurately, signal ongoing mental illness.

Peril

Peril traditionally refers to the level of danger a person poses to others. The more dangerous a mark is perceived to be, the more stigmatised the marked person tends to be. For physical stigmas, social avoidance stems from the fear that the mark poses the risk of infection, even for marks that are not contagious (Oaten et al., 2011). For symbolic stigmas, peril relates to fear for personal safety, and social avoidance stems from inaccurate perceptions that people who have mental illness are dangerous and unpredictable (Corrigan & Watson, 2002). There appears to be a dichotomy in the way potential peril associated with NSSI is viewed. Some see NSSI as inherently related to suicidal behaviour and thus highly perilous (Kumar et al., 2004; Long, 2018), while others tend to dismiss the behaviour as attention-seeking and inconsequential (Long, 2018; Newton & Bale, 2012).

Damage to the body can be seen as inherently perilous. People may injure themselves more severely than intended (Rissanen et al., 2009), and NSSI can result in accidental death (Lofthouse & Yager-Schweller, 2009). For this reason, NSSI is sometimes perceived as dangerous, or associated with high peril (Lloyd et al., 2018). While marks that are associated

with higher levels of peril tend to be more highly stigmatised, the understatement of the importance of NSSI may, in fact, reflect stigma. Refusal (or inability) to perceive NSSI as a significant health concern renders it illegitimate, which translates to discrimination in the form of poor treatment and support across multiple settings (Anonymous, 2016; Berger et al., 2014; Karman et al., 2015; Mitten et al., 2016).

Additionally, fear of “social contagion” of NSSI is rife, with many believing that NSSI “spreads” through peer groups, being passed on from one person to another. While social influences may be involved in NSSI, the notion that it is a “contagious” behaviour perpetuates harmful stereotypes that NSSI is attention seeking, enacted for peer approval, or isolated to certain sub-cultures (for a detailed commentary, see Hasking & Boyes, 2018). Teachers and parents in particular tend to perceive NSSI as a “contagious” behaviour (Berger et al., 2014; Rissanen et al., 2009). This fear of “contagion” leads to policies to avoid talking about NSSI (Parker, 2018) and encouraging people who self-injure to conceal their scars (despite evidence that acceptance of scars can be part of the healing process; Bachtelle & Pepper, 2015; Lewis et al., 2019), which may perpetuate stigma and reduce help-seeking (Parker, 2018).

Aesthetics

Aesthetics refers to how visibly displeasing a mark is. People tend to equate attractiveness with morality, meaning that if a person is perceived to be unattractive, they may be perceived as bad or immoral (Jones et al., 1984). Aesthetics is most commonly associated with physical stigmas, and marks that cannot be hidden, although a concealable stigma is still subject to an aesthetics evaluation when it is revealed. Physical marks that are considered to be visibly displeasing are more highly stigmatised than those that are not considered to be visibly displeasing. Therefore, NSSI is likely to incur stigma as a result of the displeasing appearance of injuries and scars. It follows that more evident or extensive injuries are likely to incur more stigma. People who self-injure have reported that others find their scars “ugly” and “gross” (Mitten et al., 2016) or describe NSSI as a “disgusting” behaviour (Rissanen et al., 2009). People who have a history of self-injury have discussed feelings of ambivalence, acceptance, and shame when discussing their scars (Chandler, 2014; Lewis & Mehrabkhani, 2016), meaning that others’ perceptions of scarring may or may not be internalised.

The subjective aesthetic quality of self-injury and its resulting scars is important to consider because the physical component of NSSI is potentially the most salient and stigma-provoking attribute of the behaviour. The interaction between aesthetics and concealability

may add an additional complexity to NSSI stigma. For example, a person who perceives their scars as beautiful and representative of strength may experience less self-stigma than a person who sees their scars as ugly and shameful (Mitten et al., 2016). Efforts to conceal scars may directly relate to these aesthetic evaluations, which may then give rise to different experiences of enacted or anticipated stigma. Someone who accepts their scars may be less likely to cover them and thus more likely to be exposed to stereotype, prejudice, and discrimination. In contrast, someone who does not accept their scars may be more likely to conceal them, decreasing risk of exposure.

Disruptiveness

Disruptiveness refers to the impact a mark has upon relationships, and according to Jones and colleagues (1984) is the least clearly demarcated construct, as it tends to capture evidence of stigma rather than reasons for it. Marks that interfere with relationships tend to be more highly stigmatised than those that have limited impact on personal interactions. In the context of NSSI, disruptiveness likely varies depending on the nature of the relationship. NSSI is unlikely to cause major disruption to general interactions, given its capacity to be concealed; however, it may cause significant disruption to close or romantic relationships. Impacts to close relationships may stem from concern for the person who has self-injured that plays out in a damaging way. For example, a parent may respond to a child's NSSI by removing autonomy or expressing anger, which may cause the child to withdraw, disrupting feelings of trust and safety (Ferrey et al., 2016; Hughes et al., 2017). Within the broader family dynamic, NSSI may catalyse sibling tensions (Tschan et al., 2019) or elicit judgment and blame from extended family (Ferrey et al., 2016). Within friendships and romantic relationships, avoiding conversations about NSSI has been described as a common response to disclosure, which can lead to an individual feeling unsupported (Rosenrot & Lewis, 2018). Yet, when a loved one is urging an individual to stop self-injuring - and they do not - this can put pressure on the relationship.

Disruptiveness may also be relevant beyond interpersonal interactions and extend to activity choices that indirectly impact socialisation. For example, people trying to conceal evidence of self-injury may avoid going to the beach, playing sport, or entering romantic relationships (Hodgson, 2004). Anticipation of social disruption may motivate avoidance of certain activities or disclosure reluctance; indeed, fear of burdening family has been cited as a barrier to disclosure (Rosenrot & Lewis, 2018). NSSI may also disrupt relationships with the self, possibly generating self-hatred (Breen et al., 2013). Both anticipated and enacted experiences of disruption are likely to be particularly relevant to self-stigma.

A Framework for NSSI Stigma

NSSI is subject to public, self, enacted, and anticipated stigma. The reasons for this stigmatisation are complex due to the presence and interaction of the physical, behavioural, and mental illness components of stigma. NSSI is typically perceived to be a mental health difficulty (Newton & Bale, 2012) and therefore incurs mental illness stigma, it is self-inflicted and therefore incurs behavioural stigma, and it frequently leaves evidence in the form of wounds and scars (Lewis & Mehrabkhani, 2016), therefore incurring physical stigma. NSSI stigma is further complicated by the interactions between, and tensions within, each stigma construct, meaning that the application of existing conceptualisations may not be able to capture important aspects of how NSSI stigma operates or is experienced. For example, a mental illness stigma lens may not capture the complexities found within the origin construct, where responsibility and blame are complicated by the behavioural and mental components of NSSI.

While research suggests that NSSI stigma is widely expressed and experienced, most of these findings are ancillary and emerge from work investigating other elements of NSSI (e.g., recovery, scarring). There has been relatively little attention directed at understanding the processes underlying the stigmatisation of NSSI, much less an evaluation of how the field should approach such a task. Exploring the constructs underlying stigma, and the many ways in which it may be experienced, begins to paint a picture of the complex nature of NSSI stigma. In line with the levels of stigma (i.e., public, enacted, self, anticipated), we have provided theoretically and empirically driven examples of how each stigma construct may manifest in the context of NSSI (see Table 2.1). For example, when considering NSSI origin, public stigma is evidenced in the tendency to blame an individual for their self-injury without considering precipitating reasons.

Within the same construct, self-stigma is evidenced by negative views toward the self in relation to the origin of self-injury; for example, shame and embarrassment are common. Then, at the level of anticipated stigma, concerns about how others will perceive NSSI origin emerge in expectations of being blamed or labelled as an attention-seeker (Lesniak, 2010). Finally, at the level of enacted stigma, beliefs about the origin of NSSI inform poor treatment, such as denying a person who has self-injured analgesia due to the belief that self-injury was motivated by a desire for pain (Anonymous, 2016). In providing examples at each level of stigma and within each stigma construct, we have presented a holistic conceptualisation of how NSSI stigma manifests within a framework that can direct relevant research questions and guide future work.

Table 2.1

A Framework for Conceptualising NSSI Stigma

	Public Stigma	Self-Stigma	Anticipated Stigma	Enacted Stigma
Origin	*What the public think about the origin of NSSI*	*What an individual thinks/feels about the origin of their own NSSI*	*What an individual expects from others re: the origin of their NSSI*	*How people are treated as a result of beliefs about NSSI origin*
	"It's their own fault"[1(pg. 110)] Belief that only those with mental illness self-injure[1] Belief that people who self-injure enjoy pain[2]	Shame, guilt, embarrassment "I've felt it was inconceivably pathetic of me to do it"[3(pg. 81)]	Expectations of blame "I felt as though … they would think I was being a stupid attention-seeker, or it was just my hormones"[4(pg. 7)] Falsifying origin of wounds/scars[5,6]	Being denied analgesia[2] "… is it just you attention seeking?"[7(pg. 124)]
Concealability	*How concealability influences public attitudes toward NSSI*	*How NSSI concealability influences an individual's perceptions of self*	*How concealability influences an individual's expectations of others*	*How people are treated as a result of beliefs about NSSI concealability*
	NSSI scars tend to be recognisable as self-inflicted[8] Marker for mental illness[9] Visible = attention seeking or manipulative[10,11] Not a "real" problem[12]	Feelings of shame[6,13] Falsifying narratives[5,6] Negative feelings toward scars[14,15]	Hiding/covering/removing scars[14,5,6] Avoiding activities (e.g., swimming)[5] Injuring concealable areas of the body[6,13,7]	Being instructed to hide/cover scars or being forced to prove NSSI[16] Labelled as attention-seeking due to visibility of scarring[10,17]
Course	*What the public think about the course of NSSI*	*How an individual perceives the course of their own NSSI*	*What an individual expects others to think about the course of their NSSI*	*How people are treated as a result of beliefs about the course of NSSI*
	Belief that NSSI is suicidal[1,16] Belief that NSSI can easily be stopped[7] Frustration with continued self-injury[18]	Ongoing urges, notions of recovery[7,19] Visible scars as triggering[9]	Fear of impact to career prospects[20] Scars do not necessarily indicate current self-injury[14]	"Just stop it" Judgement from others leading to continued self-injury[21] Being told how expensive dressings are[1]
Peril	*What the public think about the peril of NSSI*	*How an individual perceives the peril of their own NSSI*	*What an individual expects others to think about the peril of their NSSI*	*How people are treated as a result of beliefs about the peril of NSSI*

	Conflation of NSSI and suicide[16] Belief that NSSI is contagious[22,23]	Possible self-directed beliefs about one's own "contagion" or mental stability	Fear of being labelled/perceived as suicidal[6,20] "I did not feel it was serious enough for help"[4(pg. 6)]	Not talking about it; being forced to cover scars[16] Being forced to admit to being suicidal, even when not[6] Being put on suicide watch[24] Lack of follow-up due to perception that NSSI is nonserious[21]
Aesthetics	*What the public think about the aesthetics of NSSI*	*What an individual thinks/feels about the aesthetics of their own NSSI*	*What an individual expects others to think about the aesthetics of their NSSI*	*How people are treated as a result of beliefs about the aesthetics of NSSI*
	"…you know big gashes down their arm, you'd think oh my God"[1(pg. 110)]	Feeling disgust toward own scars[12,23] Scarring as a trigger for continued self-injury[14]	Hiding/covering/removing scars[5]	Aversive reactions to scars "…oh that's so gross"[12(pg. 9)]
Disruptiveness	*How the public believe NSSI disrupts relationships*	*How an individual perceives their NSSI has disrupted relationships*	*How an individual expects their NSSI to disrupt relationships*	*How NSSI disrupts relationships*
	"Wasting doctor's time"[10(pg. 7)] Using ED resources (e.g., time, dressings)[2]	May disrupt relationship with self[25] Feeling isolated/unsupported[13]	Change in activities/ behaviours (e.g., no longer going to the beach)[5] Avoiding disclosure to avoid disruption[7] Pretending to be okay[20]	Arguments with loved ones[7] Impact to family dynamics[26,27] Increased bullying or social isolation[12]

References: [1]Newton & Bale, 2012; [2]Anonymous, 2016; [3]Straiton et al., 2012; [4]Fortune et al., 2008; [5]Hodgson, 2004; [6]Lesniak, 2010; [7]Wadman et al., 2017; [8]Ho et al., 2018; [9]Burke et al., 2017; [10]Klineberg et al., 2013; [11]Lloyd et al., 20128; [12]Mitten et al., 2016; [13]Rosenrot & Lewis, 2018; [14]Chandler, 2014; [15]Lewis & Mehrabkhani, 2016; [16]Parker, 2018; [17]Crouch & Wright, 2004; [18]Sandy & Shaw, 2012; [19]Lewis et al., 2019; [20]Long, 2018; [21]Long et al., 2015; [22]Berger et al., 2014; [23]Rissanen et al., 2008; [24]Kumar et al., 2004; [25]Breen et al., 2013; [26]Ferrey et al., 2019; [27]Tschan et al., 2019.

Limitations

In synthesising multiple conceptualisations of stigma, we acknowledge that there are potential theoretical gaps in our framework. Because we were guided by a psychological lens, the behavioural and physical components of the framework may be limited. Given that this framework is a first attempt at combining these perspectives in the context of NSSI, we have no doubt that the framework will evolve over time as the more research is generated. Additionally, while the framework is theoretically robust and grounded in available evidence, it is limited by a sparsity of NSSI stigma research. Further empirical work is required to validate this framework and determine whether the components operate in the proposed manner. Finally, while we have acknowledged the importance of power in our overview of stigma theory, further research is required to understand how power contributes to NSSI stigma within the proposed framework.

Future Directions

A fruitful starting point may be to investigate the types of messages that are conveyed about self-injury at a broad societal level, given that stereotypes are socially learned scripts that inform prejudice and discrimination (Corrigan, 2000). Mass media can be a vehicle for the communication of stereotypes (Frankham, 2019), and presents an important avenue for investigating messaging about NSSI. Exploring how NSSI is portrayed by news and other popular media may give important insights into the development of public NSSI stigma. For example, if media consistently purports NSSI to be "contagious", this may inform public notions of origin and peril, which contribute to harmful stereotypes and generate public stigma. This may also inform understanding of the development of self-stigma; if people who self-injure are exposed to stigmatising attitudes through mass media, these attitudes may be internalised, contributing to self-stigma. While media representations of self-injury are beginning to be explored (e.g., movies; Trewavas et al., 2010, online; Brown et al., 2018; Lewis & Seko, 2016), more work in this area is needed.

Investigating if media messages about NSSI translate into attitudes and beliefs at a community level will be an important next step, if we are to understand the extent of public NSSI stigma and how it develops and functions. While some research has investigated public attitudes towards NSSI (Law et al., 2009; Lloyd et al., 2018; Nielsen & Townsend, 2018), important constructs (e.g., aesthetics, peril, concealability) may not be captured within the attribution-affect framework used, leaving facets of NSSI stigma uninvestigated. Other research (e.g., Newton & Bale, 2012) has focused on self-harm more broadly, which tends to encompass both suicidal and nonsuicidal actions, meaning a clear picture of NSSI stigma

cannot emerge. To understand, and ultimately reduce NSSI stigma, research with the general community needs to be informed by questions specific to NSSI that draw on the complexities discussed here, and focus on constructs relevant to self-injury, such as aesthetics, peril, and concealability.

Explicitly exploring the experiences of NSSI stigma for people with a history of self-injury is vital. While stigma experiences have emerged in other work (e.g., Mitten et al., 2016), these findings are ancillary and limited in scope. Understanding which stigma constructs are most salient for people who self-injure can inform directions for future research. From this we can also gain a better understanding of the differentiation between self, enacted, and anticipated stigma for people with lived experience, and how each may be associated with outcomes such as support-seeking, recovery, and self-esteem. Additionally, the development and evaluation of efforts to reduce NSSI stigma will need to occur. Programs designed to improve attitudes toward self-harm have demonstrated efficacy for nurses (Gibson et al., 2019), and the utility of NSSI-specific stigma reduction programs should be investigated.

Conclusion

The model proposed by Jones et al. (1984) provided a conceptually sound and empirically supported scaffold for us to build upon in the context of NSSI (Pachankis et al., 2018). By considering how the constructs of NSSI stigma manifest at various levels (i.e., public, enacted, self, and anticipated), we have proposed a multi-level framework that encourages a holistic investigation of NSSI stigma. The growing awareness of intersectional stigma (Turan et al., 2019) points to the importance of considering multiple facets of a single stigma experience, and there is scope to introduce additional layers of complexity to this framework, such as the influence of culture or gender on NSSI stigma.

This framework may also have utility beyond a research context. While there are some interventions available to address self-stigma of mental illness (Corrigan & Rao, 2012), this framework may provide guidance as to where clinicians could direct attention when working with clients who have self-injured. An understanding of how anticipated and self-stigma influence lived experience may therefore inform better outcomes for people with lived experience of self-injury seeking therapeutic support. Additionally, this framework may be able to inform the reduction of stigma. While educational programs exist to reduce NSSI stigma in a medical context (e.g., Gibson et al., 2019), addressing the specific constructs underlying NSSI stigma may yield more efficacious stigma reduction efforts that could be broadened to the wider public.

Despite the multifarious impact of stigma, research investigating and addressing NSSI stigma is lacking. Given the sparse nature of this research, we have a unique opportunity to establish a theoretically grounded foundation that can guide meaningful research questions. By incorporating robust conceptualisations of stigma, the framework we have presented offers a holistic approach that illuminates both procedural and experiential facets of NSSI stigma. We hope that this paper acts as a call-to-action for fellow researchers interested in improving the lives of people with lived experience of NSSI.

Chapter 3

Crazy, Weak, and Incompetent: A Directed Content Analysis of Self-Injury Stigma Experiences

In the previous chapter, I proposed an empirically informed and theoretically grounded framework through which to understand and investigate self-injury stigma. While the framework was developed based on existing research and an integration of existing stigma models, the applicability of the framework to lived experiences of self-injury stigma was unknown. In this chapter, I apply the NSSI Stigma Framework to a set of responses to open-ended questions relating to stigma, using a directed content analysis. This chapter provides preliminary evidence for the applicability and utility of the NSSI Stigma Framework in conceptualising NSSI stigma.

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Attributions

Author	Contribution	Acknowledgement
Lexy Staniland	Development of research question and methodology, data management and analysis, interpretation of results, and manuscript preparation	
Penelope Hasking Stephen Lewis Mark Boyes	Assisted with development of research question, interpretation of results, and manuscript preparation	
Sylvanna Mirichlis	Assisted in data analysis, and establishing inter-rater reliability	
Permission for inclusion can be found in Appendix B.		

Abstract

Despite significant impacts to mental health and support-seeking, nonsuicidal self-injury (NSSI) stigma remains under-studied and poorly understood. Recently, Staniland et al. (2021) conceptualized NSSI stigma as comprising six constructs (origin concealability, course, peril, aesthetics, disruptiveness) that manifest across four perspectives (public, self, anticipated, enacted). The present study investigates the extent to which this framework can account for individuals' NSSI stigma experiences using a directed content analysis. Written responses from 99 university undergraduates (Mage = 21.5, SD = 3.7; 83.8% female) generated 731 data units for analysis, of which 299 (40.9%) were coded.

Results demonstrated support for the public and enacted contexts, with participants describing stigma experiences within friendships, families, schools, and workplaces. Data pointed to both direct and indirect experiences of public stigma, suggesting a more nuanced understanding of this context is required. While there was sufficient support for a majority of elements, more work is needed to verify the applicability of the self and anticipated contexts. Our findings contribute to a growing body of research investigating NSSI stigma and provide preliminary support for the utility of the NSSI Stigma Framework in identifying multiple facets of NSSI stigma. Implications for intervention and future research are discussed.

Introduction

Nonsuicidal self-injury (NSSI) is the intentional, self-directed damage done to one's own body without suicidal intent (ISSS, 2022), and can take many forms, including skin cutting or burning, breaking bones, and self-battery, excluding socially (e.g., piercing) or religiously (e.g., self-flagellation) sanctioned practices (ISSS, 2022). NSSI is relatively prevalent, with 17.2% of adolescents, 13.4% of young adults, and 5.5% adults reporting lifetime prevalence (Swannell et al., 2014), and is engaged in for both intrapersonal (e.g., emotion regulation) and interpersonal reasons (e.g., signaling distress; Klonsky & Olino, 2008). Notwithstanding potential physical damage, NSSI is associated with mental illness and heightened psychological distress, and is a reliable predictor of suicidality (Kiekens et al., 2018). As such, it is important that people who have self-injured feel comfortable and able to access physical, psychological, and/or social support. Unfortunately, most people do not voluntarily disclose their NSSI (Simone & Hamza, 2020), with stigma cited as a significant barrier to disclosure (Staniland et al., 2021).

NSSI Stigma

Stigma is a social construct comprising the stereotype, prejudice, and discrimination of characteristics, conditions, and behaviors deemed socially unacceptable (Goffman, 1963). Conditions and behaviors of psychological origin are often subject to greater stigma than those of physical origin due to perceptions that they are controllable and, therefore, the fault of the individual experiencing them (Pachankis et al., 2018). Such is the case for mental illness (Michaels et al., 2012) and associated behaviors, such as alcohol and drug dependence (Corrigan, Kuwabara, et al., 2009; Schomerus et al., 2011), sexual deviance (Jahnke & Hoyer, 2013), and self-injury (Staniland et al., 2021).

Stigma is galvanized by misconceptions (Link & Phelan, 2001), and in the context of self-injury, these typically relate to who engages in the behaviour and why. For example, a pervasive belief is that NSSI is a form of attention-seeking (Wadman et al., 2017) or manipulation (Sandy, 2013), despite extensive evidence to the contrary (Taylor et al., 2018). Other misconceptions include that NSSI is always suicidal (Kumar et al., 2004), a phase people will "grow out of" (Klonsky et al., 2014), or isolated to teenagers (Hughes et al., 2017), girls/women, or people with mental illness (Lewis et al., 2014).

Despite a paucity of research directly investigating NSSI stigma, qualitative accounts of self-injury experiences often feature themes reflecting NSSI stigma (Hodgson, 2004; Long et al., 2015; Mitten et al., 2016), which is described as a significant barrier to support-seeking (Chandler, 2014; Long, 2018), fomenting shame (Lesniak, 2010) and social isolation

(Rosenrot & Lewis, 2018), potentially increasing frequency and severity of NSSI (Bachtelle & Pepper, 2015). The frequency with which stigma features in these narratives suggests it is a salient and important factor in lives of people who have self-injured. Despite this, only recently has there been an effort to theoretically conceptualize NSSI stigma.

The NSSI Stigma Framework

The NSSI Stigma Framework (Staniland et al., 2021) captures the unique ways in which NSSI stigma emerges, providing a template through which NSSI stigma can be identified, described, and explained. Drawing on two theoretical approaches, the framework is a matrix of intersecting components (Table 3.1). On the left side of the framework, six domains are proposed to underlie NSSI stigma. Drawn from work by Jones et al. (1984), these domains are the constituents of NSSI stigma and identifying what it is about self-injury that leads to stigma.

Origin relates to the onset of NSSI and deals with perceptions and beliefs about why a person has self-injured and who or what should be 'blamed' for it. Perceptions of responsibility lead to blame (Weiner, 1995), and this may inform misconceptions (e.g., that self-injury is manipulative), and discrimination (e.g., withholding treatment). Concealability relates to the visibility of NSSI, with greater visibility argued to lead to greater potential for stigmatization. Course relates to how self-injury changes over time, and includes genuine change as well as perceived and expected changes; for example, the assumption that only teenagers self-injure may inform the expectation that self-injury should cease in adulthood. Peril refers to the perceived lethality of self-injury and captures the paradoxical perceptions that self-injury is both insignificant (e.g., something an individual will 'grow out of') and highly dangerous (e.g., associated with suicide). Aesthetics refers to the subjective appearance of self-injury, with appraisals informing stigmatization. Lastly, disruptiveness refers to the degree to which self-injury impacts relationships. This domain is the least explicit and may differ in relevance depending on the condition or behavior of interest (Jones et al., 1984). In the context of NSSI, disruptions to relationships may arise because of NSSI stigma, rather than stigma arising due to disruptive qualities of NSSI. Across the top of the framework are four contexts within which NSSI stigma may manifest. Drawing on work by Corrigan and Watson (2002) and Quinn and Chaudoir (2009), it is proposed that stigma occurs at the public level (attitudes and beliefs held by the general public), at the self-level (internalization of public stigma), at the enacted level (actions and experiences driven by stigma), and at the anticipated level (expectations of enacted stigma).

Table 3.1
The NSSI Stigma Framework

	Public Stigma	Self-Stigma	Enacted Stigma	Anticipated Stigma
Origin	People who self-injure are just attention seeking.	I feel ashamed for needing to self-injure.	You are just an attention seeker.	I am worried people will think I am attention-seeking.
Concealability	People should not have their self-injury on display.	I must hide my self-injury from others.	You should cover your self-injury.	I cover my self-injury so others won't comment on it.
Course	People who self-injure should just stop doing it.	I am weak for continuing to think about self-injury.	Just stop self-injuring, it's that simple.	I am worried my scars will make people think I am still self-injuring.
Peril	Self-injury is definitely suicidal, even if the person doesn't realise it.	I don't want to end my life, so why am I self-injuring?	I don't believe you when you say you aren't suicidal, so we are sectioning you.	If I talk about my self-injury, people will assume I am suicidal.
Aesthetics	Self-injury is disgusting to look at.	My scars are disgusting to look at.	Wow, your scars are so gross.	I am worried about what people will say or think about my scars.
Disruptiveness	People who self-injure are wasting hospital resources.	I don't deserve medical help for this injury.	My mum said I can't be friends with you anymore because you self-injure.	I am worried that people will reject me if they find out I self-injure.

Note. From "Stigma and Nonsuicidal Self-Injury: Application of a Conceptual Framework" by Staniland et al., 2020.

While the NSSI Stigma Framework (Staniland et al., 2021) is theoretically and empirically grounded, the degree to which it can account for experiences of NSSI stigma has yet to be investigated. Using a directed content analysis (Hsieh & Shannon, 2005) of open-ended responses to an online questionnaire, we examined the extent to which the framework could account for university students' descriptions of NSSI stigma experiences. A directed content analysis is a deductive analytical approach using the proposed variables of a conceptual framework as coding categories (Hsieh & Shannon, 2005). Data is coded according to these categories to investigate the applicability of a framework to a set of data. In the present study, the 24 cells (6 domains x 4 levels of stigma) of Staniland et al.'s NSSI Stigma Framework formed 24 coding categories, which were used to code participants' data, allowing assessment of the framework's applicability.

Method

Measures

Participants completed a battery of measures and open-ended questions related to various NSSI and mental illness experiences. Only the measures used in the present study are reported here.

Demographics

Participants were asked to report their age, sex, whether they had a mental illness diagnosis, and if so, what the diagnosis was.

NSSI

The Inventory of Statements About Self-Injury (ISAS; Klonsky & Olino, 2008) was used to measure NSSI. This measure has good construct validity and test-retest reliability (r = .85), and asks participants whether they have ever self-injured, what their primary form of self-injury was/is, how often they self-injured during the past year, and at what age they first and most recently self-injured.

Stigma Experiences

Participants who reported a mental illness diagnosis or history of self-injury were asked whether they had experienced stigma related to their mental illness or self-injury. Those who answered 'yes' were invited to describe that experience by typing their response into a textbox with no character limit. All participants were asked whether they had overheard people talking about self-injury in a way that made them feel uncomfortable, angry, or upset. Those who answered 'yes' were invited to describe what they overheard, how it made them feel, and how they responded. All participants were asked whether anyone had ever said anything to them directly about self-injury that made them feel uncomfortable, angry, or

upset. Those who answered 'yes' were invited to describe what had been said to them, how it made them feel, and how they responded.

Procedure

After obtaining ethical approval (Appendix C) the study was advertised to an undergraduate psychology research participation pool. All students were eligible to participate, regardless of their personal experiences with mental illness or self-injury. Interested participants were directed to an information sheet on Qualtrics outlining participants' rights and requirements. Participants provided consent by checking a box that routed them to the questionnaire. Part of a larger project about experiences with NSSI and mental illness the questionnaire was available to people with and without experiences of self-injury and/or mental illness, and took approximately 60 minutes to complete and course credit was awarded for participation.

Participants

Of the 239 university students who responded to the Qualtrics survey, 25 completed less than 75% of the survey and 60 did not respond to any of the open-ended questions of interest; these responses were removed. The final sample comprised 149 participants, aged 17-52 years (*M* = 22.31, *SD* = 5.31), with 116 females (77.9%), 24 males (16.1%), and two of another sex (1.%). One-hundred and two (68.5%) participants reported a mental illness diagnosis, with the most common being comorbid anxiety and depression (*n* = 38, 37.3%). Reported age of NSSI onset ranged from three to 41 (*M* = 13.50, *SD* = 3.68), with 13 being the most common. The most common form of self-injury was cutting (*n* = 82), followed by self-battery (*n* = 20). Most participants reported self-injuring within the last year between one (*n* = 19) and five or more times (*n* = 36).

Data Analysis

Data were exported from Qualtrics into SPSS for cleaning, and analysis of descriptive data. Each participant was assigned an identification code (e.g., P110) and their text responses to the open-ended questions were exported to Microsoft Excel. Each response was then segmented into units of codable data, which were interpreted in context before being quantitatively accounted for within the relevant framework element (see Table 3.2 for examples).

A 'data unit' represents a shift in meaning within a sentence or statement (Campbell et al., 2013). A single sentence may comprise multiple sections of meaning that are distinct from one another in terms of how they contribute to an understanding of self-injury stigma. Take the following response for example, "They said the person who self-harmed was an

idiot and just wanted attention". Here, "idiot" meaningfully differs from "just wanted attention" and should be separately codable; therefore, this response was segmented into two data units, each representing a piece of information that was distinct and whole in its meaning. Data units were identified within each response using brackets, allowing retention of the context from which the data unit was derived. A participants' responses across questions were considered in combination, meaning that interpretations could be informed by a participants' responses to the other open-ended questions. A data unit could be coded to multiple elements. The fourth example in Table 3.2 depicts an instance of this, whereby the data unit "suck it up and be stronger" captured the perception of self-injury as controllable and changeable (course) and the implication that a lack of strength is the reason for self-injuring (origin). Participants' responses were analysed verbatim, with errors in spelling and grammar retained.

Eight cases were used to operationalize the rubric, and two authors, one naive to the framework prior to undertaking analysis (Kolbe & Burnett, 1991), cross-coded 14 (10%) randomly selected cases in a stepwise manner (O'Connor & Joffe, 2020). Intercoder reliability was first assessed using Cohen's Kappa (κ; Cohen, 1960), calculated with the *irr package* for R (version 0.84.1; Gamer et al., 2019). Despite high percentage agreement, intercoder reliability remained low after round three of cross-coding, likely due to the Kappa paradox (Feinstein & Cicchetti, 1990). Gwet's first-order agreement coefficient (AC_1; Gwet, 2008), calculated with the *irrCAC package* for R (version 1.0; Gwet, 2019), was subsequently used and demonstrated high agreement. The lead author coded the remaining 99 cases.

Findings

Each of the 99 participants yielded between 0 and 55 (M = 7.31, SD = 7.86) data units, totaling 731 units for analysis. Each of the 85 (85.9%) participants whose data was coded into the framework contributed between 1 and 29 (M = 3.02, SD = 4.06) data units to the framework (see Tables 3.3 and 3.4).

Table 3.2

An Example of the Analytic Process

Response	Data Units	Code
The few close family members that found out I self-harmed reacted quite poorly. I was patronised and treated as if I was unpredictable or incapable. The experience was frustrating and made it extremely unlikely for me to tell anyone else.	[The few close family members that found out I self-harmed reacted quite poorly.]	Enacted Stigma - Disruption
	[I was patronised]	Enacted Stigma - Disruption
	[and treated as if I was unpredictable or incapable]	Enacted Stigma - Peril
	[The experience was frustrating]	Not coded.
	[and made it extremely unlikely for me to tell anyone else.]	Anticipated Stigma - Concealability
In High School, some of my friends were talking about someone else in our year who openly self-harmed. They were unaware I had experience with NSSI. They were talking about how she only did it for attention and had nothing to truly be sad about.	[In High School, some of my friends were talking about someone else in our year who openly self-harmed.]	Not coded.
	[They were unaware I had experience with NSSI.]	Not coded.
	[They were talking about how she only did it for attention]	Public Stigma - Origin
	[and had nothing to truly be sad about.]	Public Stigma - Origin
This made me feel frustrated, isolated and misunderstood. I knew if people reacted to others in that way then I could never disclose my NSSI.	[This made me feel frustrated,]	Not coded.
	[isolated]	Not coded.
	[and misunderstood.]	Not coded.
	[I knew if people reacted to others in that way then I could never disclose my NSSI.]	Anticipated Stigma – Concealability
That I should suck it up and be stronger and not attention seeking	[That I should suck it up and be stronger]	Enacted Stigma – Origin & Course
	[and not attention seeking]	Enacted Stigma - Origin

Public NSSI Stigma

Origin

Origin was the most prevalent domain in the public stigma level, with common references including that people who self-injure are attention-seeking, weak, cowardly, pathetic, stupid, silly, a freak, or crazy. Four responses related to perceived legitimacy of NSSI. For example, Participant 149 described, "*They were talking about how she only did it* [self-injured] *for attention and had nothing to truly be sad about*", and Participant 91

reported overhearing, "*self-injury is weak… people do it for no reason*." Further responses related to responsibility and blame, as evidenced by Participant 59 who overheard, "*they brought it on themselves*" and Participant 65 who overheard, "*It's the fault of the person themselves*." NSSI stereotypes were also present in participants' responses, with common NSSI myths evident. For example, the myth that only teenage girls self-injure was captured by Participant 127 who overheard, "*I swear self harmers are just angry 14 year old girls dying for attention*", and Participant 145 who overheard "*a joke about girls who 'act depressed, have a tumblr and slit their wrists'*." Likewise, the myth that people who self-injure belong to emo subgroups was evident in Participant 34's response: "*The 'emo' stereotype was commonly used throughout my highschool years by many of my peers, insinuating that self-injurers were within that group*."

Taken together, data units relating to NSSI origin captured (inaccurate) ideas about who self-injures and why. Attributions of responsibility were apparent, whereby perceptions that self-injury is a choice appeared to inform blame, and assumptions that self-injury is attention-seeking, or a sign of weakness appeared to inform dismissal. Blame and dismissal may legitimize stigmatizing responses.

Concealability

The data unit coded to concealability was provided by Participant 18, who wrote that someone had been "*mocking a person for having scars*." The visibility of NSSI scarring may give rise to stigma.

Course

The course domain captured assumptions that NSSI is transitory or that it can be easily stopped. Participant 59 overheard someone say that self-injury is "*just a phase*", Participant 100 overheard, "*They can stop if they want*", and Participant 65 overheard that people who self-injure "*just need to get over it*." These responses suggest that people have limited understanding of the function of self-injury, viewing it as a trivial behaviour that warrants dismissal, rather than as a strategy for dealing with difficult experiences. While these responses reflect minimization of self-injury, assumptions that self-injury leads to suicide were also evident. Participants 21, 97, and 119 reported overhearing variations on the comment that people who self-injure should "*just kill themselves*", with Participant 110 also overhearing, "*they're just cowards who can't reach for help or go all the way*." These statements may relate to an assumption that self-injury is a precursor to suicide.

Table 3.3
Quantitative Results from Directed Content Analysis

	Public Sigma		Self-Stigma		Anticipated Stigma		Enacted Stigma			
	Sum	*n*	Sum	*n*	Sum	*n*	Sum	*n*	Total Domain Units	Total *n* at Domain
Origin	77	57	8	6	4	3	60	33	149	73
Concealability	1	1	0	0	15	10	26	13	43	21
Course	13	9	2	1	2	2	10	7	27	20
Peril	18	14	0	0	0	0	15	10	33	28
Aesthetics	1	1	0	0	2	1	6	6	9	7
Disruption	1	1	2	2	2	1	33	18	38	24
Total	111	67	12	7	25	12	150	48		

Note. Sum = the sum of data units coded to the element, *n* = number of participants providing a data unit at the element. Total *n* = number of unique participant contributions.

Table 3.4

Qualitative Results from Directed Content Analysis

	Public Stigma	Self-Stigma	Anticipated Stigma	Enacted Stigma
Origin	"that if you cut, you're mentally crazy"P136 "I swear self harmers are just angry 14 year old girls dying for attention"P127 "People who hurt themselves are weak"P131	"I felt even worse about my Non-Suicidal Self Harm"P110 "... questioning whether I was 'supposed' to be in that stereotype"P34 "Ashamed"P137	"... I don't want to be seen as weak or incompetent"P89 "… because I would be met with the same judgement"P147	"Comments from my mother about being untrustworthy delusional and incapable"P149 "Yeah, you're only doing it for attention"P122 "That I'm weak"P43
Concealability	"Mocking a person for having scars"P18	-	"They made it very awkward to reveal that I applied to a group that they were bashing, and insulting."P111 "I could never possibly disclose my history of self-harm, because I would be met with the same judgement"P147	"That's disgusting."P34 "Don't do that to yourself, imagine if your great-grandmother saw that"P77 "Some people think because my scars are visible it's a green card to bring it up"P89
Course	"They can stop if they want"P100 "They just need to get over it"P65 "It's just a phase"P59	"Suddenly I thought that I was worse for not going 'all the way" to suicide."P110	"the only concern I have is in my career/professional life…"P89 "... thinking about how upset my [family] would get… I really considered stopping the self-harm for good"P77	"That I should just stop cutting"P43 "That I should suck it up and be stronger"P71 "Oh my god not again… just stop it"P89

Peril	"assuming every self injury is an attempt to comit [*sic*] suicide "[P16] "people joking about slitting wrists][P47] "... treat it as if it was nothing"[P98]	-	-	"... stating to my face that I 'should have tried a bit harder to kill myself', adding that I 'clearly didn't do a good enough job'."[P34] "I was called immature"[P85] "... they were worried I would hurt them"[P110]
Aesthetics	"... and the scars it leaves are unattractive"[P118]	-	"worried about the image it [NSSI scars] might portray will be unprofessional or undesirable." "I worry about my scars in professional situations"[P89]	"They said it was disgusting"[P56] "Why would you ruin your arms like that"[P89] "just looks of disgust when they see scars"[P145]
Disruptiveness	"… that they didn't deserve sympathy."[P110]	"it made me feel worse about myself"[P138] " I felt even worse about my Non-Suicidal Self Harm" [P110]	"[I felt] like I could never say anything"[P130] "The harsh responses don't encourage me to open up to them."[P110] "... it made me realise that i couldn't trust [them] with vulnerable information about myself"[P88]	" told that I'm a waste to taxpayer dollars presenting at emergency for severe self harm requiring stitches."[P28] "Mum told me… it would be unfair for me to marry anyone."[P33] "they acted like I was a burden to them"[P89]

Peril

The peril domain captured to paradoxical perceptions that NSSI is both dangerous and insignificant. While Participant 21 overheard, "*If you're going to kill yourself, just do it, don't do a half arsed job*" and Participant 16 described, "*assuming every self injury is an attempt to comit [sic] suicide and saying 'they're doing it wrong'*," other participants overheard "jokes" or minimizing statements such as that reported by Participant 47: "*People are constantly joking about slitting their wrists if anything goes wrong.*" The assumption that NSSI is a suicide attempt may inadvertently foster dismissal. While counter-intuitive, this is apparent in the comment that NSSI is a "half arsed job" of suicide. The impact of dismissal was conveyed by Participant 98, who felt "*negative emotions when people wave off self-injury or treat it as if it was nothing*."

Aesthetics

Only one data unit was coded into the aesthetics domain at the public stigma level, which was provided by Participant 118, who overheard someone say that "*the scars it* [NSSI] *leaves are unattractive.*" Assessment of the aesthetic appearance of scarring likely inform NSSI stigma.

Disruptiveness

The only data unit coded in the disruptiveness domain at the public stigma level was provided by Participant 110, who overheard someone's opinion that people who have self-injured "*didn't deserve sympathy*". This speaks to the way in which NSSI stigma can manifest as disruption to relational care.

Self NSSI Stigma

Origin

Self-stigma related to participants' reactions to hurtful things said about NSSI, and included descriptors such as ashamed/shame, embarrassed, worthless, and guilty. While these types of descriptors are presented as examples of self-stigma in the NSSI Stigma Framework, it was rarely possible to determine whether they represented self-stigma for our participants. In the few instances that the phrase "*ashamed*" was categorized, the shame described clearly related to a stigmatizing experience, as evidenced by Participant 137, who described feeling "*ashamed*" after being told, "*I was attention seeking… that I was looking for attention*". While this participant's sense of shame does not necessarily reflect an internalization of the belief that the origin of NSSI is attention-seeking, it fits within the Framework that shame, guilt, and embarrassment represent an individual's thoughts and/or feelings about the origin of their own NSSI (Staniland et al., 2021).

Applying NSSI stereotypes to oneself may also reflect origin-related self-stigma. This was evident in Participant 34's response to being frequently described as *emo:* "*I was the furthest from said stereotype in every other sense and was internally invalidated on a regular basis, questioning whether I was 'supposed' to be in that stereotype due to my self-injury*." Persistent stereotyping appeared to foster doubt for this participant, who may have experienced confusion regarding the origin of their own self-injury as a result.

Concealability

No data units reflecting concealability were coded at the self-stigma level.

Course

Data units coded at course reflected internalization of a belief that NSSI is a "failed" suicide attempt. In response to overhearing people say, "*those who self harmed* [are] *'weak' and 'cowards' because they didn't have the guts to kill themselves*," Participant 110 wrote, "*Suddenly I thought that I was worse for not going 'all the way' to suicide. I was oddly stuck between being pathetic enough to self-harm but not good enough to commit suicide*." Misconceptions related to the course and peril of NSSI appear to foment confusion and negative self-perceptions.

Peril

No data units reflecting peril were coded at the self-stigma level.

Aesthetics

No data units reflecting aesthetics were coded at the self-stigma level.

Disruptiveness

Disruptiveness represented impact to participants' self-perceptions, as evidenced in Participant 110's response, "*I felt even worse about my* [NSSI]", and Participant 138's description that an overheard comment "*made me feel worse about myself.*" NSSI stigma appeared to disrupt relationship with self, demonstrating how this domain represents outcomes of stigma rather than reasons for it.

Anticipated NSSI Stigma

Origin

One response comprising two data units was coded into the origin domain at the anticipated stigma level, provided by Participant 89: "*I don't want to be seen as weak or incompetent*". This response captures concern with the potential responses of others, who may hold assumptions regarding the origin of NSSI – that it is isolated to people who are "weak" or "incompetent". Another participant described concern disclosing their self-injury

"*because I would be met with the same judgement*." Here, the participant appears to be anticipating how others may interpret the origin of their self-injury.

Concealability

Concealability was the most prevalent domain within the anticipated stigma level, evidenced in participants' choices about where on their body to injure, what clothes to wear, and who to disclose NSSI to. Injuring concealable parts of the body may be motivated by avoiding the "attention-seeker" label, as evidenced by Participant 83 who wrote that remarks about NSSI being attention seeking "*made me sad because I have done it but no one knew about it so it obviously wasn't for attention* [I] *would do it in covered places*." Avoidance of stigma was also apparent in Participant 122's response: "*I came in to work one day wearing a jacket as I had self injuries (cuts) on my arms*." While not explicitly stated, it may be inferred that wearing a jacket (and therefore concealing NSSI) was informed by anticipated stigma. After removing their jacket, the manger "*saw my arms, she said 'Oh why do you have that? Are you crazy?'*" – a stigmatizing response the participant was likely trying to avoid by concealing their self-injury.

Regarding self-injury disclosure, hurtful comments may impact whether individuals feel they can talk about their self-injury or seek help. Participant 89 described, "*I have not experienced the stigma directly but I've seen it play around me so I try to keep things hidden in such situations*", and Participant 149 explained that comments about another's self-injury "*made me feel frustrated, isolated and misunderstood. I knew if people reacted to others in that way then I could never disclose my NSSI*." Experiences of stigma also informed future disclosure, as described by Participant 147, who, after negative responses from their parents, "*hid my self-harm*[2] *from everyone else to avoid judgment*." In these examples, participants chose to conceal their NSSI in anticipation of being stigmatized.

Course

Course related to expectations of stigma regardless of NSSI continuation or cessation, as evidence by Participant 89: "*the only concern I have is in my career/professional life*" and Participant 77, who "*considered stopping the self-harm for good*" when reflecting on "*how upset my [family] would get*." Anticipated responses may inform consideration of NSS continuation, or prompt concern about future responses to past NSSI.

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[2] While the term "self-harm" may refer to both suicidal and nonsuicidal behaviors, it tends to be used to refer to nonsuicidal self-injury in Australia.

Peril

No data units reflecting peril were coded into the anticipated level.

Aesthetics

Aesthetics at the anticipated domain appears linked with course, whereby concern about how NSSI scars may impact future experiences was reported. Participant 89 described they were "*worried about the image it [NSSI scars] might portray will be unprofessional or undesirable*."

Disruptiveness

Overlap between concealability and disruptiveness was apparent, with concealment possibly driven by fear of disruption to relationships. In response to overhearing their father state to their brother, "*It's not like you're cutting yourself*", Participant 130 described that they felt "*Lost, judged, like I could never say anything*," a response that reflects anticipated disruption to the relationship with their father if they disclosed their self-injury. Therefore, this response captures NSSI concealment due to anticipated disruptiveness. The two additional units centered on lost trust following a stigmatizing experience. After a close friend said that people who self-injure "*didn't deserve sympathy*," Participant 110 felt "*heartbroken because I thought this individual was someone I would eventually trust enough to disclose my self harming*" and Participant 111 described that "*harsh responses don't encourage me to open up to them*." While overlap with concealability is present (both participants refer to concealment), these responses focus on interpersonal impacts, thereby representing disruptiveness.

Enacted NSSI Stigma

Origin

Origin was the most prevalent domain at the enacted stigma level, emerging across various contexts, including the medical system, workplace, friendship groups, and the family. Hurtful comments centred on reasons for NSSI, or assumptions made based on NSSI history, including attention seeking, being crazy, weird, weak, incapable, stupid, manipulative, or lying. An assumption of attention-seeking was described by Participant 28, who described that mental health professionals "*focused on my self destructive behaviour as though I wanted attention*", pointing to potential misunderstanding of NSSI origins manifesting as inappropriate treatment of people seeking support. Participants also described being perceived as incapable due to their self-injury, as evidenced by Participant 147, whose parents "*automatically assumed I couldn't be trusted and that I wasn't capable,*" and Participant 30, who described that, "*I have had people assume I can't do stressful tasks after*

they've seen my scars". While "incapable" was not operationalized, participants may be referring to perceptions of incompetence or instability.

Perceptions of instability were also evident in responses related to mental health. Participant 33 relayed that "*Mum told me I was fucked in the head*", Participant 122 explained that "*people at work or my family thought that I was crazy*", and Participant 147 described her parents saying, "*oh she's self harming, she's completely lost it then*." These examples reflect an assumption that self-injury originates from or reflects mental instability. Paradoxically, participants also relayed experiences whereby their self-injury was not believed or was perceived as unwarranted. Participant 81 was asked "*why do you need to seek attention by hurting yourself?*", Participant 147 was told "*I didn't have enough bad things going on in my life to warrant it* [NSSI]", and Participant 122 was told, "*Yeah, you're only doing it for attention. Stop pretending something's wrong with you*." Within an assumption that self-injury represents a particular type of person or experience, it can be disbelieved or minimized.

Concealability

This domain often related to responses received when another person had seen evidence of their self-injury. Participant 88 described that "*they saw the cuts on my thigh and got angry*" and in Participant 34's experience, the visibility of their self-injury scars led to the following exchange on public transport:

> *The mother looked at my arm (with a couple of scars exposed due to my sleeve rolling up without my knowledge) and got my attention... She then proceeded to give me an angry look and say (quite loudly): That's disgusting; you really shouldn't be out in public with 'those' (pointing to my arm) exposed. It sends the wrong messages to children; what gives you the right to show something like that to innocent kids?*

The mother's statement taps into many domains of stigma but most clearly represents concealability due to her expression that NSSI scars should be concealed.

Course

The course domain captured assumptions about NSSI recovery, representing ideas about how self-injury should be stopped. Participant 43 described being told "*That I'm weak and I should just stop cutting*", and Participant 71 described that they were told "*I should suck it up and be stronger*". The assumption that self-injury should "just be stopped" reflects an expectation that the course of NSSI should (and can) be easily halted, which ignores lived experience perspectives of recovery (Lewis & Hasking, 2021). In contrast, Participant 136

wrote that someone had demanded, "*do it again, right in front of me*," perhaps to force proof of self-injury. It is possible that course captures complex and conflicting perceptions about changes in self-injury over time.

Also relevant to course is a consideration of how self-injury scars may elicit stigma, regardless of whether self-injury is past or present. This was evidenced in Participant 89's descriptions that living with self-injury scars means "*People don't realise I'm recovered*", and Participant 130's description that "*People who have been about to have sex with me have stopped because of it* [scarring]*, which is fair because consent is important, but also rude because my scars are an unfortunate part of my past*." These experiences demonstrate the ongoing nature of NSSI stigma, whereby residual NSSI scarring can lead to stigmatization despite self-injury cessation.

Peril

Perceptions of danger, suicide, or insignificance reflected the peril domain. Danger appeared in experiences of avoidance or ostracization due to self-injury, such as that described by Participant 110: "*I've been excluded from otherwise lovely friend groups because they were worried I would hurt them or 'lure' them into being mentally ill*." Such exclusion may be driven by an assumption that self-injury is "contagious", representing danger to others. Danger also emerged in perceptions of being "untrustworthy", as evidenced by Participant 147, whose parents "*automatically assumed I couldn't be trusted*" which may reflect a belief that people who have self-injured are perilous toward themselves and others.

The misconception that all self-injury is suicidal was also apparent, as evidence by Participant 30: "[people] *stating to my face that I 'should have tried a bit harder to kill myself', adding that I 'clearly didn't do a good enough job'*." Paradoxically, other participants described being minimized or dismissed due to their self-injury. Participant 85 described being called "*immature and told I needed to be more resilient*", and Participant 98 was told "*That I was just being stupid, and a child*." These examples may reflect a belief that NSSI is non-significant, contradicting the perception that NSSI is suicidal.

Aesthetics

Participants described experiences of aesthetic evaluation of their scars, often hearing that NSSI scars are "*disgusting*". Participant 89 was asked, "*Why would you ruin your arms like that?*", with an apparent assumption that self-injury scars irreversibly damage one's appearance. Additionally, Participant 133's description of being told, "[you] *don't look like someone that suffers a mental illness, and would resort to self-injury*" was coded to aesthetics, capturing expectations regarding the appearance of someone who self-injures.

Disruptiveness

Disruptiveness was evident in descriptions of responses to self-injury, such as Participant 147's experience: "*my parents responded negatively when they found out I self-harmed. It impacted my relationship with them a lot. They had preconceptions about me that led to a loss of trust*." Participant 149 relayed a similar experience, "*The few close family members that found out I self-harmed reacted quite poorly. I was patronised*", as did Participant 33, being told by their mother that "*it would be unfair for me to marry anyone*." Across these cases, the discovery of self-injury co-occurred with a disruption to the relationship.

Beyond the family, disruption was also evident in friendships. Participant 113 described, "*i feel like people talk to me or act towards me as if theyre walking on eggshells, i feel like they treat me differently when i tell them that i have self-injured*," and Participant 127 wrote, "*Once people found out I self-harmed, they acted differently around me and were almost scared to talk to me*." Misconceptions about self-injury may underlie disruption to relationships.

Uncoded Data

Of the 731 data units, 455 (62.2%) were not coded. To investigate whether patterns among the uncoded data indicated a need to modify the framework, a post-hoc exploration of these data was conducted. A large proportion (n = 212, 46.6%) of the units were directly related to emotion, which were organized according to the classifications outlined by Parrot (2001), leading to 72 indications of anger, 114 of sadness, 18 of fear, and 7 that were unclassified (e.g., awful, horrible; Table 3.5). "Angry" was the most reported emotion (n = 40), and participants sometimes provided an explanation regarding their anger. For example, Participant 22's response to overhearing someone say that self-injury is "stupid" was: "*Frustrated and angry at their uneducated opinion and lack of understanding*." Righteous anger has been described by Corrigan and Watson (2002) as an empowering emotion in the context of mental illness stigma. The same may be true for people faced with self-injury stigma and these responses speak to an avenue for further investigation.

While the emotions reported by participants provide insight into the impact of NSSI stigma, the NSSI Stigma Framework (Staniland et al., 2021) does not intend to account for stigma outcomes. Therefore, this data did not serve to extend the framework.

Table 3.5
Uncoded Data Patterns

Primary Emotion	n	Secondary Emotion	n	Tertiary Emotion	n
Anger	72	Irritation	8	Irritated	1
				Annoyed	7
		Exasperation	14	Frustrated	14
		Rage	48	Angry	40
				Mad	4
				Infuriated	3
				Resentful	1
		Disgust	2	Disgusted	2
Sadness	114	Suffering	8	Hurt	7
				Heartbroken	1
		Sadness	38	Sad	14
				Upset	23
				Depressed	1
		Disappointment	4	Disappointed	4
		Shame	15	Ashamed	13
				Guilty	2
		Neglect	49	Isolated	3
				Alienated/didn't belong	2
				Unloved/unlovable	2
				Lost/alone	4
				Embarrassed	4
				Vulnerable/ Exposed	2
				Self-conscious/ Awkward	3
				Misunderstood	11
				Worthless/insignificant/like dirt	7
				Pathetic/weak/ small	3
				Invalidated/ dismissed	3
				Judged/offended/	3
				Confused/betrayed	2
Fear	18	Nervousness	18	Anxious	1
				Uncomfortable	10
				Attacked/defensive	7
Other	7	Emotional	1		
		Awful	3		
		Horrible	2		
		Screwed-up	1		
		Unbothered	1		
Total	212				

Note. Organization of data patterns was informed by Parrot's (2001) classifications outlined in *Emotions in social psychology: Key readings in social psychology*. Psychology Press.

The remaining 243 data units were either irrelevant to self-injury stigma (e.g., "*someone playing off sexual assault victims*"), not specific to self-injury (e.g., "*people can control whether they are mentally ill or not*"), or ambiguous (e.g., "*someone saying they were cutting themselves because it was fun*") and were not coded into the framework.

Discussion

The aim of this study was to investigate the applicability of the NSSI Stigma Framework (Staniland et al., 2021) using a directed content analysis (Hsieh & Shannon, 2005) of text responses to open-ended questions related to mental illness and self-injury. Participants described experiences of stigma that aligned with the framework's proposed elements, suggesting that the framework has utility to guide the identification and prediction of NSSI stigma. Most components of the framework were present in the data set, largely pertaining to public or enacted stigma. With more direct questioning, it could be expected that responses would more closely map onto the framework.

Many data units that captured stigma experiences were classified as public rather than enacted stigma because the comments were not directed toward the participant (i.e., they were overheard) or because the person making the comments was not aware of the participant's NSSI history (i.e., not directed at the participant). Given that these comments still impacted participants, indirect stigma represents an area of interest. It is plausible that being exposed to indirect stigma may increase an individual's self or anticipated stigma. Research into HIV stigma proposes vicarious stigma as a channel through which public stigma is communicated to individuals living with HIV, contributing to anticipated stigma (Steward et al., 2008), and mental illness research suggests that vicarious stigma leads to self-stigma (Serchuk et al., 2021). A person with lived experience may experience stigmatizing effects after witnessing NSSI stigma as a form of vicarious stigma. Extending the framework to include vicarious stigma as a context may allow for a more nuanced understanding of how NSSI stigma is experienced.

Minimal evidence of self-stigma likely reflects the nature of the questions asked. While emotional responses such as shame, guilt, and embarrassment may reflect self-stigma, the extent to which these feelings reflected self-stigma for our participants could not be determined with certainty. Future research should explore experiences of self-stigma to accurately determine the applicability of the framework at this level. Interviews are a viable method to achieve this, with the ability to clarify and explore participant responses with the framework in mind.

Few examples of anticipated stigma also likely reflect the questions asked. Participants did, however, describe stigma management - behaviors enacted to avoid stigmatization (Elliott & Doane, 2015). Hiding scars, injuring concealable parts of the body, and avoiding disclosure are examples of stigma management, and reflect anticipated stigma (Hodgson, 2004; Lewis & Mehrabkhani, 2016; Piccirillo et al., 2020). In this way, enacted stigma (both direct and indirect) appears to give rise to anticipated stigma, with both experiences and observations of NSSI stigma informing subsequent choices to keep NSSI concealed.

Turning to the stigma domains, we found evidence for origin across the public and enacted levels, with stereotypes and misconceptions about self-injury present. Origin was minimally evidenced within the self and anticipated stigma levels, likely reflecting the questions asked rather than a lack of validity at these levels. Evidence was found for concealability, most frequently at the anticipated and enacted stigma levels. This makes sense given that direct stigmatization is more likely to occur in response to seeing self-injury. The course domain emerged in data related to being told to "just stop it," which is a common instruction that dismisses the complexity of cessation and recovery (Kelada et al., 2016; Lewis & Hasking, 2019; Lewis et al., 2019). Concealability interacted with course, in that the visible nature of NSSI scarring may lead to ongoing stigmatization, despite cessation. This finding corroborates the suggestion by Staniland et al. (2021) that stigma may persevere due to scarring.

Perceptions of being dangerous, untrustworthy, and unpredictable were captured in the peril domain, and reflect prominent misconceptions about mental illness (Corrigan & Watson, 2002). Conversely, perceptions that self-injury is insignificant and trivial were also evident, supporting the argument by Staniland et al. (2021) that there is a dichotomy within this domain. The least prevalent domain was aesthetics, and due to visibility giving rise to evaluations of appearance (Staniland et al., 2021), shared data with the concealability domain. As expected, the disruptiveness domain interacted with other domains, as disruption to relationships may be an outcome of stigmatization rather than a construct underlying it (Jones et al., 1984). NSSI stigma may be responsible for disruptiveness, rather than self-injury itself.

Limitations

While the present research supports the utility of the NSSI Stigma Framework to account for experiences of NSSI stigma, the format and nature of the questions asked presents a limitation. As part of a larger project about self-injury and mental illness, the open-ended questions were developed to collect information about stigmatizing experiences and

were not directly informed by the framework. Therefore, the data were relatively general and related most often to public or enacted stigma. Further research is required to assess the framework's applicability to experiences of self and anticipated NSSI stigma. Using a method similar to the one used in this study, researchers could pose open-ended questions such as, "Please tell us about a time when you were worried about how others might react if they found out about your history of self-injury" to capture anticipated stigma, and "When you consider your history of self-injury, how do you think and feel about yourself?" to capture self-stigma. Follow up questions asking participants to elaborate on why would provide further insight into self-injury stigma.

While online formats of data collection may allow participants to feel more at ease sharing their experiences, the nature of text-based responses can limit the complexity and detail of the data. Without an opportunity to clarify ambiguous responses, we were often limited in the inferences that could be made about what a participant meant in their response. Only data units clearly representative of a framework component were coded, meaning ambiguous responses with potentially relevant detail were left uncoded. For example, in response to the question about hurtful things overheard, one participant wrote "*Someone saying they were cutting themselves because it was fun*" and that they felt "*angry… because I know how people reacted when they found out what id* [sic] *been through*". Without probing, it is difficult to determine whether this statement reflects stigma, and if so, from what perspective it originates. The participant could be reporting an example of public stigma or perhaps an example of in-group stigma. In depth, interview-based approaches to data collection are required to better understand the nature of self-injury stigma.

Despite accounting for an acceptable proportion of the data, some components of the framework (disruptiveness and self-stigma in particular) were difficult to code. While this may reflect limitations of the questions asked, coding difficulties may point to a need for greater definitional clarity within the framework. Based on Jones et al.'s (1984) original conceptualization, Staniland et al. (2021) identified potential complexities in the disruptiveness domain, arguing that self-injury may disrupt relationships because of the stigma of self-injury, rather than self-injury itself. This may explain the limited evidence of disruptiveness in participants' responses. At the self-stigma level, it was difficult to accurately discern whether a participants' reaction (e.g., shame) reflected an internalization of stigma, a response to stigma, or both. Shame is a salient emotion for people who have a history of self-injury (Long, 2018; Rosenrot & Lewis, 2018; Sheehy et al., 2019), and research has demonstrated that shame plays an important role in the self-stigma of mental

illness (Hasson-Ohayon et al., 2012), however, more research is needed to clarify whether the relationship between shame and stigma in this context.

Implications and Future Directions

Overall, evidence was found in support of the public and enacted levels of the NSSI stigma framework. While this suggests the framework has utility in identifying stigma through these perspectives, more research will be needed to evaluate the framework's applicability to self and anticipated stigma. The coding of several data units to multiple domains suggests there is overlap and interaction between domains, which should be considered in future work informed by or investigating the framework. For example, research on NSSI scarring requires consideration of concealability alongside aesthetics, but may also require consideration of course, given the potential for long-lasting scarring to give rise to stigma. Similarly, practitioners working with clients who have self-injured may need to consider the complexity of living in a scarred body and how mental health may be impacted by stigma even when NSSI is not an active experience.

The framework may hold utility for the development of multi-level self-injury stigma interventions. The need for multi-level stigma interventions has been highlighted (Smith et al., 2022) and the framework provides evidence that effective reduction of self-injury stigma requires a multi-level approach. Prior stigma reduction work has involved contact-based education, workshops, drama and performance, motivational interviewing, and social marketing to address stigma at the community level (Rao et al., 2019). Such approaches may prove useful in the context of self-injury stigma. The framework could be used in the development of such interventions by directing focus to specific aspects of self-injury stigma that may be amenable to change, such as beliefs about the functions of self-injury.

At the intrapersonal level, stigma-informed therapy may improve outcomes for clients who have a history of self-injury. Regardless of a client's motivation for seeking support, understanding and acknowledgement of the complexities of NSSI stigma is likely to benefit therapeutic engagement. Clinicians may find benefit in using the framework to further understand the impacts of NSSI stigma, such as shame and low self-esteem, and its implications for potential continued self-injury. Acknowledging and addressing NSSI stigma while providing clients with the safety to discuss their experiences may strengthen the therapeutic alliance and improve psychological outcomes. Indeed, interventions have shown promise in reducing self-stigma and related outcomes such as shame in the context of mental illness (Lucksted et al., 2011; Luoma et al., 2008).

Our findings also provide support for the framework's potential to inform stigma reduction through identification of how stigma develops and manifests, pointing to viable areas of intervention. Alongside this, assessment of NSSI stigma, its impacts, and effectiveness of interventions necessitate the development of an NSSI-specific stigma measure. The NSSI Stigma Framework may offer a basis for the development of such a tool.

Conclusion

In assessing the applicability of the NSSI Stigma Framework, we found it was able to account for experiences of NSSI stigma in a set of textual data. Public, self, anticipated, and enacted stigma were evidenced, with the presence of vicarious stigma apparent. Whilst further assessment of the framework is required, the present work offers encouraging support for its utility in research and practice as the field continues to develop a better understanding of NSSI stigma.

Chapter 4

News Media Framing of Self-Harm in Australia

In Chapter 2, I presented the NSSI Stigma Framework, which offers a theoretical conceptualisation of self-injury stigma that can be used as a basis for directing future research. In Chapter 3, I provided a preliminary validation of this framework. Researchers can use the NSSI Stigma Framework to inspire research questions that are directly relevant to self-injury stigma. This can be done at the stigma level (e.g., public), the stigma domain (e.g., origin), or at the intersection of any level/s and domain/s. Given current understanding of NSSI stigma is still limited, research questions with a wide scope are required. Therefore, for the study presented in Chapter 3, I posed a research question at the public level, encompassing all domains: How does the news media portray self-injury? In the following chapter, I present a media framing analysis of news articles published in Australia. Of note, the term "self-harm" is used throughout this chapter, rather than the term "self-injury", which is used in the rest of this thesis. This is because the term "self-harm" is used predominantly in Australia.

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Attributions

Author	Contribution	Acknowledgement
Lexy Staniland	Development of research question and methodology, data collection, management, and analysis, interpretation of findings, and manuscript preparation	
Penelope Hasking Stephen Lewis Mark Boyes	Assisted with development of research question, interpretation of findings, and manuscript preparation	
Permission to include from the journal can be found in Appendix H.		

Abstract

As a conduit of knowledge for the general public, news media inform the development and maintenance of attitudes and beliefs about a range of topics, including mental health and related behaviors. News media portrayals of such topics can therefore contribute to stigma - the culmination of harmful stereotypes, prejudice, and discrimination. A topic of increasing media and research interest is self-harm, a behaviour that is still poorly understood and highly stigmatized. Despite the potential for news media to be a source of self-harm stigma, few investigations of such portrayals have been conducted. To understand how news media portrays self-harm, a qualitative media framing analysis was conducted on 545 news articles published in Australia during 2019. Six frames were identified: Inevitably Suicidal, A Tragic Outcome, Mentally Unwell, An Epidemic, Threatening and Dangerous, and A Manipulative Tactic, each drawing on a broader narrative of pathology, instability, and damage. Use of problematic language and a lack of definitional clarity reinforced these frames. While the analysed articles are limited to an Australian context, findings demonstrate continued misrepresentations of self-harm, which arguably contribute to ongoing self-harm stigma. Greater education and support for journalists reporting about self-harm is needed.

Introduction

Nonsuicidal self-injury (NSSI), the deliberate damage done to oneself without intent to die (ISSS, 2022), is relatively prevalent among adolescents (17.2%), young adults (13.4%), and adults (5.5%; Swannell et al., 2014), and is typically used to regulate unwanted emotions (Taylor et al., 2018). While explicitly a nonsuicidal act, NSSI is associated with increased risk of suicidality (Kiekens et al., 2018). With NSSI being a reliable predictor of later suicidality, understanding the lived experience of NSSI is an important component of suicide prevention. Whilst the aetiological and functional constructs of NSSI are well understood in the field, public and professional understanding of NSSI is still limited (Fu et al., 2020; Hamza et al., 2021; Newton & Bale, 2012) and despite increasing research and public interest in NSSI (Lewis & Plener, 2015), damaging myths about the behavior are pervasive. Such myths include that NSSI is manipulative, attention-seeking, isolated to teenagers, women, and girls, synonymous with mental illness, or invariably reflective of suicidality (Jeffery & Warm, 2009). These myths contribute to NSSI stigma (Staniland et al., 2021).

NSSI Stigma

According to a recently proposed framework (Staniland et al., 2021), NSSI stigma is a function of six constructs: origin, the reason underlying NSSI; concealability, the extent to which NSSI can be concealed; course, the way NSSI changes over time; peril, the lethality of NSSI, and disruptiveness, the extent to which NSSI impacts relationships (Jones et al., 1984). It is argued that NSSI incurs stigma above and beyond mental illness stigma due to its potential visibility, the responsibility attributed to the person who engages in it, and the misconceptions about why people self-injure (e.g., for attention; Staniland et al., 2020). NSSI stigma is evidenced across the research literature, with experiments (Burke et al., 2019; Lloyd et al., 2018; Nielson & Townsend, 2018), surveys (Fortune et al., 2008), and interviews (Mitten et al., 2015) demonstrating that NSSI stigma is endorsed and experienced.

Furthermore, research has illustrated detrimental impacts of NSSI stigma. Individuals seeking medical care report being disbelieved and having their concerns minimized (Mitten et al., 2015), with experiences of being misunderstood leading to fear, confusion, and reluctance to seek further support (Long et al., 2015). Negative attitudes toward self-injury also foster self-stigma and shame, further compounding fear and secrecy that may lead to worsening mental health (Long, 2018). Given the association between NSSI and increased distress and suicidality, appropriate support must be available to those who are self-injuring, however, NSSI stigma is a significant barrier to support seeking (Fortune et al., 2008; Mitten et al.,

2015). While there is a growing literature exploring what NSSI stigma is and how it is experienced, the question remains: how does NSSI stigma proliferate?

Stigma Communication

It has been argued that the primary function of stigma is to detect threat (Neuberg et al., 2000). Within this conceptualization, stereotypes operate as cognitive shortcuts that allow members of a group to quickly identify an individual who may pose a risk to the physical and social safety of the group, with the subsequent prejudicial thoughts and feelings informing discriminatory behaviours, such as withholding access to community resources. For stigma to operate effectively as a form of threat detection, members of the group must be aware of the stereotypes that identify those who may pose a risk (Smith, 2011). This awareness is developed via stigma communication, whereby messages that distinguish and categorize people based on some characteristic, condition, or behaviour (e.g., self-harm) teach that a stigmatized individual is dangerous to the physical and/or social safety of the group and that they are responsible for both the danger they pose and their subsequent stigmatization (Smith, 2007). Stigma messages are communicated socially, through networks such as news media (Smith, 2011).

Despite the contemporary media landscape offering a wide array of avenues to access and consume information, news media is still widely endorsed by the general public as a primary knowledge source (Newman et al., 2020). Specifically, news media is regularly used as a source of information about health-related matters (Van Slooten et al., 2013), including mental health (Oliver et al., 2020). Because news media are perceived as a reliable and accurate (Tsfati & Ariely, 2014) the presentation of information can profoundly impact public perceptions of mental health issues (Cohen & Kolla, 2019), meaning there is a unique power to provide balanced and compassionate perspectives of complex topics, including mental health. Unfortunately, many news media portrayals of mental health are negative (Ciydem et al., 2020) and promulgate stigma messages about mental health difficulties (Ma, 2017). News media often situate mental illness within a context of violence or danger (Ciydem et al., 2020; Corrigan, Watson, et al., 2005), which can inform and reinforce stereotypes about people living with mental illnesses, including that they are dangerous and unpredictable (Quintero Johnson & Riles, 2018). Exposure to such stereotypes can lead to prejudice and discrimination, compounding the already difficult symptoms of mental illness (Smith, 2007; Switaj et al., 2017). What is yet to be established is how the news media communicate about self-injury.

Of interest for the present research is the conflation between nonsuicidal and suicidal self-injury, both often discussed using the same referent: self-harm (Angelotta, 2015), which is a broad category of behaviors encompassing any deliberate damage caused to oneself regardless of intent (NICE, 2013). Therefore, self-harm captures both suicidal and nonsuicidal behaviors. While the term self-harm tends to bring NSSI to mind, a lack of distinction between suicidal and nonsuicidal behaviors may contribute to a misconception that all self-harm is suicidal in intent. Defining and categorizing self-injurious behavior is a topic of ongoing academic debate, with researchers in various locations across the globe opting to differentiate between NSSI and suicidal self-harm, while others use the undifferentiated term self-harm (Kapur et al., 2013). In Australia, this distinction is unclear in both academic and public spheres; however, given the general public tends to rely on informal sources, such as television, for information about mental health-related issues (Reavley et al., 2011), it is likely that understandings of self-harm are drawn from news media. Indeed, news media is cited as a primary source of information about self-harm (Newton & Bale, 2012). News media portrayals of self-harm may therefore have a significant impact on how consumers understand the behavior.

Media Representations of Self-Harm

Self-harm is represented across various media formats, including song (Baker & Brown, 2016; Whitlock et al., 2009), film (Bareiss, 2017), television (Whitlock et al., 2009), social media (Brown et al., 2018), and news media (Bareiss, 2014; Whitlock et al., 2009). Despite the important role news media plays in public information, few investigations of news media portrayals of self-harm have been conducted, and those that have find that self-harm is portrayed negatively (Bareiss, 2014; Whitlock et al., 2009). Recently published media guidelines (Westers et al., 2020) highlight the importance of responsible reporting about self-harm due to the potential for influence on public opinion. Six recommendations were made, including avoiding misinformation, avoiding sensational or stigmatizing language, and centering stories of recovery. These guidelines echo those published in Australia, which have been active in varying iterations since 2009 (Everymind, 2020). Given that Australian journalists have operated under this guidance for over a decade, Australian news media offers a unique site to examine framing of self-harm.

The Current Study

As a fundamental source of information, the news media is a primary conduit for stigma messages and is therefore an important site for investigating the types of self-harm related information consumers are exposed to. With limited understanding of how self-harm

stigma develops, research efforts are required to explore contexts that may communicate such stigma. Therefore, exploring how the news media portrays self-harm can provide insight into the role of news media in communicating self-harm stigma. The aim of the current study was to investigate news media framing of self-harm across digital and print news articles published in Australia during 2019. Doing so facilitates an understanding of how news media may perpetuate self-harm stigma through framing and provides potential insight into how this can be avoided.

Method

A qualitative media framing analysis was adopted, which allows a methodical examination of how news media portrays a phenomenon of interest (Entman, 1993). The six steps developed by Giles and Shaw (2009) for use in psychology research were followed. Step one involves identifying a story by categorizing articles into meaningful groups. Next, characters are identified by noting which individuals are most prominently featured within and across articles. The third step involves determining with whom the reader is invited to identify. From here, narrative structure and form are explored to determine how narrative conventions are employed by the writer. Step five involves analysis of linguistic constructions, exploring how the use of language informs a particular message or interpretation. In the final step, generalization of the frame/s to an ongoing phenomenon is attempted.

Procedure and Analysis

Search terms included: self-harm, self-injury, self-mutilation, self-abuse, self-cutting, and parasuicide, with alternative suffixes (-ed, -ing). The Factiva database and Google's search engine were used to find news articles published in Australia between January 1 and December 31, 2019. A total of 619 articles (205 print, 416 digital) were saved for screening (Table 4.1). All articles were catalogued into Microsoft Excel, where information regarding each article's title and publisher was stored. Media framing analysis was then conducted. During analysis, reactions, thoughts and ideas, and key decisions were documented by the lead author in a reflexive journal. Frequent discussions were also had within the research team to share insights and interpretations; these contributed to the formation of the findings. Screening and data familiarization occurred during thorough reads of each article. Duplicate (n = 84) and irrelevant (n = 22) articles were removed from the data set, as were articles not in news media format (e.g., radio transcript, book review; n = 18).

Table 4.1
Print and Digital Search Results

	Self-harm			Self-injury			Total		
Print	Found	Saved	Analysed	Found	Saved	Analysed	Found	Saved	Analysed
AAP	31	10	9	1	1	0	32	11	9
ABC	21	12	11	1	1	1	22	13	12
Daily Telegraph	39	14	12	2	2	0	41	16	12
Herald Sun	14	11	9	0	-	-	14	11	9
The Advertiser	10	8	7	0	-	-	19	8	7
The Age	18	11	10	0	-	-	18	11	10
The Australian	26	13	13	2	2	1	28	15	14
The Conversation	7	4	4	1	1	1	8	5	5
The Courier Mail	16	9	9	0	-	-	16	9	9
The Sydney Morning Herald	26	11	8	0	-	-	26	11	8
The West Australian	8	7	7	0	-	-	8	7	7
Other	188	88	71	1	0	-	189	88	71
Total Print	404	198	168	8	7	3	412	205	171
Digital									
news.com.au	78	69	65	1	0	-	79	69	65
abc.net.au	177	99	87	1	0	-	178	99	88
sbs.com.au	96	88	70	1	1	1	87	89	71
au.yahoo.com	0	-	-	0	0	-	-	-	-
theguardian.com/au	0	-	-	0	0	-	-	-	-
smh.com.au	176	156	149	1	0	-	177	157	150
huffingtonpost.com.au	1	0	-	35	0	-	36	0	0
thewest.com.au	1	1	1	0	-	-	1	1	1
Total Digital	529	413	371	39	3	3	568	416	374
Combined Totals	933	611	540	47	8	4	980	619	**545**

Note. No search results from terms “self-mutilation” ($n = 2$) or “self-abuse ($n = 3$) were saved for analysis

The final sample comprised 545 articles. Each article was re-read and categorized according to the dominant narrative focus (Table 4.2). Following categorization, steps two through five were completed by recording summaries, quotes, and interpretations in the catalogue. This was an iterative process; frames were formulated through a process of reading, identifying, describing, and reflecting (see Appendix I for journaling excerpts).

Table 4.2

Article Categories

Category	*n*	%
Aboriginal & Torres Strait Islander	24	4.43
Abuse/trauma	23	4.24
Crime	107	19.74
Entertainment/sport	30	5.53
General news/health	13	2.40
LGBTQI+	22	4.06
Mental health/illness	88	15.87
Nonsuicidal self-injury	4	0.74
Politics	29	5.35
Prison/detention	22	4.06
Refugee/asylum seeker	76	14.02
School	6	1.11
Suicide	33	6.09
Social media/internet	26	4.61
Teenagers	42	7.75
Total	$N = 545$	100%

Findings

Overall, self-harm was framed as an indication of pathology or damage. While six distinct frames emerged, each drew on a broader framing of self-harm as synonymous with mental illness, with self-harm leveraged to substantiate claims or bolster a narrative and was positioned as increasingly problematic.

Inevitably Suicidal

Many articles were related to suicide, and "self-harm" was used to reference suicidal behaviors; however, this was not universal, and definitions were typically ambiguous. "Self-harm" was used interchangeably to refer to both suicidal and nonsuicidal behaviors, as evidenced in article 163, wherein the journalist reported that two prisoners had died, "*one by suicide and one by self-harm.*" While accidental death following nonsuicidal self-injury can occur (Doshi et al., 2005), readers may be confused by the language in this article: why was the death by self-harm not referred to as suicide? Similarly, in article 33, "*the horrendous rates of suicide and attempts at self-harm involving a firearm*" were referred to as part of a discussion regarding firearm laws. Self-harm involving a firearm is likely suicidal in intent; therefore, the identification of the attempt as self-harm and not suicide creates confusion. Lack of distinction between suicidal and nonsuicidal self-harm, particularly when the method is likely suicidal, may lead readers to perceive all self-harm as suicidal.

Even in articles where there was an attempt to distinguish between suicidal and nonsuicidal self-harm, confusion arose. This was seen in article 191, wherein, despite stating that "*not everyone who self-harms is suicidal,*" the journalist presented behaviors typically viewed as suicidal, such as hanging and overdosing, as self-harm. Definitional ambiguity may lead to confusion regarding what people mean when they talk about self-harm. Indeed, it may influence the way a person reacts to someone who has engaged in nonsuicidal self-harm. If a person believes that all self-harm is suicidal, they may respond in an inappropriate or damaging way to an individual who has self-harmed, such as reacting with horror (Long, 2018) or forcing hospitalization (Lesniak, 2010).

A Tragic Outcome

Within 147 articles, self-harm was positioned as a tragic outcome of negative experiences such as sexual abuse, discrimination, detention, bullying, and social, school, and work pressures. Articles reporting on cases of sexual abuse referred to a survivor's self-harm as indicative of how impactful the abuse was, as evidenced in article 99: a survivor "*developed an eating disorder and started self-harming.*" Such articles told of individuals significantly impacted by trauma, with self-harm framed as an outcome worse than the traumatic experience preceding it. Emblematic of pain and suffering, self-harm appeared to legitimize the impact of the survivor's experience, as though self-harm was the indicator of impact, rather than the abuse itself warranting significant concern. Consistent linking of self-harm and trauma reinforces the misconception that sexual abuse causes self-harm (Klonsky & Moyer, 2008), which can inform an assumption that experiences of trauma are a prerequisite

for self-harm. In assuming that self-harm is preceded by trauma, the lived experience of many people may be dismissed. In absence of a 'legitimate' reason to self-harm, the behavior may be perceived as attention-seeking (Lloyd et al., 2018).

Drawing on self-harm to demonstrate impact was also employed in discourse related to LGBTQI+ discrimination. All 22 articles in this category referred to the comparatively high rates of self-harm among gender/sexuality diverse people to demonstrate the consequences of discrimination, as though in absence of self-harm, LGBTQI+ discrimination may be dismissed. For example, it was described in article 276 that "*Gay people who are the target of homophobic bullying are twice as likely to self-harm*" and in article 444 it was described that "*LGBTQI youth are 4 times more likely to attempt suicide, experience suicidal thoughts, and engage in self-harm* [than non-LGBTQI+ youth]." References to self-harm drew on a perception that self-harm is 'tragic' to encourage the reader to view LGBTQI+ discrimination as important, as though this detail was required to legitimize the impacts of LGBTQI+ discrimination. This 'tragic' perception was also drawn on when framing Australia's ongoing offshore detention of asylum seekers. Of these 77 articles, 48 inferred that self-harm stemmed from detention-related factors (e.g., isolation, hopelessness). In article 462, the journalist drew on the perspective of a psychologist to demonstrate this position, writing that "*She recalled witnessing the process of how adult asylum seekers and refugees gradually lost hope and even started to self-harm*." The use of "*even started*" suggests strategic use of self-harm to legitimize the narrative surrounding the impact of offshore detention.

The most prominent discourse in the context of asylum seeker detention pertained to the 2019 Australian federal election, in which the Liberal Party, a right-leaning political party that has campaigned against accepting refugees (Norman, 2019), was re-elected. The election result was portrayed as a catalyst for self-harm, with self-harm positioned as indicative of the damage caused by the re-election of a government with no intent to assist refugees. For example, it was written in article 148 that "T*he Morrison government has refused to address claims of an unprecedented self-harm crisis among refugees and asylum seekers… following the election*," and in article 522, a journalist "*echoed reports of a self-harm crisis… after the Morrison government's election victory*." Self-harm narratives were leveraged in these articles to depict a state of despair, with an underlying assumption that in absence of self-harm, the circumstances at hand were invalid. This may lead to a perception that only those experiencing extreme difficulties have legitimate reason to self-harm. This is problematic as the difficulties people face are highly individual and relative to prior experiences. Assuming self-harm occurs only in response to extreme difficulties ostensibly diminishes the

experiences of people whose self-harm has occurred in response to difficulties not perceived as 'sufficiently serious'.

Self-harm as an indication of severe circumstances was further exemplified in stories about people living with disabilities. Self-harm was positioned as an important component of the impact of disability, as seen in article 385: "*he requires 24-hour supervision to stop him self-harming*." References to self-harm as evidence of impact were seen in more complex reports, such as article 374, which focused on a person named Yoey: *"... he believed Yoey's life was an example of just how wrong things could go for someone with a disability… We heard Yoey smashing herself up in the toilet*." Through proximity and narrative flow, an implicit link may be drawn between self-harm and the idea that Yoey's life had gone "*wrong*". In the mind of a reader, self-harm may be interpreted to represent 'a life gone wrong'. Similarly, the following was included in article 385 outlining the experience of a boy named Alex:

> *He requires 24-hour supervision to stop him self-harming and hurting others… He was scratching his legs and his upper body, so there were just huge scratch marks that were bleeding all over him and we went 'what do we do?'*

In these articles, self-harm was framed as both an allegory for tragedy and an indication of desperation. Language such as "*smashing herself up*" and "*bleeding all over him*" may evoke emotional responses such as fear and horror, and in combination with the narrative context, may portray self-harm as violent, frightening, and uncontrollable. These portrayals may contribute to a perception that people who engage in self-harm are dangerous, a perception that has been associated with discrimination in mental illness research (Corrigan et al., 2003).

Self-harm as a tragic outcome was also framed across contexts such as workplace stress: "*high anxiety and extreme work conditions drove them to the brink of suicide and self-harm*" (173); school pressures: "*We're seeing self-harm in children as young as four, the push down of formalised education isn't working*" (370); childhood adversity: "*after fleeing a home full of verbal and physical violence… 'I got to the stage where I was self-harming'*" (398); bullying: "*The bullying and social isolation soon became so bad Imogen began self-harming*" (257); relational issues: "*family breakdown… can lead to teenage self-harming*" (645); and abuse: "*the psychological abuse she suffered led her to begin cutting herself*" (307). Across these contexts, self-harm was positioned to be caused by negative experiences, and framed as the tragic outcome of such experiences.

Mentally Unwell

Beyond being framed as an outcome of difficult experiences, self-harm was positioned as indicative of mental health difficulties. In article 554, the journalist reported on excessive waiting times at hospitals, with a doctor quoted as stating, "*often people presenting with mental health problems also need to be assessed… for self-harm injuries*." This may reinforce the idea that self-harm is always accompanied by "*mental health problems*". In some cases, self-harm was presented as a disorder in and of itself, as seen in article 155: "*We now know up to one-third of depression, anxiety and self-harm conditions experienced by Australian adults are related*." Described as a "*condition*", self-harm is positioned as an illness or disorder, which aligns with an incorrect assumption that self-harm is a mental illness (Vega et al., 2018).

Reports about particular mental illnesses, such as premenstrual dysphoric disorder (PMDD; 413), dissociative identity disorder (DID; 429, 451), and borderline personality disorder (BPD; 392, 486) were accompanied by references to self-harm. Historically, self-harm has been inaccurately attributed to BPD (Klonsky & Moyer, 2008); however, while self-harm is one diagnostic criterion for BPD, it is neither necessary nor sufficient to diagnose based on self-harm alone (APA, 2013). Despite this, self-harm was positioned as a salient experiential component of BPD, as seen in article 392, in which the featured individual, Claire "*had often presented to emergency departments distressed after self-harming*." Consistent representations of self-harm alongside mental illness may encourage the inaccurate inference that self-harm indicates mental illness.

References to self-harm were also used to indicate psychological instability. This was particularly prominent in reports about alleged and convicted criminals. In article 639, it was reported that a woman charged with attempting parricide "*has severe psychological problems, self-harming and has tried to commit suicide,"* and in article 447, the writer described that an inmate had "*many 'slash marks' (scars) from numerous attempts at self-harm*." References to self-harm in these articles tether the behavior to instability by implicating it as an important contextual fact about the individual. Rendered as salient detail, inclusion of alleged and convicted criminals' self-harm history may inform a spurious association between self-harm and criminality.

Psychological instability was also leveraged in articles about celebrities and public figures engaging in self-harm. Article 605 was an album-promoting piece for artist Iggy Pop, with his behavior described as "*Not so much intravenous cocaine and on-stage outrage and self-harm, more swims at the beach… and pre-gig meditation*." Here, drug use, outrage, and

self-harm are linked to portray a juxtaposition to the comparatively wholesome "*swims at the beach*" and "*meditation*." The reference to self-harm appears to strengthen the perception of Iggy Pop as unpredictable and unstable. Similarly, an entertainment piece about television program The Crown, referred to an advertisement calling for an actress to play the Princess of Wales, including the request for someone who could play a "*desperate and lonely self-harmer*" (298). The journalist subsequently reiterated: "*Desperate. Lonely. Self-harmer*," before writing, "*While it may be an accurate description of the doomed royal, this is bad news for Princes William and Harry*." Linguistic choices such as "*desperate*" and "*doomed royal*" portray a sense of mental instability, and the decision to identify the advertisement as an "*accurate description*" works to legitimize assumptions about self-harm being a behavior isolated to people perceived as mentally unstable.

In addition to instability, self-harm was also used to demonstrate vulnerability, particularly among criminal offenders who were "*at-risk*" and "*in need of protection*" (103). Choices to specifically mention when an offender was not at risk of self-harm illustrates a perception that this detail is important and/or interesting. This was seen in article 145, where a so-called "*notorious baby killer*" was "not regarded as being at imminent risk of self-harm". In addition to the possibility that the journalist assumed reader interest in this type of detail, reference to an absence of self-harm risk may act to indicate that despite having murdered a child, the offender is not so psychologically impacted to be at risk of self-harm.

References to self-harm were also apparent in mental health awareness and advocacy pieces, sourced from a range of perspectives, including mental health centers (166) and charities (236). Invariably, cessation of self-harm was central their mission. While cessation may be a goal for many people who self-harm, it is important to recognize the diversity and variability in people's recovery journeys (Lewis & Hasking, 2021) Emphasis on cessation may encourage a belief that self-harm is pathological and must be stopped at all costs, a belief that can lead to significant harm. Reliance on the opinions and correspondence of professionals (largely psychologists) to provide context and explanation for self-harm strengthened the portrayal of the behavior as pathological, a notion argued to contribute to NSSI stigma (Hasking et al., 2021).

In addition to pathologization, at times advocacy pieces featured language that invited judgement. Reporting on tattoo parlors offering discounted or free tattoos to cover self-harm scars, the journalist in article 11 wrote "*the cuts and bruises she inflicted on herself became a 'very nasty habit'*," and the writer of article 231 described that "*Underneath the images… lies something much darker. From the age of 12 until 19, Laila self-harmed*." Describing self-

harm as a "*nasty habit*" and framing it as something "*dark*" evokes judgment and fear. These narratives could have been framed as stories of recovery and hope; however, the chosen language framed self-harm as a regrettable behavior that should be hidden. Scar acceptance can be an important element of recovery (Kendall et al., 2021) and news media that portrays scars as shameful may negatively impact readers with lived experience of self-harm.

Further problematic phrasing was present in article 299, which reported on a prominent cardinal's visit to a prison. The journalist described offenders met by the cardinal, such as a woman who "*despite the best efforts of prison officers, was a repeat self-harmer*" and "*two other chronic self-harmers*". Labelling an individual by their behavior, as is seen by referring to someone as a "*self-harmer*", is dehumanizing and stigmatizing and should be avoided. Furthermore, referring to people who self-harm in an ongoing manner as "*chronic*" evokes pathology. By definition, chronic refers to persistent illness; identifying persistent self-injury as chronic medicalizes the behavior and removes autonomy, by implying that self-injury is an illness.

An Epidemic

Rates of self-harm were referenced across all article categories, but in 32 articles there was an implication that rates are increasing. For example, in article 405, it was described that "*The number of young women attempting suicide and self-harm is on the increase, causing concern for suicide prevention groups*" and in article 86 it was reported that "*Half of all state teachers and staff in Victoria say they know of students who have self-harmed*." The sentiment that adolescents are increasingly engaging in self-harm was further evidenced in language such as that found in article 175, which described "*the brutal reality of teens in harm's way*."

Articles also pointed to a downward trend in age at onset, implying that not only is self-harm increasing in prevalence, it is also being engaged in by younger and younger people. Indeed, article 174 reported, "The number of children aged under 13 treated at WA hospital emergency departments for self-harm has doubled in the past five years" and article 181, "*I have seen self-harming in children as young as prep* [pre-school], *grade one and two*." While there is evidence to suggest that age of onset is decreasing (Griffin et al., 2018) and that rates are increasing (Hiscock et al., 2018; Morgan et al., 2017), there is limited distinction between suicidal and nonsuicidal self-harm when collecting and analyzing hospital data. Presenting self-harm as increasing in prevalence and decreasing in onset age may create unnecessary fear and panic amongst readers, particularly parents.

While articles did not categorically describe self-harm as an epidemic, the language used to describe rates of engagement positioned it as such. Statistics were described as "*shocking*", "*disturbing*", and "*terrible*", with emphasis placed on rising rates. These linguistic choices evoke fear and panic that may encourage a reader to perceive self-harm as epidemic; indeed, the development of self-harm as a moral panic has previously been identified (Gilman, 2013). The impact of self-harm rates was also positioned as a significant burden. In article 644 and 180, it was outlined that teachers and principals are "*struggling to respond", and in article 39 it was described that "self-harm is adding to the pressure on… stretched* [emergency] *departments*." While we do not dispute these accounts, there is an implication that self-harm is the problem, rather than underlying systemic issues (e.g., resource allocation). By framing self-harm as epidemic, news media establish it as a problem beyond control, a sentiment magnified by linguistic choices, such as "*disturbing*" and "*shocking*".

Self-harm as epidemic was linked to an implication that the behavior is 'spreading.' In articles 179 and 632, it was described that "*a contagion effect is driving an alarming trend* [self-harm increase]." This language implies that people who self-harm are contagious and can cause those around them to start self-harming as well. This perception may lead to discriminatory behaviors such as forced covering of scars and social isolation. While peers may influence self-harm engagement (Schwartz-Mette & Lawrence, 2019), disease-based language such as 'contagious/contagion' has been highlighted as problematic due to its stigmatizing potential. Furthermore, the representation of self-harm as driven by a "*contagion effect*" is reductionistic and does not provide the nuance required to understand how peer influence operates. News media have a responsibility to acknowledge and discuss the complexities of peer influence to ensure that damaging perceptions about self-harm are not perpetuated.

Threatening and Dangerous

Reports of police being called to attend situations involving an individual "*threatening self-harm*" were prominent - 37 articles had this focus. Such articles often criminalized the individual and conveyed a sense of danger, as seen in the description of a "*Christmas Eve siege*" where a "*knife-wielding man was threatening to self-harm*" (546). Likewise, articles 119 and 120 described a "*siege*" that was "*sparked when a man threatened self-harm.*" The word "*siege*" evokes war-like imagery, with the individual in need of support positioned as an enemy and danger to society. A similar narrative emerged in the case of a man who "*threatened to harm himself outside parliament house*" (62), with the situation described:

"*Dramatic scenes unfolded outside state parliament yesterday when heavily armed police swarmed a car that was loaded with fuel and removed a man who was threatening self-harm*" (64). Language such as "*dramatic scenes*" and "*swarmed*" evoke urgency and danger. While warranted in a life-threatening situation, these reactions may be inadvertently attached to self-harm rather than to the potential act of terrorism. Hence, self-harm may come to be understood as a dangerous and violent action.

Framing of self-harm as dangerous was also present in articles discussing the use of restraint and Tasers by police to prevent self-harm. In article 393 it was described that Patrina, a woman living with an intellectual disability "*was placed in handcuffs and put in the back seat of a wagon*" by police reportedly "*trying to protect Patrina who was self-harming at the time*." A similar narrative was present in article 185, which reported on police attendance to a teenage girl engaging in self-harm: "*two male officers arrived at the house where they restrained the girl and tried to force a self-harming implement from her hand*." Additionally, it was described in article 318 that, "*The officer said he finally fired the Taser when Mr Caristo stabbed himself in the leg, having formed the view that there was no other way to stop him harming himself more*." While it can be understood that these acts of intervention were attempts to help people who may pose a risk to themselves and others, self-harm is framed in these articles as a threat warranting police action. Linguistic choices, such as "*force a self-harming implement from her hand*" and "*finally fired the Taser*" position the actions of law enforcement as urgent, representing a justification of police intervention when an individual is self-harming. This may encourage a perception that when an individual engages in self-harm their autonomy is surrendered and restraint is acceptable. These articles also demonstrate the potential for confusion when self-harm is not defined. While restraining someone to prevent suicide may be appropriate, it may be less appropriate to restrain someone who intends to engage in nonsuicidal self-harm.

Perceptions of self-harm as threatening and dangerous were further evidenced in narratives pairing self-harm with acts of violence. It was described in article 521 that a man had "*stabbed his girlfriend and tried to set her alight, and he threatened self-harm*," and in article 365, it was described that after stabbing multiple people, a woman "*allegedly punched an officer and also attempted to self-harm*." More explicit links were evident in descriptions such as that found in article 396, wherein an offender was described as "a*n aggressive drunk who had been admitted to psychiatric units multiple times after self-harming*." Similarly, a man who attacked a police officer was described in article 218 as "*an alcoholic who, when intoxicated, makes contact threatening self-harm*." Narrative constructions that describe self-

harm and violence in proximity may lead to perceptions that people who self-harm are violent.

A Manipulative Tactic

Self-harm was frequently framed as manipulative, particularly within prison, abuse, and refugee narratives. Within the prison context, self-harm was portrayed as a tool used to modify circumstances, justify actions, or manipulate others. The self-harm of serial killer Ivan Milat was described with relative prominence and invariably as a method of escape: "*he was always scheming an escape, usually via hospital stay after self-harming*" (258). Likewise, serial killer Bradley Edwards reportedly injured himself to delay court proceedings: "*A cotton wool bud in his right ear was the only sign of the previous day's drama that led to the first day of his pretrial court hearing being adjourned*" (209). As in Milat's case, Edwards' self-harm was portrayed as a manipulation of circumstances. While prisoners may use self-harm in this way, a lack of alternative media representations may reinforce the myth that self-harm is typically used to manipulate people and circumstances. These portrayals also ignore the complexities of self-harm, which may be used as a means of expression or help-seeking when other options are not known or available (Edmondson et al., 2016). Failure to acknowledge these complexities reduces the behavior to a devious and manipulative tactic, a perception that can lead to poor treatment of people who have self-harmed (Karman et al., 2015) and help-seeking reluctance (Long, 2018).

Within the context of abuse, perpetrators were reported as using threats of self-harm to control their victim. This was evident in articles 335 and 620, where it was reported that "*the teacher threatened self-harm if the* [victim] *revealed what was going on*," and in article 584 where it was reported that "*the stepfather threatened self-harm after his partner confronted him with allegations* [of sexual abuse]." In these examples, it is evident that the motivation to self-harm was to influence others' behavior, and while an accurate portrayal of events, inclusion of detail regarding self-harm appears to leverage the stereotype that self-harm is manipulative. Activation of this stereotype may serve to bolster the characterization of perpetrators as manipulative, and also reinforce harmful stereotypes about people who have self-harmed.

Framing of self-harm as manipulative was also present in articles about asylum seekers. Eighteen of these 76 articles referred to a claim made by then Home Affairs Minister, Peter Dutton, that "*People have come to our country, people have self-harmed on advice from some of the refugee support groups or advocates, people have self-harmed in significant numbers*" (75). In articles 85, 465, 640, journalists reported that Home Affairs was "*concerned that self-*

harm is perceived as the most expedient means of accessing medical transfer [to Australia]." While counterclaims were included, this narrative fosters a perception that self-harm is enacted for the purpose of 'getting what you want'. It is important to consider the wider political context when interpreting articles covering asylum seeker issues. The current Australian government has led a strong deterrence campaign that has informed anti-refugee prejudice in Australia (Hartley et al., 2019). Therefore, claims made by politicians that the "*system was being exploited by asylum seekers who were being encouraged to self-harm*" (417) is likely to carry weight despite conflicting evidence. Regardless of the accuracy of the claims, the pairing of self-harm and manipulation is pervasive in these articles, and given public sentiment regarding asylum seekers, may be more readily accepted than claims of self-harm made in other contexts.

Discussion

Using media framing analysis, we investigated self-harm portrayals in Australian news media articles published in 2019. Our findings provide valuable insight into how the news media positions self-harm, and points to the news media as an important avenue through which people may develop stigmatizing views about the behavior. Six frames of self-harm were formed, each contributing to an overall perception that self-harm is dangerous and engaged in by people who are mentally unwell. While each frame captured distinct messaging, they were not mutually exclusive, and appeared to draw on a broader symbolism of pathology and damage.

While self-harm has long been tied to mental illness, first referenced in asylum records (Angelotta, 2015) before subsequent pathologization throughout the 1960's and 1970's (Millard, 2013), it is well established that not all people who self-harm have a mental illness (Kiekens et al., 2018). Despite this, self-harm was frequently synonymized with mental illness in the articles analysed, a sentiment strengthened by the prioritization of the voices of psychologists and medical professionals leveraged as experts. Contemporary news media continue to frame self-harm through a mental illness lens, which offers a limited perspective of what self-harm encompasses and how to best support people engaging in it. With news media a common information source about self-harm (Newton & Bale, 2021), it is important that journalists offer diverse and accurate perspectives of self-harm, including accurate definitions.

Ambiguity surrounding the distinction between suicidal and nonsuicidal self-harm was prominent and may lead to a conclusion that these concepts are one and the same. By continuing to amalgamate suicidal and nonsuicidal self-harm, news media inadvertently

contribute to the myth that all self-harm is suicidal. This amalgamation may also lead to a perception that self-harm without suicidal intent is non-serious or undeserving of support. In either case, reductionistic portrayals of self-harm impede understanding of the behavior, resulting in inaccurate and harmful beliefs that may inform inappropriate support. Delineating suicidal and nonsuicidal self-harm is necessary to improving portrayals of self-harm.

While references to self-harm were often fleeting or subtle, such references contribute to a reader's overall mental representation of self-harm. Mental representations include all relevant cognitive, emotive, and sensory experiences, both subtle (a line in a news article) and direct (a close friend with lived experience; Bartlett, 1932). Regardless of prominence, media frames of self-harm contribute to readers' mental representations of the behavior, which may inform subsequent attitudes and reactions toward to self-harm. For example, through exposure to news media about self-harm a person may develop a mental representation that concludes the behavior is inevitably suicidal in intent, which may lead to inappropriate support (e.g., forced hospitalization). By contributing to readers' mental representations of self-harm, the news media can impact how self-harm is appraised and how people who self-harm are treated. Furthermore, individuals with lived experience also absorb media framing of self-harm. When exposed to articles that imply people who self-harm are unstable, dangerous, or at fault for their difficulties, individuals may internalize such messages, which may result in feeling misunderstood, invalidated, and hurt. This may foment self-stigma (Staniland et al., 2021), which is associated with shame, isolation, and continued self-injury (Bachtelle & Pepper, 2015).

Our findings provide evidence that news media, at least that which is published in Australia, contributes to self-harm stigma. The extent to which this influences people's attitudes towards and beliefs about self-injury is unknown; however, mental illness research suggests that news media plays a role in the development and maintenance of stigma (Sieff, 2009). Despite operating under guidelines for responsible reporting on self-harm since 2009 (Everymind, 2020), Australian news media continue to use sensational and stigmatizing language. Research is needed to understand how reporting guidelines translate into practice, and whether more detailed advice, such as that found in the resource published by Westers et al. (2020), is required.

Furthermore, journalists must consider the impact of their language (see Hasking et al., 2021 for a data-informed commentary) and critically evaluate the need to include references to self-harm, particularly in reports about crime. While it is established in guidelines that reporting on self-harm methods is inappropriate, it should be considered whether the need to

report on self-harm is necessary at all. Many articles in our data set referred to self-harm in the context of a crime to establish a history or background for the offender. This detail was usually irrelevant to the story and connected self-harm with violence, instability, and danger. Asking “what purpose does this information serve?” may be an important reflection during the writing process. If self-harm detail is necessary to the story, then sensitive and considered inclusion of the information is warranted, but if the detail serves to explain the mental state of an offender or otherwise evoke emotion from a reader, the inclusion of the information is questionable.

Limitations, Implications, and Future Directions

While we drew on a large sample of news articles to analyze, our focus on Australian news media means that we were only able to capture a small section of a much larger mass media agglomerate. The role of social media in information sourcing is growing, and consumers source their information from a range of outlets, published both nationally and internationally (Newman et al., 2020). Therefore, the frames outlined here may not be representative of mass media at large. While our conclusions may be transferrable to news media from other English-speaking countries, it will be important to investigate the framing of self-harm across countries and across platforms (e.g., social media) in order to develop a more holistic understanding of the self-harm frames readers are exposed to.

While we have endeavoured to be transparent in our methodology and conclusions, media frames are never obvious or explicit, meaning that our analysis, like other approaches, relied on human interpretation. We acknowledge that the positioning of each member of the research team inevitably permeates these interpretations. In line with qualitative reporting standards (Levitt et al., 2018), we adopted structured methods of reflexivity including regular team meetings, reflexive journaling, and bracketing. In our bracketing efforts, we acknowledged and reflected on our relevant stigma foci to minimize the risk of transposing frames that we expected, rather than finding frames that were there. Furthermore, while our interpretations are described and explained with examples, we cannot account for journalistic intention. Understanding framing of self-harm would benefit from collaboration with journalists.

Reducing the stigma of self-harm requires interdisciplinary efforts. In absence of a commitment from journalists and media organizations to address the harmful impacts of negative self-harm frames, efforts made by advocates and researchers will be impeded. While challenges such as editorial pressures, fulfilling public interest, and funding competition contribute to writing choices, and should be considered (Holland, 2018), there are freely

accessible guidelines that direct responsible and appropriate reporting on self-harm (Westers et al., 2020). Like the behaviour itself, portrayals of self-harm must be nuanced, with meaningful efforts made to center lived experiences and stories of hope without sensationalizing the behaviour (as seen in article 11 with the description of self-harm as a "nasty habit").

In addition to researching the framing of self-harm in other types of media, future work should investigate what aspects of framing are attended to and retained. This could be achieved experimentally, by exposing participants to various representations of self-harm and administering pre- and post-observation measures of relevant knowledge, attitudes, and beliefs. The findings of such research may point to potential impacts of media framing on readers' understanding and perception of self-harm. Furthermore, investigating reader responses to self-harm related media can provide insight into how people think and feel about self-harm. Many people access news media through social media platforms that allow public commenting, therefore, there is potential to investigate reader framing of self-harm in comments sections. This could be achieved by extracting comments made on self-harm-related news articles and completing a framing analysis on the comments.

Finally, as the field continues to investigate self-harm stigma and work to reduce it, consideration must be made to macro-level influences. As Scambler (2018) articulates, stigma is a product not just of evolutionary processes (i.e., fundamental aversion to difference) but also a tool through which to maintain the status quo. A shift in news media portrayals, while necessary, may not be sufficient to disrupt the pervasive nature of stigma (Scambler, 2018). Change in news media portrayals is one small component of a larger movement needed to destigmatize mental health difficulties and requires collaborative advocacy efforts. The inclusion of lived-experience narratives and recovery-oriented foci is vital, but it must also be acknowledged that self-harm stigma, like other stigmas, are intersectional and complex, and require intersectional and complex solutions.

Conclusion

Self-harm continues to be misunderstood and misrepresented, in part due to ambiguity regarding what constitutes self-harm and why people engage in the behavior. While research focused on self-harm stigma is emerging, there is still limited understanding of how self-harm stigma propagates and perpetuates. We know that news media provides the public with health information, and in doing so sets an agenda for what is perceived as important and true (Kennedy & Prat, 2019). As such, the way news media frame an issue has an impact on how the public perceive it. With news media being a dominant source of information about self-

harm (Newton & Bale, 2012), stigma messages communicated by news media have significant implications for public understanding about the behavior and people who engage in it. The present work provides valuable insight into the types of stigma messages conveyed about self-harm in news media and highlights an important site through which self-harm stigma may manifest. By drawing attention to the subtle ways stigma is communicated, we hope this work encourages the widespread use of Westers and colleagues' (2020) reporting guidelines and critical consideration of how self-harm narratives are constructed and construed.

Chapter 5

Development and Validation of the Self-Injury Stigma Scales (SISS)

The preceding chapters have contributed to a foundational understanding of self-injury stigma. By developing the NSSI Stigma Framework, I proposed a conceptualisation of self-injury stigma that offers a way to consider, identify, and explain NSSI stigma. In Chapter 3 I demonstrated the applicability of the Framework to individuals' lived experiences of self-injury stigma and in Chapter 4 I demonstrated the utility of the Framework to direct the development of research questions. An additional limitation of the field is the lack of a measure of stigma specific to NSSI. In the following chapter, I present the development and validation of the Self-Injury Stigma Scales.

Staniland, L., Hasking, P., Boyes, M., & Lewis, S. (under review). The development and validation of the self-injury stigma scales (SISS).

Attributions

Author	Contribution	Acknowledgement
Lexy Staniland	Development of research question and methodology, data management and analysis, interpretation of results, and manuscript preparation	
Penelope Hasking Stephen Lewis Mark Boyes	Assisted with development of research question, interpretation of results, and manuscript preparation	

Abstract

Nonsuicidal self-injury is a highly stigmatised behaviour. Individuals who have self-injured report stigma to be a significant contributor to ongoing distress and a barrier to support-seeking and recovery. Despite these potential impacts, limited research has investigated self-injury stigma. Without a valid and reliable tool through which to assess self-injury stigma, our understanding of it remains limited. In study one, we drew on a conceptual framework of self-injury stigma to develop item pools representing five types of stigma (Public, Personal, Self, Anticipated, Enacted). The item pools were piloted with a sample of 316 MTurk participants before being reduced through correlation and factor analyses. In study two, the reduced item pools were administered alongside validation measures to a sample of 722 participants recruited via social media, our university, and MTurk. Confirmatory factor analyses revealed four factors (Origin, Concealability, Peril, Disruption) which were consistent across the five scales. Internal consistency was sound, and both convergent and divergent validity were demonstrated through correlations with measures of mental illness stigma, social exposure to self-injury, social both reactions to self-injury, self-esteem, and shame. Psychometric equivalence across samples with and without a history of self-injury was demonstrated. The Self-Injury Stigma Scales (SISS) were theoretically informed and represent reliable and valid measures of self-injury stigma. The SISS offers a comprehensive tool that may allow researchers to investigate how self-injury stigma develops and persists, and the impact it has on the wellbeing of individuals with lived experience of self-injury.

Introduction

Nonsuicidal self-injury (NSSI) is a highly stigmatized behavior (Staniland et al., 2021) that involves damaging one's own body without intent to die (ISSS, 2022). It typically involves cutting, burning, or hitting oneself and is usually enacted as an emotion regulation strategy (Taylor et al., 2018). Relatively common, lifetime prevalence rates of NSSI are estimated at approximately 17% for adolescents, 13% for young adults, and 5% for adults (Swannell et al., 2014). People with lived experience of self-injury tend to experience greater psychological distress (Buelens et al., 2019), shame (Sheehy et al., 2019), and interpersonal difficulties (Turner et al., 2017) than people with no such experience, and a history of NSSI confers increased risk for suicidality (Ribeiro et al., 2016). Emerging evidence suggests that rates of NSSI are increasing, particularly among adolescents (Hiscock et al., 2018), although changes in how hospitals record self-inflicted injuries, as well as definitional ambiguity regarding the distinction between suicidal and non-suicidal self-injury may inflate such estimates. Regardless, associated challenges and risks position NSSI as a behavior warranting research attention.

While substantial research has investigated the etiological and functional processes of NSSI (Cipriano et al., 2017), only recently has there been a shift to exploring the lived experience of NSSI (Lindgren et al., 2021). Part of this shift has involved directing attention to the experiences involved in the well-being of individuals with lived experience of self-injury (e.g., Lewis et al., 2019). One aspect of this new focus is a consideration of NSSI stigma.

NSSI Stigma

Stigma is a social construct and represents the culmination of stereotype, prejudice, and discrimination directed toward and individual or groups of individuals who engage in a behavior that is socially derided (Link & Phelan, 2001). Whilst incipient, the extant literature demonstrates that NSSI stigma is a salient experience for people who have self-injured, who describe being stereotyped as "attention-seeking" (Rowe et al., 2014), "goth" or "emo" (Long, 2018), or perceived as "crazy" or "damaged" (Klineberg et al., 2013; Mitten et al., 2015). Prejudice has been exemplified in reactions of hostility, anger, and judgement (Long, 2018; Rosenrot & Lewis, 2018) and assumptions that NSSI is inevitably suicidal (Brown & Kimball, 2012). Discrimination has been described in the form of delayed or inappropriate treatment, invalidation, and belittlement (Klineberg et al., 2013; Long et al., 2015; Mitten et al., 2015; Williams et al., 2020). These stigma experiences impede help-seeking (Fortune et al., 2008;

Long, 2018; Rowe et al., 2014), effective prevention and intervention efforts in schools (Parker, 2018), and foment shame (Brown & Kimball, 2012; Long, 2018; Rosenrot & Lewis, 2018).

While the extent to which people experience NSSI stigma has been minimally explored, researchers suggest that healthcare workers often hold stigmatizing views toward people who self-injure (Cleaver, 2014; Karman et al., 2014) and some parents of children who self-injure endorse NSSI stereotypes (Fu et al., 2020). Interviews (Newton & Bale, 2012). Experimental studies using descriptive vignettes of characters who have self-injured have also demonstrated that people hold largely negative perceptions of NSSI (Law et al., 2009; Lloyd et al., 2018; Burke et al. 2019). Given that stigma is associated with adverse outcomes such as diminished self-esteem (Corrigan & Rao, 2012) and increased shame (Livingston & Boyd, 2010), and prevents support-seeking for people who have self-injured (Long, 2018), NSSI stigma requires urgent research attention. Despite increasing evidence that stigma is relevant to well-being, help seeking, and recovery (Staniland et al., 2021), a comprehensive and theoretically informed measure of NSSI stigma has yet to be developed. Without a valid and reliable measure of NSSI stigma, efforts to advance our understanding of NSSI stigma may be limited.

Measuring NSSI Stigma

While prior research has adapted measures of mental illness stigma to assess NSSI stigma (e.g., Hamza et al., 2021), facets of self-injury, such as its potential visibility and voluntary nature, distinguish it both conceptually and experientially from mental illness (Staniland et al., 2021). Adaptations are unlikely to capture the full scope of NSSI stigma; thus, the utility of adapted measures is likely limited. Recently, it was theorized that NSSI stigma arises as a function of six underlying domains: origin, the reason for NSSI; concealability, the visibility of NSSI; course, the modifiability of NSSI; peril, the dangerousness of NSSI; and disruptiveness, the degree to which NSSI impacts relationships (Staniland et al., 2021). Further, it was proposed that these domains emerge as five types of stigma: public, the attitudes and beliefs of the general population; personal, the attitudes and beliefs held by an individual about others; self, the internalization of public and/or personal attitudes and beliefs; anticipated, the expectation of stigma; and enacted, the direct or indirect experience of stereotype, prejudice, and/or discrimination. Staniland et al.'s (2021) framework thus offers an empirically informed rubric that may have relevance in the development a comprehensive measure of NSSI stigma.

Measuring NSSI stigma is vital to advancing our understanding of how and why it emerges and the impact it has on people with lived experience. An NSSI stigma scale would enable researchers, clinicians, and advocates to measure levels of NSSI stigma, understand how it correlates with other constructs, and evaluate the effectiveness of stigma reduction interventions and initiatives. In this paper, we outline the development and evaluation of the Self-Injury Stigma Scales (SISS) across two studies. In the first study, we developed a large pool of items intended to capture each element of the NSSI stigma framework (Staniland et al., 2021), which were pilot tested and assessed for construct validity. The item pool was then reduced based on inter-item correlations and factor loadings. In the second study, we administered the reduced item pool to a new sample and assessed the psychometric properties of the SISS.

Study One

The aims of Study One were twofold. The first was item generation, a deductive process informed by the NSSI stigma framework (Staniland et al., 2021). Items were generated within each domain of the NSSI stigma framework (origin, concealability, course, peril, aesthetics, and disruptiveness) and mapped across each type of NSSI stigma (public, personal, self, anticipated, and enacted). Each type of stigma was designed to operate as an independent scale, with each domain expected to operate as a factor. Therefore, we proposed five scales, each comprising six factors. The second aim was item reduction, a statistically and theoretically driven process.

Method

Measures

Alongside standard demographic information, the following were measured.

Self-Injury Stigma

Items were developed by the research team in consultation with the literature (e.g., Corrigan et al., 2012), qualitative data collected by the authors, and a special-interest research group comprising researchers, clinicians, advocates, individuals with lived experiences, and students interested in the study of self-injury. Using the NSSI Stigma Framework as a basis, we brainstormed attitudes, beliefs, and common stereotypes about self-injury (e.g., weak, resilient, drain on the healthcare system) which we phrased into items (e.g., people who self-injure are weak, people who self-injure are resilient). A total of 150 items were generated, 30 of these being positively worded. The item stems were modified to map onto each of the scales:

- Public stigma scale stem: “I think the public believe that…”

- Personal stigma scale stem: "I personally believe that…"
- Self-stigma scale stem: "Because of my self-injury, I…"
- Anticipated stigma scale stem: "If people find out about my self-injury, they…"
- Enacted stigma scale stem: "Because of my self-injury, people have…"

Both the public and personal scales comprised 150 items, 34 of which were positively worded. The self-stigma scale comprised 130 items, 34 of which were positively worded. Twenty of the items did not translate from the public/personal scales to the self-stigma scale due to some items (e.g., people who self-injured did it because their friends did) not representing self-stigma. Similarly, two items from the public/personal scales did not map onto the anticipated and enacted scales, which each comprised 148 items, 34 of which were positively worded. The final item pool comprised 726 items (see Appendix J). The latter three scales are completed only by people with a history of self-injury. Each item is responded to on a 7-point Likert scale from 1 (*strongly disagree*/*extremely unlikely*/*never*) to 7 (*strongly agree*/*extremely likely*/*always*), with higher scores indicating greater stigma.

Nonsuicidal Self-Injury

The Inventory of Statements about Self-Injury (ISAS; Klonsky & Olino, 2008) was used to collect data about self-injury. Participants were asked whether they have self-injured during their lifetime and if so, at what age they first self-injured, how many times they had done so during the past 12 months, and what their primary method was/is. The ISAS has established test-retest reliability (Glenn & Klonsky, 2011) and is a widely used (Taylor et al., 2018).

Procedure

Upon receiving ethical approval (Appendix K), the survey was built via Qualtrics and advertised to participants on Amazon's Mechanical Turk (MTurk, 2019), an online recruitment platform that allows researchers access to a large sample of people who complete surveys in exchange for monetary compensation. Participants were paid according to the anticipated completion time, which was one hour for people with a history of NSSI (USD $5.00) and 15 minutes for those without a history of NSSI (USD $2.00). Interested participants were routed from MTurk to Qualtrics where they were presented with an information sheet. Consent was obtained using a check box that allowed participants to proceed to the survey.

Participants

A total of 472 responses were recorded. After removing incomplete (*n* = 85), duplicate (*n* = 55), and nonsense (e.g., free text entry in wrong format; *n* = 16) responses, the sample comprised 316 individuals aged between 20 and 67 years (*M* = 32.1, *SD* = 7.7). Most participants reported as male (*n* = 215, 68.0%) and heterosexual (*n* = 171, 54.1%). Fifty-five (17.4%) participants reported a mental illness diagnosis and 189 (40.0%) reported a history of NSSI. Most participants were employed full-time (*n* = 291, 92.1%), with 18 (5.7%) part-time/casual, six (1.9%) unemployed, and one unreported. Participants were mostly from Asia (*n* = 161, 50.9%) and the Americas (North = 64, 20.3%; South = 36, 11.4%), with the remainder from Europe (*n* = 15, 4.7%), another region (*n* = 7, 2.2%), or unreported (*n* = 33, 10.4%).

Data Analysis

Responses were first evaluated for normality, with univariate skewness < ± 2 and kurtosis < ± 7 demonstrating normal distribution (West et al., 1995). Data were then disaggregated by NSSI history and assessed by scale and factor. Item reduction occurred iteratively through examination of inter-item correlations and exploratory factor analyses using SPSS Version 27.

Results

Preliminary Results

Data provided by participants with no history of NSSI were missing completely at random $\chi^2(79.961) = 15728$, $p = 1.000$, as were data provided by participants with a history of NSSI, $\chi^2(.000) = 103612$, $p = 1.000$ (Little, 1988). Expectation Maximization was used to impute missing values (EM; Scheffer, 2002). Of the 189 participants reporting a history of NSSI, 171 had self-injured within the past 12 months, most having done so once (*n* = 89, 52.1%) or twice (*n* = 45, 26.3%). Reported age of onset ranged from 2 to 47 years (*M* = 22.2, *SD* = 7.7). Participants reported up to five physical scars, most reporting one (*n* = 91, 28.8%) or two (*n* = 68, 21.5%), with cutting the most reported main form of self-injury (*n* = 95, 50.3%).

Item Reduction

Item evaluation occurred in two stages: first via inter-item correlations, and second via factor loadings. Because items were developed within the six domains proposed by the NSSI stigma framework (origin, concealability, course, peril, aesthetics, and disruptiveness; Staniland et al., 2021), it was expected that each of these domains would represent a factor within each scale (public, personal, self, anticipated, and enacted). For example, the item "people who self-

injure are weak" was developed to capture origin, so it was expected that this item, along with other items developed within the origin domain, would load onto an "origin" factor. Additionally, each item was represented across each scale, rephrased to fit the type of stigma. For example, the item "people who self-injure are weak" represents the public and personal scales, whereas on the self-stigma scale, this item was phrased as "I am weak". An overview of the reduction process can be seen in Table 5.1

Inter-Item Correlations

As per Ferketich's (1991) guidance, items correlating ≥ 0.70 or ≤ 0.40 were considered for removal. Items with high correlations were compared for face-validity; the item with the preferred wording was retained. Items with low correlations were compared across scales and retained only if inter-item correlations were ≥ 0.70 on two or more scales. Several iterations were performed until all inter-item correlations fell within the desired range, resulting in 53 items for the public, personal, anticipated, and enacted NSSI stigma scales (origin = 14, concealability = 7, course = 7, peril = 8, aesthetics = 6, disruption = 11) and 42 for the NSSI self-stigma scale (origin = 10, concealability = 7, course = 6, peril = 6, aesthetics = 6, disruption = 9).

Exploratory Factor Analyses

Exploratory factor analyses (EFA) were used to assess each item's performance as an indicator of its theorized factor (see Table 5.2). Because the SISS comprises five scales, each with six proposed factors, items were clustered into their theorized factors and then assessed using EFA with oblique Promax rotation and principal axis extraction, forcing a one factor solution. Each item's factor loading was compared across scales to identify those that did not load onto their respective factor consistently across scales. In the first round of EFAs, all items loaded ≥ 0.50. Given the item pool was still large, items loading < 0.70 were considered for removal. Several iterations were performed until all factor loadings exceeded 0.70, resulting in 33 items for the public, personal, anticipated, and enacted NSSI stigma scales (origin = 7, concealability = 5, course = 5, peril = 5, aesthetics = 4, disruption = 7) and 28 for the NSSI self-stigma scale (origin = 5, concealability = 5, course = 5, peril = 3, aesthetics = 3, disruption = 7).

Table 5.1
Item Reduction Process

	Public Stigma			Personal Stigma			Self-Stigma			Anticipated Stigma			Enacted Stigma		
	I think the public believes…			I believe that…			My experience of self-injury means that…			…how likely do you think the following would occur?			…how often the following have happened?		
	Number of items at each step														
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Origin	36	14	7	36	14	7	32	10	5	37	14	7	37	14	7
Concealability	22	7	5	22	7	5	18	7	5	19	7	5	19	7	5
Course	18	7	5	18	7	5	16	6	5	18	7	5	18	7	5
Peril	23	8	5	23	8	5	19	6	3	23	8	5	23	8	5
Aesthetics	13	6	4	13	6	4	11	5	3	13	6	4	13	6	4
Disruptiveness	38	11	7	38	11	7	35	9	7	38	11	7	38	11	7
Total	150	53	33	150	53	33	130	42	28	148	53	33	148	53	33

Note. Step 1 = initial pool of items, step 2 = after reduction based on bivariate correlations, step 3 = after reduction based on exploratory factor analysis.

Table 5.2
Factor Loadings

	NSSI-N (n = 127)						NSSI-Y (n = 189)														
	Public			Personal			Public			Personal			Self			Anticipated			Enacted		
	Factor Loadings at each Iteration																				
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Origin																					
… are/am manipulative	.85	.79	-	.79	.84	-	.80	.84	-	.87	.84	-	.80	.79	-	.77	.81	-	.82	.81	-
… are/am self-injured are crazy	.78	.83	-	.84	.78	-	.81	.82	-	.83	.84	-	.82	.80	-	.76	.74	-	.76	.75	-
… copied it from social media/internet	.76	.84	-	.81	.74	-	.72	.78	-	.79	.83	-	-	-	-	.69	.74	-	.75	.76	-
… are/am attention seeking	.77	.72	-	.71	.75	-	.69	.70	-	.81	.83	-	.81	.81	-	.77	.79	-	.81	.81	-
… are/am to blame for their/my problems	.76	.73	-	.78	.77	-	.78	.78	-	.84	.85	-	.74	.76	-	.81	.80	-	.83	.82	-
… are/am weak	.77	.78	-	.76	.81	-	.77	.78	-	.85	.87	-	.80	.79	-	.70	.69	-	.77	.78	-
… did it because their/my friends did	.76	.76	-	.76	.77	-	.73	.74	-	.79	.81	-	-	-	-	.73	.76	-	.83	.85	-
… are/am masochistic	.76	-	-	.72	-	-	.74	-	-	.74	-	-	-	-	-	.71	-	-	.79	-	-
… are/am childish	.75	-	-	.72	-	-	.72	-	-	.73	-	-	-.77	-	-	-.66	-	-	.76	-	-
… are/am dysfunctional	.74	-	-	.69	-	-	.79	-	-	.72	-	-	.76		-	.75	-	-	.74	-	-
… are/am “emo” or “goth”	.68	-	-	.76	-	-	.76	-	-	.84	-	-	-	-	-	-.66	-	-	.81	-	-
… have a mental illness	.67	-	-	.68	-	-	.77	-	-	.65	-	-	.75	-	-	.71	-	-	.75	-	-
… don’t really have anything to complain about	.66	-	-	.81	-	-	.73	-	-	.83	-	-	.80	-	-	.71	-	-	.75	-	-
… are/am emotionally unstable	.54	-	-	.65	-	-	.78	-	-	.67	-	-	.77	-	-	.76	-	-	.79	-	-

Concealability																					
… should not let others know about it	.84	.85	.81	.82	.81	.82	.83	.83	.82	.79	.81	.83	.77	.76	.74	.72	.73	.72	.83	.84	.84
… should avoid talking about self-injury	.75	.76	.76	.76	.75	.76	.82	.83	.83	.83	.83	.84	.78	.80	.81	.78	.78	.76	.84	.83	.83
… should cover up their/my self-injury	.75	.75	.75	.73	.75	.76	.74	.77	.77	.78	.77	.78	.80	.81	.86	.75	.76	.79	.86	.87	.88
… don't need to talk about it	.74	.75	-	.54	.52	-	.66	-	-	.73	.75	-	.67	.67	-	.78	.76	-	.84	.83	-
… should not post about self-injury online	.71	.71	.82	.81	.82	.73	.79	.79	.79	.79	.80	.79	.74	.75	.72	.70	.71	.73	.82	.83	.83
… should toughen up	.66	.64	.80	.80	.79	.65	.70	.67	.78	.81	.79	.65	.76	.74	.72	.77	.78	.75	.75	.75	.75
…should show evidence of their self-injury when asked	.64	-	-	.83	-	-	.59	-	-	.70	-	-	.58	-	-	.72	-	-	.83	-	-
Course																					
… will never be able to manage their/my emotions	.78	.79	-	.77	.77	-	.72	.71	-	.77	.77	-	.77	.80	-	.68	.69	-	.80	.80	-
… will never be able to cope	.74	.71	-	.73	.74	-	.78	.77	-	.77	.74	-	.78	.82	-	.75	.72	-	.80	.77	-
… just going through a phase	.73	.74	-	.79	.74	-	.81	.79	-	.74	.76	-	.66	.58	-	.71	.66	-	.78	.75	-
… should be forced to stop	.67	.71	-	.70	.72	-	.76	.79	-	.76	.75	-	.78	.78	-	.68	.72	-	.73	.77	-
… don't have the guts to kill themselves	.63	-	-	.75	-	-	.69	-	-	.75	-	-	-	-	-	.71	-	-	.79	-	-
… should be able to easily recover	.58	-	-	.68	-	-	.77	-	-	.78	-	-	.67	-	-	.65	-	-	.77	-	-
… should be checked for signs of self-injury	.58	.58	-	.52	.545	-	.74		-	.72	-	-	.80	.79	-	.76	.78	-	.77	.79	-
Peril																					
… belong in a mental institution	.77	.77	.78	.82	.83	.84	.78	.79	.78	.81	.80	.80	.86	.91	.93	.82	.82	.81	.80	.81	.80
… are/am dangerous	.74	.73	.74	.77	.75	.75	.76	.76	.75	.84	.86	.86	.78	.79	.79	.79	.82	.82	.87	.87	.87

… share pictures of their self-injury online	.74	.74	.72	.70	.69	.69	.77	.75	.77	.77	.76	.75	-	-	-	.72	.74	.75	.78	.79	.80
… copied the behaviour from someone else	.70	.67	.66	.78	.79	.76	.75	.74	.75	.82	.83	.83	-	-	-	.71	.74	.75	.81	.82	.83
… always be at risk of suicide	.69	.69	.71	.74	.74	.75	.79	.81	.80	.78	.79	.79	.79	.81	.79	.75	.72	.70	.84	.83	.81
… are/am impulsive	.69	.69	-	.70	.70	-	.80	.79	-	.67	.64	-	.71	.61	-	.72	.69	-	.84	.83	-
… are/am reckless	.64	-	-	.65	-	-	.70	-	-	.79	-	-	.81	-	-	.75	-	-	.75	-	-
… self-injury is not important	.63	-	-	.66	-	-	.65	-	-	.72	-	-	.76	-	-	.70	-	-	.82	-	-
Disruptiveness																					
… don't care if they upset their friends and family	.77	.76	.75	.77	.75	.71	.81	.78	.76	.71	.67	.61	.87	.87	.87	.74	.74	.72	.78	.79	.79
… should not have children	.76	.77	.78	.74	.73	.75	.74	.75	.76	.78	.82	.84	.84	.86	.86	.82	.81	.82	.80	.80	.80
… do not care about others	.80	.9	.80	.72	.76	.78	.78	.79	.82	.76	.77	.80	.84	.83	.83	.84	.83	.84	.79	.79	.80
… should avoid talking about it with others	.77	.80	.78	.70	.71	.74	.77	.77	.78	.80	.81	.82	.72	.70	.70	.75	.75	.74	.77	.76	.75
… should stay away from me/people who self-injure	.77	.75	.76	.72	.70	.71	.81	.81	.81	.76	.75	.78	.89	.89	.89	.82	.82	.83	.85	.86	.86
… waste their/my friends' time	.77	.80	.79	.70	.72	.69	.77	.77	.77	.67	.65	.58	.81	.80	.81	.76	.78	.77	.80	.79	.79
… deserve poor treatment	.61	.63	.64	.60	.63	.63	.68	.71	.70	.72	.76	.77	.85	.86	.86	.78	.78	.80	.82	.83	.84
… are selfish	.77	-	-	.65	-	-	.78	-	-	.65	-	-	.70	-	-	.67	-	-	.81	-	-
… refuse to accept help	.76	.77	-	.64	.607	-	.81	.80	-	.61	.58	-	-	-	-	.74	.74	-	.80	.80	-
… need to be controlled	.71	-	-	.63	-	-	.66	-	-	.72	-	-	.67	-	-	.78	-	-	.79	-	-
… need to be treated delicately	.40	-	-	.43	-	-	.67	-	-	.61	-	-		-	-	.77	-	-	.77	-	-

Study Two

The aim of Study Two was to assess the psychometric properties of the SISS. Confirmatory factor analyses were used to examine the factor structure of the scales and measurement invariance between participants with and without a history of NSSI on the public and personal scale. Further item reduction occurred as appropriate. Construct validity was assessed through examination of correlations between the SISS and measures of mental illness stigma, social exposure to NSSI, and indicators of stigma impact including shame and self-esteem. Internal consistency was assessed using Cronbach's alpha and McDonald's omega.

Method

Measures

Alongside standard demographic information, the following constructs were measured.

Nonsuicidal Self-Injury

As described in Study One, NSSI was assessed using the ISAS (Klonsky & Olino, 2008).

Self-Injury Stigma Scales

The final set of items from Study One was used.

Mental Illness Stigma

The Self-Stigma of Mental Illness Scale (SSMIS; Corrigan et al., 2006) was included as a validation measure for the SISS. The SSMIS comprises four subscales, each with 10 items: awareness ("I think the public believes most people with a mental illness cannot be trusted); agreement ("I think most people with a mental illness cannot be trusted"); application ("Because I have a mental illness, I cannot be trusted); and harm ("I currently respect myself less because I cannot be trusted"). The harm subscale was not used, as it indicates an outcome of stigma, rather than the construct itself. Participants reporting a mental illness diagnosis were presented with the SSMIS and asked to rate each item on a 9-point Likert scale, ranging from 1 (*strongly disagree*) to 9 (*strongly agree*), with higher scores indicating greater stigma. Each subscale has acceptable internal consistency (awareness, $\alpha = 0.91$; agreement, $\alpha = .0.72$; application, $\alpha = .81$) and test-retest reliability (awareness, $r = 0.73$; agreement, $r = .0.68$; application, $r = .82$; Corrigan et al., 2006). In the present sample, Cronbach's alphas were 0.94 for awareness, 0.92 for agreement, and 0.89 for application. Positive correlations were expected between awareness and public NSSI stigma, agreement and personal NSSI stigma, and between application and self-stigma.

NSSI Social Exposure

The 10-item[3] Social Exposure to NSSI Scale (SENS; Zelkowitz et al., 2017) measures the degree of exposure participants have had to NSSI-related media (e.g., "I have seen references to different forms of NSSI in movies") and in interpersonal relationships (e.g., "I have friends who engage in NSSI"). Each item has a 4-point Likert response scale from 1 (*never*) to 4 (*frequently*), with responses on each subscale summed to provide a media exposure score and an interpersonal exposure score, with higher scores indicating more social exposure to NSSI. Both subscales demonstrate acceptable internal consistency (interpersonal, α = 0.85; media, α = 0.79; Zelkowitz et al., 2017), including in the present sample (interpersonal, α = 0.89; media; α = 0.84). Positive correlations were expected between the SENS subscales and the SISS.

Social Reactions to NSSI

The 39-item Social Reactions to Self-Injury Disclosure scale (SRSD; Ammerman & McCloskey, 2020) measures three types of possible reactions experienced in response to disclosing NSSI: negative reactions (e.g., "pulled away from you"), tangible aid (e.g., "distracted you with other things"), and emotional support (e.g., "spent time with you"), each scored on a 5-point Likert scale from 0 (*never*) to 4 (*always*). Each subscale has acceptable internal consistency (negative reactions, α = 0.96 - 0.97; tangible aid, α = 0.69 - 0.71; emotional support, α = 0.91 - 0.92; Ammerman & McCloskey, 2020), including in the present study (negative reactions, α = 0.97; tangible aid, α = 0.72; emotional support, α = 0.93). Positive correlations were expected between negative reactions and the self-, anticipated, and enacted NSSI stigma scales. Negative correlations were expected between tangible aid and emotional support, and the self-, anticipated, and enacted NSSI stigma scales.

Self-Esteem

The 10-item Rosenberg Self-Esteem scale (RSE; Rosenberg, 1965) was used to assess self-esteem (e.g., "On the whole I am satisfied with myself"). Each item is scored on a 4-point Likert scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*), with higher scores indicating higher self-esteem. The RSE has sound internal consistency (α = 0.84 - 0.95; Sinclair et al., 2010), including in the present sample (α = 0.94). Negative correlations were expected between the RSE and the self-, anticipated, and enacted NSSI stigma scales.

[3] Zelkowitz et al. excluded items 2 and item 8 due to poor factor loadings. In the present sample both items meaningfully loaded onto the media factor as expected and were thus included (output presented in Appendix L).

Shame

The 25-item Experiences of Shame Scale (ESS; Andrews et al., 2002) comprises three subscales: characterological shame (e.g., "have you felt ashamed of any of your personal habits?"), behavioral shame (e.g., "do you feel ashamed when you do something wrong?"), and bodily shame (e.g., "have you felt ashamed of your body or any part of it?"). Each item is scored on a 4-point Likert scale from 1 (*not at all*) to 4 (*very much*), with higher scores indicating stronger feelings of shame. The ESS has demonstrated internal consistency (α = 0.92; Andrews et al., 2002), including in the present sample (α = 0.96). Positive correlations were expected between the ESS and the self-, anticipated, and enacted NSSI stigma scales.

Instructional Attention Check

An instructional attention check is a response-format matched item embedded within a scale that provides participants with a specific instruction, such as “Please select *strongly agree* for this question” (Huang et al., 2015). To identify careless responses, which can contaminate data and challenge validity, an instructional attention check was included for each of the self-injury stigma scales. Participants without lived experience were exposed to two attention checks, one in the public stigma scale and one in the personal stigma scale, with incorrect responses to both resulting in the participant’s data being excluded from analysis. Participants with lived experience were exposed to five attention checks, one each on the public, personal, self, anticipated, and enacted stigma scales, with incorrect responses to two or more resulting in the participant's data being excluded from analysis.

Procedure

Upon receiving ethical approval, the study was advertised on MTurk, social media platforms, and our university’s research participant pool. Details about the study were provided in the advertisements and interested participants could click a link to take them to an information sheet. Informed consent was obtained via clickable checkbox, which took participants to a set of three multi-choice questions (e.g., what is the study about?) that assessed comprehension of the information sheet. Correct responses indicated that participants understood the detail given in the information sheet and were therefore able to provide informed consent. Incorrect responses suggested comprehension of the information sheet was insufficient to provide informed consent. Participants who responded incorrectly were unable to proceed and were shown a thank you message, participants who responded correctly proceeded to the survey, where they completed

the battery of measures. Participants recruited via MTurk were reimbursed as per Study One, those recruited via social media were not reimbursed, and those recruited through our university's research participation pool were awarded course credit for their contribution.

Participants

A total of 1112 participants responded to the survey. After removing incomplete responses (*n* = 314), duplicate cases (*n* = 22), and those who failed the attention checks (*n* = 54), the final sample comprised 722 participants aged between 14 and 75 years (*M* = 29.2, *SD* = 12.7). Participants were recruited via social media platforms (*n* = 271, 37.5%), our university research participant pool (*n* = 262, 36.3%), and MTurk (*n* = 188, 26.0%). Of the sample, 402 (55.7%) reported a lifetime history of NSSI. Of these participants, 269 (66.9%) had self-injured within the past year, most having done so five or more times (*n* = 145). Reported age of onset ranged between 4 and 44 years (*M* = 14.6, *SD* = 4.89), with cutting the most common main form of self-injury (*n* = 217, 54.9%). Sample demographics are displayed in Table 5.3.

Table 5.3
Sample Demographics Disaggregated by NSSI history for Study Two

	NSSI History		No NSSI History		Total Sample	
	n	%	*n*	%	*n*	%
Gender						
Woman	261	65.1	201	62.8	462	64.1
Man	85	21.2	112	35.0	197	27.3
Transgender	15	3.7	3	0.9	18	2.5
Nonbinary	37	9.2	3	0.9	40	5.5
Other*	3	0.6	1	0.3	4	0.9
Sexual Orientation						
Gay/Lesbian	37	9.2	13	4.1	50	7.0
Bisexual	119	29.7	31	9.8	150	20.9
Asexual	22	5.5	5	1.6	27	3.8
Heterosexual	206	51.4	264	83.3	470	65.5
Queer	9	2.2	1	0.3	10	1.4

Other*	8	1.9	4	0.9	12	1.5
MI Diagnosis						
Yes	275	68.8	94	29.4	369	51.2
No	125	31.3	226	70.6	351	48.8

Note. *Other included genderfluid (n = 1), unsure (n = 1), and prefer not to say (n = 2). MI = mental illness.

Data Analysis

Due to the theoretically informed structure of the proposed measurement model, confirmatory factors analysis (CFA) was deemed most appropriate (Brown & Moore, 2012). Evaluation of univariate skewness and kurtosis revealed several positively skewed (>2) and leptokurtic (>7) items (West et al., 1995; see Tables 5.4 – 5.8). Consequently, maximum likelihood mean adjusted (MLM) estimation with robust standard errors was used, scaled with the Satorra-Bentler (SB) correction factor (scf; Satorra & Bentler, 1994). Model fit was assessed iteratively as per conventions outlined by Brown (2015), with Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI) values of 0.95 or above, Root Mean Error of Approximation (RMSEA) and Standardized Root Mean Square (SRMR) values below 0.08, and non-significant chi-square values representing good fit.

The psychometric equivalence of the public and personal subscales across participants with and without a history of NSSI was assessed using multigroup CFA, again with MLM estimation and SB correction. Configural, metric, scalar, and strict invariance were evaluated as per conventions outlined by Chen (2007), whereby invariance is demonstrated through non-significant chi-square changes and changes in CFI, RMSEA, and SRMR less than 0.01, 0.015, and 0.015 respectively. Being the first assessment of the SISS' psychometric properties, evaluation of factor structure and measurement invariance occurred in tandem, such that measurement invariance results informed the final model. This enabled appropriate representation of the construct informed by successive modification indices. All CFA analyses were conducted using the *lavaan* package for R (version 0.6-8; Rosseel et al., 2021).

Internal consistency was evaluated using Cronbach's alpha and McDonald's omega, both computed in JASP (JASP Team, 2020), with values ≥ 0.70 considered acceptable (Lance et al., 2006). Using SPSS Version 27, a one-way analysis of variance was conducted to examine

differences between participants with and without a history of NSSI on the public and personal scales, and bivariate correlations were used to investigate convergent and discriminant validity.

Results

Preliminary Results

Data were missing completely at random for all scales except negative reactions, $\chi^2(483) = 547.14$, $p = .023$, and shame, $\chi^2(561) = 693.94$, $p < .001$. Given no more than 5% of data were missing, EM was used to impute missing values (Scheffer, 2002).

Scale Evaluation

Model Identification and Factor Structure

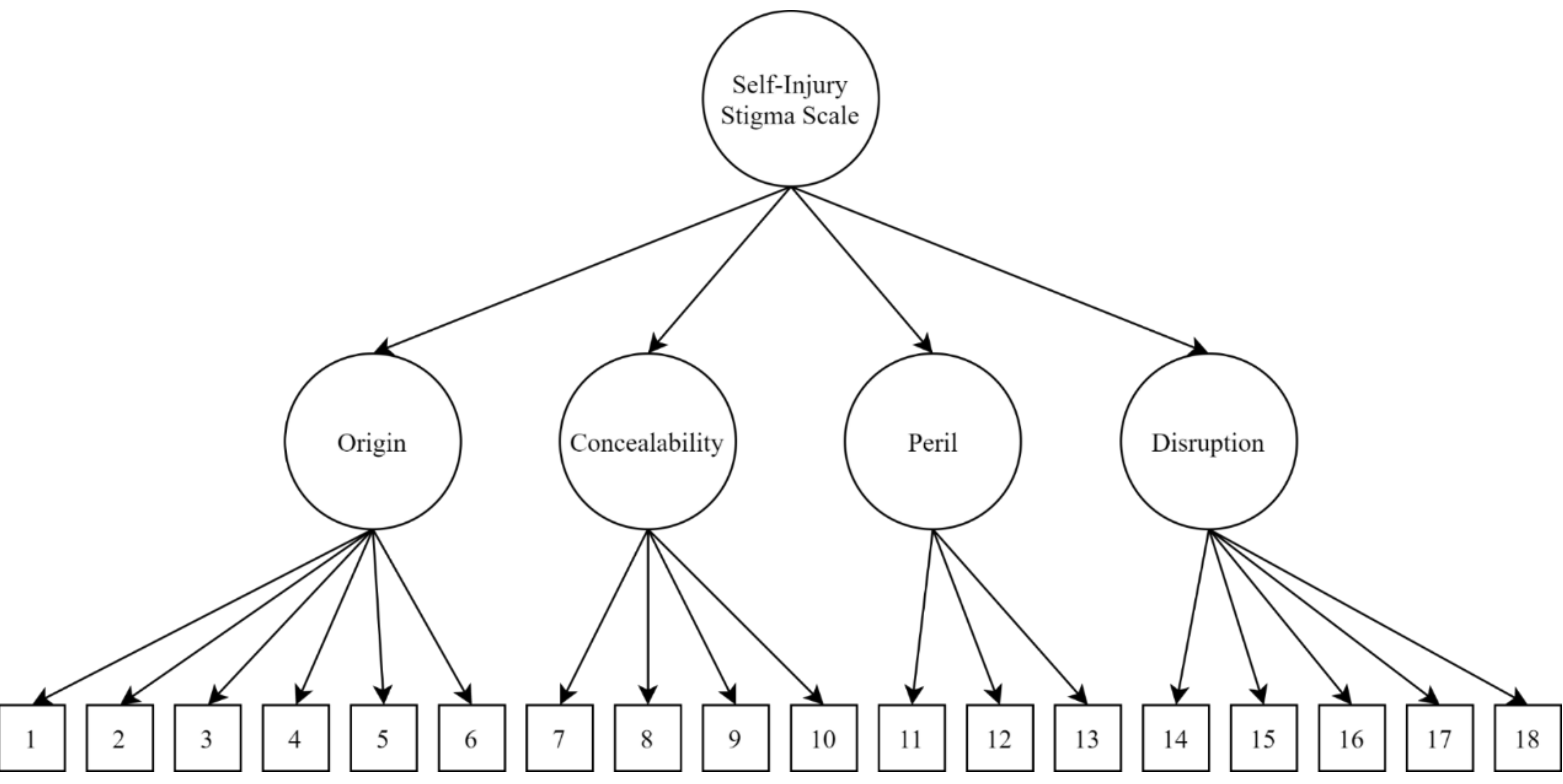
The theorized model was first evaluated per scale (public, personal, self, anticipated, and enacted stigma) and then iteratively re-specified. Model fit statistics can be found in Table 5.4 for the public and personal scales, completed by the whole sample, and in Table 5.5for the self, anticipated, and enacted scales, completed only by participants with lived experience of NSSI. A conceptual diagram of the SISS can be seen in Figure 5.1.

Public and Personal NSSI Stigma Scales. Initial model fit was poor for the public scale and reasonable for the personal scale. Due to a non-positive-definite sample covariance matrix for the public scale, model re-specification began with the personal scale. Three low-loading (< .40) items were removed and factors five (aesthetics) and six (disruption) were collapsed due to high covariance (> .90) and conceptual overlap of items. Subsequent re-specifications were informed by theoretically valid modification indices, whereby items were iteratively moved, removed, or covaried. Prior to analysis of measurement invariance, this intermediate model comprised five factors: Origin, represented by five items; Concealability, represented by four items; Course, represented by three items, Peril, represented by three items; and Disruption, represented by five items. This model demonstrated acceptable fit to the public scale.

Measurement invariance of the public and personal scales was then assessed. Configural invariance was demonstrated for the public scale but not the personal scale. Examination of modification indices indicated Chi-square improvement if factors one (origin) and three (course) were collapsed. Due to theoretical and conceptual overlap between the indicators of these constructs, we opted to proceed with the modified four-factor model. Configural invariance was subsequently met for both the public and personal scales. Factor loadings were then fixed across both groups to assess metric invariance, which was demonstrated for the public scale but not the

Figure 5.1

Visual Conceptualization of Factors and Indicators of the Self-Injury Stigma Scale



Note. This conceptualization is applicable to each of the five scales: Public, Personal, Self, Anticipated, and Enacted.

personal scale. Modification indices identified items 12 ("I think people who have self-injured should be forced to stop") and 14 ("I think people who have self-injured will never be able to manage their emotions") as variant. These were removed and metric invariance was subsequently met.

Intercepts were then fixed to assess scalar invariance, which was partially met for the public scale by allowing two items to intercept freely, and for the personal scale by allowing five items to intercept freely. Finally, residuals were fixed to assess strict invariance, which was partially met for the public scale by freeing five residuals and for the personal scale holding prior specifications. Despite achieving only partial strict invariance, examination of latent mean score differences demonstrated that accounting for such invariance did not substantially alter the latent mean scores for each sample on each scale. The final model comprised four factors: Origin, represented by six items; Concealability, represented by four items; Peril, represented by three items; and Disruption, represented by five items.

Self, Anticipated, and Enacted NSSI Stigma Scales. Initial model fit for each of the self, anticipated, and enacted scales was acceptable. We fit the final model specified above onto the self, anticipated, and enacted scales, each demonstrating acceptable fit.

Table 5.4

Model Fit Statistics for Confirmatory Factor Analyses of the Public and Personal NSSI Stigma Scale

	$_{SB}\chi^2$ (df)	*scf*	$\Delta\chi^2$(df)	*p*	CFI	ΔCFI	TLI	ΔTLI	RMSEA	ΔRMSEA	SRMR	ΔSRMR
Public Scale												
Initial Model	2601.39 (480)[a]	1.29	-	< .001	0.853	-	0.838	-	0.089	-	0.061	-
Intermediate Model	432.82 (141)	1.32	-	< .001	0.964	-	0.956	-	0.061	-	0.039	-
Configural Model	479.47 (248)	-	-	-	0.967	-	0.960	-	0.058	-	0.041	-
Metric Model	493.24 (262)	-	13.77 (14)	0.467	0.968	0.001	0.962	-0.002	0.056	-0.002	0.047	-0.006
Partial Scalar Model	508.24 (274)	-	15.00 (12)	0.241	0.968	0.000	0.964	0.002	0.055	-0.001	0.047	0.000
Partial Strict Model	509.21 (286)	-	0.97 (12)	1.000	0.969	0.001	0.967	0.003	0.052	-0.003	0.048	0.001
Final Model	355.67 (124)	1.29	-	< .001	0.969	-	0.962	-	0.058	-	0.038	-
Personal Scale												
Initial Model	2452.86 (480)	1.57	-	< .001	0.765	-	0.740	-	0.094	-	0.078	-
Intermediate Model	421.55 (160)	1.73	-	< .001	0.942	-	0.931	-	0.062	-	0.051	-
Configural Model	415.44 (250)	-	-	-	0.958	-	0.948	-	0.056	-	0.048	-
Metric Model	427.08 (264)	-	10.64 (14)	0.714	0.958	0.000	0.952	0.004	0.054	-0.002	0.057	0.009
Partial Scalar Model	443.35 (273)	-	16.27 (9)	0.061	0.957	-0.001	0.952	0.000	0.054	0.000	0.058	0.001
Partial Strict Model	460.47 (291)	-	17.12 (18)	0.515	0.956	-0.001	0.954	0.002	0.053	-0.001	0.060	0.002
Final Model	322.37 (125)	1.69	-	< .001	0.952	-	0.941	-	0.061	-	0.047	-

Note. [a]Initial fit for the public scale produced a non-positive-definite sample covariance matrix. All $_{SB}\chi^2$ values significant at $p < .001$.

Table 5.5

Model Fit Statistics for Confirmatory Factor Analyses of Self, Anticipated, and Enacted NSSI Stigma Scales

	Initial Fit						Final Fit					
	$_{SB}\ \chi^2$ (df)	*scf*	CFI	TLI	RMSEA	SRMR	$_{SB}\ \chi^2$ (df)	*scf*	CFI	TLI	RMSEA	SRMR
Self	954.69 (309)	1.25	0.835	0.813	0.089	0.084	243.37 (126)	1.21	0.957	0.948	0.058	0.052
Anticipated	1602.11 (480)	1.25	0.814	0.795	0.095	0.082	225.45 (125)	1.30	0.968	0.961	0.056	0.039
Enacted	1242.38 (480)	1.64	0.846	0.831	0.091	0.061	166.95 (124)	1.64	0.983	0.979	0.043	0.034

Note. All $_{SB}\chi^2$ values significant at $p < .001$.

Validity Analyses

The convergent and divergent validity of each factor was assessed by scale, disaggregated by NSSI history for the public and personal scales. Correlation tables are presented in the supplementary materials.

Public NSSI Stigma Scale. Within the full sample, all factors of the public NSSI stigma scale positively correlated with public mental illness stigma, demonstrating convergent validity. Origin and concealability were negatively correlated, and peril and disruption were uncorrelated with personal mental illness stigma, demonstrating divergent validity. All factors were positively correlated with interpersonal exposure to NSSI. Origin and peril were positively correlated, and concealability and disruption were uncorrelated with media exposure. Within the sample with lived experience, all factors were positively correlated with public mental illness stigma. Origin was negatively correlated and the other factors uncorrelated with personal mental illness stigma. All factors were positively correlated with interpersonal exposure. Peril was positively correlated and the other factors uncorrelated with media exposure. Within the sample without lived experience, all factors positively correlated with public mental illness stigma. Disruption was positively correlated and the other factors uncorrelated with personal mental illness stigma. No factors were correlated with media exposure. Origin was positively correlated, and the other factors were uncorrelated with interpersonal exposure.

Personal Stigma Scale. Within the full sample, all factors of the personal stigma scale were positively correlated with personal mental illness stigma, demonstrating convergent validity. All factors were uncorrelated with public mental illness stigma, demonstrating divergent validity. All factors except peril were negatively correlated with media exposure. All factors were negatively correlated with interpersonal exposure. Within the sample with lived experience, all factors were positively correlated with personal mental illness stigma and were uncorrelated with public mental illness stigma. All factors except peril were negatively correlated with both media and interpersonal exposure. Within the sample without lived experience, all factors were positively correlated with personal mental illness stigma and were uncorrelated with public mental illness stigma. Origin and peril were negatively correlated, and concealability and disruption were uncorrelated with media exposure. All factors were negatively correlated with interpersonal exposure.

Table 5.6

Bivariate Correlations Between Factors of Public and Personal NSSI Stigma and Validation Variables for the Full Sample

Variable	1	2	3	4	5	6	7	8	9	10	12	13
1. PUB Origin	-											
2. PUB Conceal	.73***	-										
3. PUB Peril	.68***	.62***	-									
4. PUB Disrupt	.67***	.65***	.72***	-								
5. PER Origin	.01	-.06	.01	.02	-							
6. PER Conceal	.07	.16***	.08*	.11**	.46***	-						
7. PER Peril	-.08*	-.07*	.18***	.01	.56***	.35***	-					
8. PER Disrupt	-.09*	-.04	.02	.12**	.66***	.46***	.59***	-				
9. Public MI stigma	.52***	.44***	.47***	.50***	-.07	.03	.88	-.03	-			
10. Personal MI stigma	-.08*	-.09*	.03	.03	.60***	.42***	.47***	.58***	.13**	-		
12. NSSI Media Exposure	.10**	.06	.11*	.06	-.12**	-.13**	-.06	-.11**	.12**	-.04	-	
13. NSSI Interpersonal Exposure	.20***	.16***	.16***	.12**	-.17***	-.16***	-.11**	-.15***	.14***	-.13***	.61***	-

Note. $N = 722$. PUB = Public, PER = Personal, MI = Mental illness.
$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

Table 5.7

Bivariate Correlations Between Factors of Public and Personal NSSI Stigma and Validation Variables Disaggregated by NSSI History

Variable	1	2	3	4	5	6	7	8	9	10	12	13
1. PUB Origin	-	.70***	.64***	.61***	.14***	.09	-.03	-.05	.49***	-.01	.08	.15*
2. PUB Conceal	.72***	-	.58***	.58***	.05	.19**	-.02	.002	.40***	-.04	.01	.07
3. PUB Peril	.69***	.64***	-	.64***	.11*	.12*	.29***	.08	.44***	.08	.05	.08
4. PUB Disrupt	.68***	.68***	.75***	-	.18**	.17**	.09	.25***	.43***	.15**	.01	.04
5. PER Origin	-.03	-.10	-.02	-.50	-	.57***	.60***	.69***	.01	.61***	-.12*	-.18**
6. PER Conceal	.01	.10	.04	.03	.44***	-	.48***	.55***	-.002	.50***	-.10	-.14*
7. PER Peril	-.02	-.02	.16**	.03	.48***	.43***	-	.64***	.005	.57***	-.11*	-.18**
8. PER Disrupt	-.06	-.02	.01	.07	.60***	.45***	.51***	-	-.04	.62***	-.10	-.13*
9. Public MI stigma	.50***	.41***	.46***	.51***	-.09	.01	.08	.03	-	.22***	.15**	.11
10. Personal MI stigma	-.10*	-.08	.03	-.01	.58***	.41***	.55***	.53***	.06	-	-.003	-.14*
12. NSSI Media Exposure	.09	.08	.14**	.07	-.10*	-.16**	.01	-.11*	.08	-.06	-	.58***
13. NSSI Interpersonal Exposure	.17***	.15**	.17**	.11*	-.12*	-.20***	-.003	-.14**	.11*	-.10*	.62***	-

Note. PUB = Public, PER = Personal, MI = Mental illness.
Lower left correlations = sample with an NSSI history (n = 402), upper right correlations = sample with no NSSI history (n = 320).
*p < .05. **p < .01. ***p < .001

Self-Stigma Scale. All factors of the self-stigma scale positively correlated with mental illness self-stigma, demonstrating convergent validity. All factors were positively correlated with the corresponding factors on the personal NSSI stigma scale, with weak to moderate correlations demonstrating divergent validity. All factors except origin positively correlated with negative social reactions. Origin was positively correlated and the other factors uncorrelated with tangible aid. Disruption was negatively correlated and the other factors uncorrelated with social support. Peril was positively correlated and the other factors uncorrelated with both interpersonal and media exposure. All factors were negatively correlated with self-esteem and positively correlated with shame.

Anticipated Stigma Scale. All factors of the anticipated stigma scale were positively correlated with their corresponding factors on the enacted stigma scale. Weak to moderate correlations demonstrated divergent validity. No factors were correlated with personal mental illness stigma, further demonstrating divergent validity. All factors were positively correlated with public mental illness stigma and negative reactions, demonstrating convergent validity. Peril and disruption were positively correlated, and origin and concealability uncorrelated with tangible aid. All factors except peril were negatively correlated with emotional support. No factors correlated with media or interpersonal exposure.

Enacted Stigma Scale. All factors of the enacted stigma scale were positively correlated with their corresponding factors on the anticipated stigma scale. Weak to moderate correlations demonstrated divergent validity. No factors were correlated with personal mental illness stigma, further demonstrating divergent validity. All factors were positively correlated with public mental illness stigma, negative reactions, and tangible aid demonstrating convergent validity. All factors except peril were negatively correlated with emotional support and positively correlated with both interpersonal and media exposure.

Table 5.8

Bivariate Correlations Between Factors of NSSI Self-Stigma and Validation Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. SELF Origin	-															
2. SELF Conceal	.50***	-														
3. SELF Peril	.50***	.26***	-													
4. SELF Disrupt	.65***	.47***	.60***	-												
5. PER Origin	.24***	.12*	.09	.09	-											
6. PER Conceal	.06	.31***	.04	.09	.44***	-										
7. PER Peril	.15**	.13*	.40***	.12*	.48***	.32***	-									
8. PER Disrupt	.16**	.13*	.16**	.23***	.60***	.45***	.51***	-								
9. MI self-stigma	.43***	.23***	.42***	.48***	.26***	.06	.28***	.18**	-							
10. Negative Reactions	.11	.13*	.18**	.20**	-.06	.01	.11*	.006	.15*	-						
11. Tangible Aid	.13*	.03	.01	.11	-.04	-.01	.03	-.001	.01	.13	-					
12. Emotional Support	-.001	-.08	-.09	-.13*	-.05	-.08	-.08	-.08	-.17*	-.52***	.41***	-				
13. IP Exposure	.01	-.09	.15**	.03	-.12*	-.20***	-.004	-.14**	.04	.20***	.20***	.06	-			
14. Media Exposure	.04	-.06	.12*	.02	-.10*	-.16**	.01	-.11*	.02	.21***	.07	.08	.62***	-		
15. Self-esteem	-.50***	-.35***	-.49***	-.65***	.07	.04	-.14**	-.02	-.49***	-.25***	-.13*	.14*	-.19***	-.16**	-	
16. Shame	.46***	.37***	.34***	.51***	-.09	-.09	.04	-.06	.41***	.32***	.25***	-.08	.19***	.21***	-.68***	-

Note. PER = Personal, MI = Mental illness, IP = Interpersonal.
*$p < .05$. **$p < .01$. ***$p < .001$

Table 5.9

Bivariate Correlations Between Factors of Anticipated and Enacted NSSI Stigma and Validation Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. ANT Origin	-														
2. ANT Conceal	.69***	-													
3. ANT Peril	.68***	.56***	-												
4. ANT Disrupt	.74***	.58***	.73***	-											
5. ENA Origin	.43***	.27***	.35***	.37***	-										
6. ENA Conceal	.34***	.37***	.34***	.37***	.73***	-									
7. ENA Peril	.42***	.30***	.49***	.39***	.75***	.64***	-								
8. ENA Disrupt	.39***	.28***	.36***	.47***	.77***	.67***	.75***	-							
9. Public MI stigma	.35***	.30***	.35***	.43***	.30***	.30***	.28***	.28***	-						
10. Personal MI stigma	.05	-.05	.05	.09	.05	.05	.28	.10	.09	-					
11. Negative Reactions	.41***	.30***	.38***	.44***	.72***	.64***	.66***	.65***	.35***	.04	-				
12. Tangible Aid	.11	.09	.21**	.13*	.13*	.22***	.25***	.13*	.07	-.04	.13*	-			
13. Emotional Support	-.20**	-.141*	-.08	-.20**	-.35***	-.22***	-.27***	-.35***	-.22***	-.10	-.52***	.41***	-		
14. Interpersonal Exposure	.004	.03	.06	.01	.17**	.19**	.28***	.22***	.11*	-.10*	.20***	.20***	.06	-	
15. Media Exposure	.06	.05	.08	.06	.13*	.18**	.13*	.15**	.08	-.06	.21***	.07	.08	.62***	-

Note. ANT = Anticipated, ENA = Enacted, MI = Mental illness.
$*p < .05$. $**p < .01$. $***p < .001$

Group Means Comparison

The sample with a history of NSSI reported significantly greater agreement (see Tables 4-8) with statements on all subscales of public NSSI stigma: Origin, F_{Welch} (1, 652.20) = 60.78, $p <$ .001; Concealability, F_{Welch} (1, 655.37) = 68.48, $p <$ .001; Peril, F_{Welch} (1, 716.10) = 23.43, $p <$ .001; and Disruption, F_{Welch} (1, 713.09) = 52.10, $p <$ .001. For personal NSSI stigma, the sample without a history of NSSI reported significantly higher agreement with Origin, F_{Welch} (1, 611.21) = 13.37, $p <$ .001, Peril, F_{Welch} (1, 618.76) = 25.95, $p = <$ .001, and Disruption, F_{Welch} (1, 580.38) = 10.08, $p =$ .002, and significantly lower levels of agreement with Concealability, F_{Welch} (1, 720.00) = 9.10, $p =$ .003, than the sample with a history of self-injury.

Discussion

The aim of this research was to develop and validate a theoretically informed and comprehensive measure of NSSI stigma. Following a phase of item generation, an item pool was selected (Study One). Further item reduction and scale validation were then conducted (Study Two), culminating in the final Self-Injury Stigma Scales (SISS). While we expected a six-factor solution based on Staniland et al.'s (2021) theoretical model of NSSI stigma, a four-factor model was the best fit to the data. Each factor comprised thematically relevant items, each representing a theorized NSSI stigma domain: Origin, Concealability, Peril, and Disruption. The structure held across the five stigma scales: Public, Personal, Self, Anticipated, and Enacted.

The construct validity of the SISS was supported through significant correlations with related constructs and psychometric equivalence between samples with and without a history of NSSI was demonstrated. While only partial measurement invariance was supported, comparison of latent means accounting for the variant items suggested the public and personal stigma scales operate equally for people who do and do not have a history of self-injury. As expected, individuals with lived experience of self-injury reported more public NSSI stigma and less personal NSSI stigma than individuals with no lived experience. This finding suggests that individuals who have self-injured are more cognizant of public NSSI stigma than individuals who have never self-injured, and that having lived experience of self-injury likely corresponds with less personal NSSI stigma.

The pattern of group differences observed at the scale level was largely sustained at the factor level; however, concealability-related personal stigma was rated more highly for individuals with a history of NSSI compared to those without. That individuals who had self-

injured reported more personal endorsement of covering NSSI and avoiding discussion of it points to the salience of scarring (Lewis & Mehrabkhani, 2016) and disclosure (Simone & Hamza, 2020) in people's lived experiences, and suggests that capturing domain-specific stigma is important for understanding the complexities of NSSI stigma. What it means for people with lived experience to believe that others with lived experience should cover their NSSI and avoid talking about it requires further investigation.

Capturing four distinct facets across five types of stigma, the SISS may offer utility to researchers, clinicians, and advocates. Researchers may use the scales to understand how stigma develops and persists. The scales point to areas where NSSI stigma may manifest and can be used to direct future research. Clinicians may use the scales to inform therapeutic practice; an understanding and appreciation of NSSI stigma may have relevance in clinical contexts (e.g., recovery, perceptions of scarring, self-acceptance). Lastly, advocates may use the scales to both inform and evaluate anti-stigma initiatives.

Limitations and Future Directions

While our development and validation processes were robust and theoretically informed, the SISS is currently limited in generality. Participants were recruited through several sources, including MTurk, social media, and a university student participant pool, however, an important next step will be investigating the psychometric properties in more diverse samples. Given the potential that conceptualizations of both self-injury (Gholamrezaei et al., 2015) and stigma (Yang et al., 2014) may differ cross-culturally, further validation will be required.

Relatedly, the present work was unable to account for intersectionality. Stigma is known to be intersectional and cumulative, meaning that when an individual holds more than one stigmatized identity (e.g., living with HIV and visible scarring) the impacts of stigma are additive. When investigating stigma, consideration of intersecting stigmatized identities is required so that the breadth of risk and vulnerability can be understood (Turan et al., 2019). While this is not thought to be crucial to the initial development and validation of the SISS, critical engagement with intersectional stigma is necessary for the advancement of our understanding of NSSI stigma, particularly given the potential for both mental illness stigma and NSSI stigma to occur simultaneously (Staniland et al., 2021). Finally, it is intended that the SISS be used for multiple purposes, including in research, clinical practice, and in program

development and evaluation. Future work will be needed to examine the validity of the SISS in clinical samples and examine its test-retest reliability to assess temporal stability.

Conclusion

Despite being an emerging research area within the NSSI scholarship, stigma is often a salient and significant experience for people who have self-injured. A concentrated and sustained effort is required, not just from researchers, but clinicians and advocates alike, to better understanding, reduce, and prevent NSSI stigma. The SISS offers a psychometrically valid way to begin addressing this priority.

Table 5.10

Descriptive Statistics Disaggregated by NSSI History, Factor Loadings, Standard Errors, and Internal Consistency Statistics for the Public NSSI Stigma Scale

"I think the public believes that people who have self-injured…"	NSSI-Y (*n* = 402)				NSSI-N (*n* = 320)							
	M	*SD*	α_3	α_4	*M*	*SD*	α_3	α_4	Loadings	Errors	α	Ω
Origin	5.63	1.20	-1.52	2.78	4.89	1.32	-1.08	0.98			0.91	0.91
… are to blame for their problems	5.41	1.45	-1.20	1.25	4.68	1.57	-0.81	0.03	0.758	0.059		
… are weak	5.62	1.36	-1.28	1.64	4.94	1.51	-1.01	0.55	0.810	0.062		
… are crazy	5.74	1.44	-1.38	1.59	4.87	1.56	-1.00	-0.41	0.883	0.056		
… are manipulative	5.30	1.57	-0.86	0.08	4.60	1.56	-0.52	-0.34	0.765	0.055		
… are attention seeking	6.04	1.33	-1.85	3.48	5.38	1.54	-1.16	1.05	0.833	0.062		
… are just going through a phase	1.93	1.26	1.47	1.65	4.83	1.66	-0.78	-0.08	0.751	0.061		
Concealability	5.39	1.40	-1.05	0.76	4.47	1.53	-0.59	-0.39			0.89	0.90
… should not let others know about it	4.81	1.77	-0.51	-0.64	3.95	1.75	-0.14	-0.94	0.707	0.060		
… should cover up their self-injury	5.56	1.62	-1.21	0.74	4.52	1.75	-0.60	-0.69	0.831	0.057		
People should avoid talking about self-injury	5.33	1.68	-0.92	-0.02	4.35	1.83	-0.36	-0.92	0.920	0.046		
People should not post about self-injury online	5.85	1.48	-1.50	1.77	5.08	1.76	-0.93	-0.11	0.779	0.063		
Peril	5.10	1.47	-0.79	0.25	4.60	1.26	-0.54	0.12			0.83	0.84
… will always be at risk of suicide	5.41	1.54	-1.03	0.60	5.11	1.47	-0.93	-0.56	0.711	0.061		
… are dangerous	4.81	1.71	-0.59	-0.43	4.25	1.49	-0.31	-0.42	0.791	0.051		

… belong in a mental institution	5.06	1.73	-0.83	-0.10	4.45	1.61	-0.35	-0.51	0.862	0.048		
Disruption	4.19	1.56	-0.21	1.81	3.40	1.37	0.07	-0.68			0.91	0.91
… injured do not deserve intimacy with others	3.58	1.76	0.25	-0.82	3.03	1.46	-0.35	-0.65	0.808	0.050		
… are a waste of time	4.15	1.87	-0.18	-1.08	3.29	1.66	0.37	-0.85	0.850	0.043		
… deserve to be treated poorly	3.82	1.81	0.18	-0.97	2.94	1.44	0.50	-0.39	0.798	0.050		
… should not have children	4.63	1.88	-0.48	-0.80	1.95	1.41	1.57	1.78	0.789	0.050		
… do not care about others	4.75	1.84	-0.52	-0.80	3.95	1.75	-0.18	-0.99	0.837	0.048		

Note. α_3 = skewness, α_4 = kurtosis, α = Cronbach's alpha, Ω = McDonald's omega. Loadings and errors are standardized.

Table 5.11

Descriptive Statistics Disaggregated by NSSI History, Factor Loadings, Standard Errors, and Internal Consistency Statistics for the Personal NSSI Stigma Scale

	NSSI-Y (n = 402)				NSSI-N (n = 320)							
"I personally believe people who have self-injured…"	*M*	*SD*	α_3	α_4	*M*	*SD*	α_3	α_4	Loadings	Errors	α	Ω
Origin	2.04	0.96	1.21	1.81	2.34	1.18	0.93	0.50			0.88	0.88
… are to blame for their problems	2.01	1.22	1.61	2.73	2.19	1.29	1.30	1.47	0.687	0.058		
… are weak	2.06	1.37	1.52	1.83	2.26	1.48	1.29	0.92	0.773	0.055		
… are crazy	1.90	1.23	1.50	1.65	2.00	1.31	1.55	1.90	0.788	0.054		
… are manipulative	2.03	1.23	1.27	1.18	2.50	1.48	0.97	0.28	0.746	0.054		
… are attention seeking	2.33	1.38	0.89	-0.08	2.86	1.63	0.59	-0.61	0.654	0.057		
… are just going through a phase	1.93	1.26	1.47	1.65	2.24	1.42	1.11	0.58	0.641	0.054		
Concealability	2.68	1.43	0.86	0.19	2.39	1.14	0.97	1.27			0.81	0.81
… should not let others know about it	2.23	1.57	1.32	1.00	1.85	1.23	1.95	4.30	0.781	0.064		
… should cover up their self-injury	2.87	1.79	0.68	-0.58	2.39	1.45	1.03	0.50	0.787	0.056		
People should avoid talking about self-injury	2.13	1.50	1.49	1.53	1.88	1.31	1.95	3.93	0.840	0.066		
People should not post about self-injury online	3.49	2.04	0.25	-1.25	3.45	1.93	0.23	-1.17	0.543	0.066		
Peril	2.02	0.98	1.01	0.58	2.44	1.18	0.76	0.18			0.72	0.73
… will always be at risk of suicide	2.66	1.59	0.68	-0.63	3.17	1.72	0.33	-0.97	0.598	0.055		
… are dangerous	1.66	1.05	1.96	3.86	2.06	1.27	1.32	1.40	0.796	0.055		

… belong in a mental institution	1.75	1.08	1.54	1.78	2.09	1.34	1.30	1.05	0.711	0.053		
Disruption	1.43	0.70	2.55	7.82	1.62	0.93	2.15	5.26			0.84	0.84
… do not deserve intimacy with others	1.41	0.88	2.88	9.04	1.48	0.97	2.75	9.09	0.799	0.063		
… are a waste of time	1.33	0.78	3.17	11.73	1.46	0.96	2.61	7.62	0.793	0.058		
… deserve to be treated poorly	1.24	0.68	3.89	16.97	1.38	0.89	3.05	10.57	0.781	0.063		
… should not have children	1.70	1.23	2.10	4.30	1.95	1.41	1.57	1.78	0.703	0.060		
… do not care about others	1.45	0.95	2.97	10.07	1.86	1.24	1.71	2.67	0.771	0.062		

Note. α_3 = skewness, α_4 = kurtosis, α = Cronbach's alpha, Ω = McDonald's omega. Loadings and errors are standardized.

Table 5.12

Descriptive Statistics, Factor Loadings, Standard Errors, and Internal Consistency Statistics for the NSSI Self-Stigma Scale

"Because I have self-injured…"	*M*	*SD*	α_3	α_4	Loadings	Errors	α	Ω
Origin	3.27	1.38	0.20	-0.63			0.82	0.83
… I am to blame for my problems	3.86	1.95	-0.09	-1.32	0.631	0.101		
… I am weak	4.06	2.11	-0.12	-1.43	0.812	0.077		
… I am crazy	3.22	1.94	0.42	-1.17	0.717	0.086		
… I am manipulative	2.21	1.59	1.28	0.59	0.421	0.097		
… I am an attention-seeker	2.38	1.75	1.10	-0.05	0.420	0.104		
… I should just toughen up	3.91	2.08	-0.03	-1.31	0.711	0.088		
Concealability	4.75	1.68	-0.51	-0.59			0.86	0.86
… I should not let others know about my self-injury	4.48	2.06	-0.36	-1.23	0.846	0.075		
… I should cover up my self-injury	4.88	1.95	-0.75	-0.61	0.818	0.086		
… I should avoid talking about my self-injury	4.59	1.96	-0.45	-1.02	0.874	0.073		
… I should avoid posting about my experiences of self-injury online	5.03	2.11	-0.64	-1.05	0.562	0.112		
Peril	2.21	1.29	1.21	1.19			0.73	0.73
… I will always be at risk of suicide	2.99	1.99	0.57	-1.03	0.757	0.093		
… I am dangerous	1.63	1.25	2.38	5.32	0.575	0.106		
… I belong in a mental institution	2.01	1.53	1.48	1.16	0.722	0.105		
Disruption	2.80	1.80	0.78	-0.53			0.91	0.91

… I do not deserve intimacy with others	2.69	2.02	0.92	-0.54	0.861	0.085
… I am a waste of time	3.52	2.36	0.25	-1.57	0.857	0.062
… I deserve to be treated poorly	2.41	1.95	1.15	-0.13	0.822	0.096
… I should not have children	2.88	2.24	0.74	-1.05	0.733	0.099
… people should stay away from me	2.50	1.88	1.07	-0.11	0.818	0.089

Note. α_3 = skewness, α_4 = kurtosis, α = Cronbach's alpha, Ω = McDonald's omega. Loadings and errors are standardized.

Table 5.13

Descriptive Statistics, Factor Loadings, Standard Errors, and Internal Consistency Statistics for the Anticipated NSSI Stigma Scale

"If people find out about my self-injury, they…"	*M*	*SD*	α_3	α_4	Loadings	Errors	α	Ω
Origin	5.10	1.43	-0.99	0.40			0.90	0.90
… will blame me for my problems	4.91	1.66	-0.83	-0.07	0.712	0.091		
… will think I am weak	5.20	1.70	-0.92	-0.02	0.795	0.082		
… will think I am crazy	5.22	1.80	-0.92	-0.21	0.825	0.083		
… will think I am manipulative	4.56	1.85	-0.52	-0.82	0.701	0.085		
… will think I am attention seeking	5.46	1.75	-1.21	0.51	0.822	0.089		
… will think I should toughen up	5.24	1.71	-0.90	-0.10	0.756	0.087		
Concealability	5.21	1.44	-0.90	0.42			0.86	0.87
… will think that I should not let others know about my self-injury	4.77	1.72	-0.59	-0.60	0.722	0.085		
… will think I should cover up my self-injury	5.35	1.70	-1.06	0.24	0.829	0.086		
… will think I shouldn't talk about my self-injury	5.10	1.75	-0.81	-0.26	0.828	0.085		
… will think I shouldn't post about my experiences of self-injury online	5.62	1.67	-1.37	1.07	0.679	0.108		
Peril	4.64	1.62	-0.50	-0.45			0.82	0.83
… will think I am at risk of suicide	5.52	1.66	-1.36	1.13	0.693	0.103		
… will think I am dangerous	3.92	2.00	-0.04	-1.25	0.768	0.077		
… will think I belong in a mental institution	4.46	1.20	-0.21	-1.21	0.871	0.069		
Disruption	4.13	1.65	-0.17	-0.85			0.90	0.90

… won't want to be intimate with me	4.19	1.98	-0.21	-1.21	0.705	0.084
… will think I am a waste of time	4.10	1.99	-0.10	-1.22	0.804	0.068
… will treat me poorly	4.19	1.87	-0.15	-1.12	0.835	0.065
… will think I should not have children	3.62	2.07	0.17	-1.29	0.746	0.077
… will stay away from me	4.53	1.82	-0.49	-0.85	0.863	0.070

Note. α_3 = skewness, α_4 = kurtosis, α = Cronbach's alpha, Ω = McDonald's omega. Loadings and errors are standardized.

Table 5.14

Descriptive Statistics, Factor Loadings, Standard Errors, and Internal Consistency Statistics for the Enacted NSSI Stigma Scale

"Because of my self-injury, people have…	*M*	*SD*	α_3	α_4	Loadings	Errors	α	Ω
Origin	2.52	1.50	0.69	-0.60			0.92	0.92
… said that I brought this upon myself	2.34	1.63	0.94	-0.21	0.737	0.079		
… said that I am weak	2.28	1.62	1.00	-0.22	0.803	0.070		
… said that I am crazy	2.57	1.82	0.81	-0.63	0.851	0.072		
… said that I am manipulative	2.26	1.62	1.07	0.08	0.771	0.087		
… said that I am attention seeking	2.84	1.91	0.57	-1.00	0.819	0.073		
… said that I should toughen up	2.83	1.98	0.64	-0.97	0.839	0.071		
Concealability	2.54	1.67	0.95	-0.09			0.90	0.91
… told me I should not let others know about my self-injury	2.52	1.80	0.90	-0.39	0.835	0.088		
… told me to cover up my self-injury	2.81	1.96	0.63	-0.97	0.877	0.074		
… told me not to talk about my self-injury	2.67	1.92	0.82	-0.63	0.886	0.077		
… told me not to post about my experiences of self-injury online	2.14	1.92	1.50	0.83	0.708	0.113		
Peril	2.44	1.50	1.00	0.32			0.83	0.82
… said I am at risk of suicide	3.22	2.02	0.35	-1.15	0.736	0.082		
… said they think I am dangerous	1.86	1.48	1.82	2.48	0.801	0.099		
… said that I belong in a mental institution	2.24	1.73	1.28	0.54	0.815	0.092		
Disruption	2.03	1.22	1.23	0.75			0.87	0.88

… not wanted to be intimate with me	1.71	1.33	1.95	3.11	0.626	0.083
… said I am a waste of time	1.77	1.39	1.83	2.52	0.805	0.089
… treated me poorly	2.69	1.84	0.68	-0.88	0.838	0.073
… said that I should not have children	1.57	1.23	2.38	5.14	0.748	0.097
… stayed away from me	2.38	1.66	0.83	-0.63	0.804	0.072

Note. α_3 = skewness, α_4 = kurtosis, α = Cronbach's alpha, Ω = McDonald's omega. Loadings and errors are standardized.

Chapter 6
General Discussion

Introduction

In the following chapter, I discuss the thesis findings, beginning with a summary of the overarching aim and explanation of how that aim was met. I then provide an overview of the key findings of the thesis before discussing implications and future directions. Finally, I address the limitations of the thesis and provide a conclusion.

Overarching Aim

Despite many years of NSSI-related research, the stigmatization of self-injury has yet to be explored in depth, which is surprising, given the negative impacts of stigma more broadly (Sickel et al., 2014). Understanding NSSI stigma with the view to drive future research and inform stigma reduction is crucial to improving the lives of individuals with lived experience of self-injury. Therefore, the overarching aim of this PhD was to develop a better understanding of NSSI stigma. This was achieved through the development and application of a theoretical framework, which subsequently informed the development and validation of a self-injury stigma measure.

Key Findings

Because self-injury is used primarily as a method of emotion regulation (Taylor et al., 2018), is related to mental health difficulties, and confers increased likelihood of suicidality (Kiekens et al., 2018), the behavior is often considered through a mental illness lens. Current considerations of self-injury stigma follow this approach, applying models derived from mental illness theory to inform NSSI stigma research. For example, the experimental research conducted by Burke et al. (2019), Law et al. (2009), Lloyd et al. (2018), and Piccirillo et al. (2020) draws on Corrigan et al.'s (2003) attribution model of mental illness stigma and adapts Corrigan et al.'s (2001) Attribution Questionnaire to assess attitudes toward self-injury. Methodologically, these choices are sound in the context of the research questions posed; however, in the broader context of understanding self-injury stigma, existing models and questionnaires adapted for use in self-injury research may not be sufficient, due to limited ability to capture key aspects of self-injury.

As a self-directed behavior that often leaves marks in the form of wounds and scars (Ho et al., 2018), the volitional and visible nature of NSSI needs to be considered when exploring and examining self-injury stigma. An absence of self-injury-specific conceptualizations of stigma led to the development of the NSSI Stigma Framework presented in Chapter 2, which represents the culmination of existing research relating to the experience of NSSI stigma

situated within established models of stigma. Specifically, and drawing on work by Jones et al. (1984), Corrigan and Watson (2002), and Quinn and Chaudoir (2009), the Framework outlines the levels at which stigma may manifest and the domains underpinning why self-injury stigma may arise. Through this intersection of models, the NSSI Stigma Framework offers a comprehensive conceptualization of how, why, and where NSSI stigma may manifest.

While the development of the NSSI Stigma Framework was grounded in prior research and theory, it was critical to assess its utility and determine its applicability to people's lived experiences of NSSI stigma. This was achieved in Chapter 3, where I used the Framework as a coding rubric in a directed content analysis of qualitative responses provided by participants about their experiences of stigma. To this end, the Framework was useful in identifying and explaining people's experiences of stigma and demonstrated utility as a guiding structure to conceptualize self-injury stigma moving forward. This preliminary validation of the NSSI Stigma Framework offered support for its utility to direct NSSI stigma research and generate relevant research questions.

The nature of the NSSI Stigma Framework means research questions can be posed at the stigma level (e.g., public), stigma domain (e.g., origin), or at any level-domain intersection (e.g., public stigma related to origin). For example, a researcher seeking to better understand how NSSI stigma develops may look to the public level of the framework and pose the research question: "How is public NSSI stigma perpetuated in the media?"; or the researcher may look to the origin domain of the framework and pose the research question: "What is the role of origin in NSSI stereotypes?" Intersecting the two, a researcher may ask: "How does the media portray the origin of NSSI?" In this way, the framework both serves and is served by researchers; the Framework directs relevant research and is subsequently improved by the findings of such research. Chapter 4 demonstrates how the NSSI Stigma Framework can support the development of research questions. Driven by the public stigma level and spanning the domains, I asked: how is self-injury portrayed by the news media?

The media are a known conduit for stigmatizing messages (Ma, 2017; Smith, 2012) and people have reported the news media as a primary source of information about self-injury (Newton & Bale, 2012). Therefore, an investigation of news media messaging related to self-injury is a relevant point of inquiry to inform our understanding of self-injury stigma at the public level. Using a media framing analysis of 545 Australian news articles, I found that news media representations of self-injury are overwhelmingly negative in valence and portrayals appear underpinned by assumptions and misconceptions related to the domains

proposed by the NSSI Stigma Framework. For example, the frames *A Manipulative Tactic* and *Mentally Unwell* relate to the origin domain; beliefs that self-injury is motivated by manipulation or enacted only by individuals living with mental illness represent common misconceptions about why an individual self-injures (origin). These misconceptions inform NSSI stigma, demonstrating one way in which public self-injury stigma may manifest.

Chapter 4 contributes to our understanding of how NSSI stigma manifests at the public stigma level and stimulates additional research questions. For example, it will be important to understand how exposure to such messaging informs the development of NSSI stigma at an individual level (personal stigma and self-stigma) and how such messaging may impact people with lived experience of self-injury (e.g., self-esteem, shame). To effectively pursue such enquiry, a measure of NSSI stigma is needed. To fulfil this need, I developed the Self-Injury Stigma Scales (SISS) in Chapter 5.

Given the theoretical and empirical underpinnings of the NSSI Stigma Framework and the subsequent evidence pointing to its utility, it served as a robust foundation from which to develop a measure. Through a rigorous process of item generation, reduction, evaluation, and validation, five 18-item scales were developed to assess NSSI stigma at each of the public, personal, self, anticipated, and enacted stigma levels proposed by the NSSI Stigma Framework. Each scale comprises four subscales, informed by the domains of the Framework. While six domains are proposed in the Framework, through empirical testing, the course and peril domains were collapsed into a single factor, as were the concealability and aesthetics domains. The overlap between these domains is conceptually supported by the findings in Chapter 3, whereby data coded to aesthetics was often coded to concealability and data coded to course was frequently coded to peril. Furthermore, in proposing the original domains, Jones et al. (1984) explained that they are not mutually exclusive.

The Self-Injury Stigma Scales serve as a comprehensive measurement tool rooted in a theoretical framework derived from and tested with people's lived experiences of NSSI stigma. In this way, it accounts for the unique components of NSSI stigma that mental illness stigma scales (e.g., the Self-Stigma of Mental Illness Scale; Corrigan et al., 2006) are not able to because they do not capture the domains that underpin self-injury stigma. While the Self-Injury Stigma Scales require further validation and testing, they present an opportunity for researchers to investigate NSSI stigma with more clarity and focus.

Theoretical Implications and Future Directions

The importance of stigma in the experiences and wellbeing of individuals who have self-injured has been emphasized (Aggarwal et al., 2021; Hasking & Boyes, 2018). As this

priority area gains traction, theoretically grounded approaches to investigating self-injury stigma are required. The NSSI Stigma Framework provides such an approach, offering a heuristic to guide how we think and pose questions about self-injury stigma. Informed by the Framework, the Self-Injury Stigma Scales offer a measure that allows nuanced and holistic assessment of self-injury stigma. In conjunction, the Framework and the Scales demonstrate that self-injury stigma is fundamentally different from other types of stigma.

While support for the NSSI Stigma Framework is evident, further validation and examination of its proposed structure is required. The Framework was developed upon the basis of lived experience accounts mined from published research and data collected within the broader research team; however, interviews driven by the Framework are recommended as part of the testing process. Interview questions that tap into the elements proposed by the Framework will allow researchers to better understand how experiences at each level and within each domain manifest. The in-depth nature of interviews will also enable exploration of missingness or redundancy, informing a more precise and targeted theory. Indeed, the potential for a sixth stigma level (vicarious stigma) illuminated in Chapter 3 points to the need to conduct more in-depth exploration of the NSSI Stigma Framework.

Vicarious stigma captures the complex experience of public stigma for individuals with lived experience of self-injury. In addition to exposure to stigma in the public sphere (e.g., through media), individuals may also experience stigma indirectly, via others who vocalize stigma without knowing that their words are directly relevant to the individual. For example, one participant described how their friends, unaware of their NSSI history, discussed another individual's self-injury, "*talking about how she only did it for attention and had nothing to truly be sad about*." Experiences such as this create a form of inadvertent enacted stigma that may impact individuals in ways different than enacted or public stigma. Indeed, it is likely that experiences of vicarious stigma have a direct impact on the development of self-stigma, anticipated stigma, and care-seeking reluctance. For example, if an individual who has self-injured reads a comment online blaming long wait times in an emergency department on individuals presenting for medical treatment of self-injury, that individual may avoid seeking necessary medical care for self-injury in the future, even if they need it. Further exploration of how the levels may inform one another is required.

The overlapping nature of the stigma domains is also a point for further investigation. Evidence was found for each domain in Chapter 3 (albeit in varying frequencies across levels); however, coding patterns in the directed content analysis together with the factor structure of the Self-Injury Stigma Scales suggest the relationship between the domains is

complex. It is possible that the salience of each domain differs across stigma levels. For example, the potentially visible nature of self-injury may mean that concealability is particularly important at the anticipated stigma level, while origin may be most important at the public and personal levels due to self-injury stereotypes centering on reasons for self-injury. However, this is speculative, and more research will be needed to further our understanding of the domains and how they interact.

While the contributions of the NSSI Stigma Framework and the Self-Injury Stigma Scales are valuable from a theoretical and measurement standpoint, neither intend to capture or assess the impact of self-injury stigma. We know from research thus far that self-injury stigma foments shame and reduces help-seeking (Long et al., 2018; Rosenrot & Lewis, 2018; Williams et al., 2020); however, a greater understanding of the impacts of self-injury stigma, and the components that may be most salient in particular contexts, is a key priority for future work. Documenting these impacts will help illuminate the importance of self-injury stigma research and hopefully encourage efforts to reduce self-injury stigma.

An additional consideration for future research will be the role of constructs such as responsibility. If perceptions of personal responsibility (i.e., self-blame) are high, this may strengthen, for example, an association between public stigma and anticipated stigma, and anticipated stigma and disclosure. This is only one of many possible predictions that may be tested and, in turn, point to subsequent areas of focus for future research. Examining how multiple constructs work together, using the NSSI Stigma Framework as a starting point and the Self-Injury Stigma Scales as a measurement tool, can further our understanding of self-injury stigma. With greater understanding, we can turn our attention to stigma reduction.

Practical Implications and Future Directions

Stigma reduction is a priority outcome for many researchers (Casados, 2017). The motivation of the present work is no different, and a major implication of the NSSI Stigma Framework and Self-Injury Stigma Scales is their potential to inform stigma reduction efforts by pointing to areas of priority and enabling evaluation of the effectiveness of such efforts. Given the limited research focussed on self-injury stigma, we do not know the extent of self-injury stigma endorsement, which limits our ability to effectively reduce NSSI stigma. Measuring the extent of NSSI stigma among different health professionals, the general public, individuals with lived experience, and friends and family of individuals who have self-injured is a critical first step in stigma reduction. A baseline from which to draw later comparisons is required to demonstrate the effectiveness of stigma reduction efforts. This can be achieved using the Self-Injury Stigma Scales, which allows NSSI stigma to be assessed

across various levels, providing insight into which domains of NSSI stigma may be most important to target.

When considering how to approach NSSI stigma reduction, we can turn to other fields for inspiration. In the mental illness field, stigma reduction frequently takes the form of awareness building or education, often delivered through public health campaigns and institutions (e.g., school and work settings; Morgan et al., 2018). Such efforts have demonstrated variable effectiveness. Short-term effects are often promising, but few interventions extend beyond the pilot phase, limiting evaluation of long-term effects (Morgan et al., 2018). A recent review of stigma reduction initiatives in Australia found face-to-face programs were effective in reducing stigma, although few programs were sufficiently evaluated to demonstrate long-term impacts (Morgan et al., 2021). The ongoing nature of mental illness stigma suggests that education and awareness building alone are insufficient to make meaningful and sustained change (Smith et al., 2022). Efforts to diminish self-injury stigma will undoubtedly face the same challenges, and it is critical that our efforts consider stigma reduction in a holistic manner, going beyond the individual level to tackle stigma at multiple social-cultural levels.

A holistic approach to self-injury stigma reduction can be informed by the NSSI Stigma Framework, which was designed to encourage consideration of the social-cultural and bidirectional nature of stigma development. The stigma levels proposed within the Framework are encompassed by macrosystemic forces that, intentionally or otherwise, work to reinforce stigma. Structures and mechanism ingrained into cultural, social, and political institutions operate as the conduits of stigma (Link et al., 2014) but are exceedingly difficult to change (Pescosolido, 2013). However, given the bidirectional nature of stigma development, individuals, as part of groups, committees, and organisations, can generate changes at the macrosystemic level.

The NSSI Stigma Framework can provide insight into where change can begin. For example, the public stigma level demonstrates the importance of stereotypes in the development and perpetuation of NSSI stigma. As evidenced in Chapter 3, self-injury stigma is often underpinned by misconceptions spanning stigma domains, including that self-injury is “just a phase”, that “people who hurt themselves are weak”, and assumptions that “every self-injury is an attempt to comit [sic] suicide”. These misconceptions represent stereotypes that may be amenable to change through education and awareness; however, in addition to disseminating information to contradict NSSI stereotypes, social contexts must also be targeted (Yzerbyt & Carnaghi, 2008).

Self-injury stigma manifests in various social contexts, including families, friendships and relationships, workplaces, schools, and healthcare settings. Affecting change across these settings requires advocacy from individuals within these settings. While individuals comprise the settings in which stigma reduction must occur, these settings are ultimately impacted by systemic issues, such as resource allocation, and governed by overarching or external bodies that impose policies to guide practice. For example, hospital emergency departments are a salient source of stigma for individuals who have attended for self-injury wound care (MacDonald et al., 2020), and are therefore a key target for stigma reduction. However, beyond education and training (which has shown success in improving attitudes; Gibson et al., 2019), interventions must tackle systemic issues. Insufficient funding and resourcing contribute to pressures that may inform NSSI stigma, such as the perception that self-injury is "low priority" (Masuku, 2019).

Furthermore, policies overarching practice can inform NSSI stigma. Such policies are often designed to protect vulnerable individuals from harm. For example, mental health ward admission policies often stipulate that self-injury wounds and scars must be concealed at all times (e.g., Perth Clinic, 2022). Of course, self-injury wounds should be dressed like any other medical injury, however, the requirement to cover scars may be harmful. While the intention of such a policy is to avoid triggering other patients, an unintentional consequence may be the conveyance of messaging that self-injury scars are "bad", "dangerous", and "shameful" (Lewis & Mehrabkhani, 2016; Stirling & Chandler, 2020). In this example, the policy to conceal self-injury scars may contribute to the development and perpetuation of self-injury stigma.

Using the NSSI Stigma Framework, we can see how such a policy is informed by the concealability and peril domains, and how the policy could manifest as stigma across all levels. In this way, the NSSI Stigma Framework may be useful to informing the development and modification of NSSI-related policies. For example, if one was to incorporate the Framework into their evaluation of a policy stipulating scar concealment, they would be able to see how that policy could perpetuate self-injury stigma. Such knowledge could be incorporated into their determination of any policy modification.

Underpinning the above is the need to understand self-injury stigma within the context of broader social-cultural phenomenon, such as sexism and homophobia. While gender and sexuality are factors currently considered within NSSI research, the focus steers toward how NSSI differs across gender and sexuality identities (Angoff et al., 2021; Speer et al., 2022). In the context of stigma reduction, however, the intersection of identities requires further

investigation. For example, boys and men may be subject to greater NSSI stigma than girls and women, due to the misconception that self-injury is more common among girls and women compared to boys and men (Klonsky et al., 2014). For individuals who identify as lesbian, gay, bisexual, transgender, queer, intersex, or another diverse gender or sexuality (LGBTQI+), self-injury stigma is compounded by stigma associated with LGBTQI+ identification (Jackman et al., 2018).

Future self-injury stigma work could be informed by intersectionality theory, which critically considers the complex interaction among identities such as race, culture, gender, sexuality, religion, and class (Turan et al., 2019). Understanding such interactions is key to understanding self-injury stigma and its impact. For example, a preponderance of NSSI stigma research has been conducted with participants sampled from the United States, the United Kingdom, Canada, Australia, and Ireland. The intersection of NSSI stigma and culture is therefore unclear but requires consideration. For example, in research by Williams et al. (2020), a participant shared that self-injury "*isn't understood in this country*", suggesting that in some cultures, NSSI may be stigmatised more harshly than others. Understanding this complexity is critical to meaningful and effective NSSI stigma reduction.

The NSSI Stigma Framework and Self-Injury Stigma Scales offer direction for the development and evaluation of anti-stigma efforts; however, it is critical that such efforts are created in partnership with individuals who have lived experience of self-injury stigma (Lewis & Hasking, 2019) and should draw on existing, effective efforts whilst incorporating the unique facets of self-injury stigma.

While it is clear that self-injury stigma reduction is a key priority, it would be remiss to ignore what may be a real expectation and belief that stigma can serve as a means of NSSI prevention. That is, some researchers and professionals may believe a consequence of reducing self-injury stigma is an increase in rates of self-injury. For example, one anonymous reviewer's feedback on the paper presented in Chapter 3 was: "*Further, as an active clinician, I worry about the goals of the project. If we aim to reduce the stigma surrounding NSSI, I wonder if there a risk that normalization will increase the prevalence of these acts*". There appears to be an underlying assumption that reduction or cessation of self-injury is primarily driven by stigma, or that stigma is a key barrier to engaging in self-injury. While the benefits and barriers model of NSSI engagement (Hooley & Franklin, 2017) suggests social norms are a key barrier to self-injuring, NSSI stigma thwarts help-seeking, impedes recovery and wellbeing (Claréus et al., 2021; Rosenrot & Lewis, 2018; Simone & Hamza, 2020, and can perpetuate self-injury engagement (MacDonald et al., 2020). Self-injury stigma

reduction is not a case of condoning or encouraging NSSI. It is a critical component to supporting and respecting individuals who have self-injured.

Limitations

Despite the significant contribution of this body of work to the field of NSSI research, it is not without limitations. Firstly, while the NSSI Stigma Framework and Self-Injury Stigma Scales are both theoretically informed and supported by existing literature, the overlap in dimensions of self-injury stigma does raise the question of how distinct they are from one another. Jones et al. (1984) made explicit that the boundary between domains is permeable; however, our ability to accurately assess, predict, and modify self-injury stigma relies on a clear conceptualisation. It may be that demarcation between the domains is not possible, due to the nature of stigma comprising interweaving elements. Future research focused on self-injury stigma will contribute to our understanding of the domains and how they do (and do not) overlap.

Secondly, this thesis provides a robust theoretical explanation for why self-injury is stigmatised and how that stigma may manifest but it does not capture the impact of self-injury stigma. The findings in Chapter 3 do offer insight, particularly with the uncoded data; however, exploring the impact of self-injury stigma was not the focus of that study. Without capturing the impact of self-injury stigma, our understanding of it remains incomplete.

Thirdly, while this program of research is cohesive and combines multiple forms of data to address the overarching aim, interviews and experiments would further contribute to an understanding of self-injury stigma. Interviews allow a rich examination of a phenomenon, and an absence of interviews means there is scope to delve further into the experience of self-injury stigma. Experiments allow testing of hypotheses within controlled environments and enable inferences that can be stronger than those generated from self-report data. A lack of experimental research means my theoretical propositions are yet to be fully tested.

Finally, the representativeness and temporal stability of the Self-Injury Stigma Scales has yet to be established. The Scales were developed with samples that are not broadly generalisable, meaning further work is required to examine the representativeness of the Scales and make necessary adjustments. As discussed above, intersectionality is critical to understanding stigma and further assessment of the Self-Injury Stigma Scales requires efforts to recruit diverse samples. Further, assessment of the temporal stability of the Self-Injury Stigma Scale is required. Alongside continued investigation of the psychometric properties of the Self-Injury Stigma Scales, test-retest reliability needs to be established.

Conclusion

Limitations notwithstanding, the work presented in this thesis makes a significant contribution to the field of NSSI research by offering a theoretical framework that conceptualises self-injury stigma and a comprehensive tool to measure self-injury stigma and inform the development and evaluation of stigma reduction efforts. Together, the NSSI Stigma Framework and Self-Injury Stigma Scales offer innovative tools to support the advancement of NSSI stigma research. It is my hope that the work presented here contributes meaningfully and productively to the reduction of NSSI stigma and the ongoing prioritisation of the wellbeing of individuals who have lived experience of self-injury.

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Portions	All content on pages 312-323.
Requestor Location	Curtin University Kent Street Bentley, WA 6102 Australia Attn: Curtin University

Appendix B

Chapter 3 Journal Permission Request

From:	Academic UK Non Rightslink
To:	Lexy Staniland
Subject:	Automatic reply: udbh20:Crazy, Weak, and Incompetent: A Directed Content Analysis of Self-Injury Stigma Experiences
Date:	14 March 2022 16:27:28

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Appendix C

Chapter 3 Ethical Approval

Office of Research and Development

GPO Box U1987
Perth Western Australia 6845

Telephone +61 8 9266 7863
Facsimile +61 8 9266 3793
Web research.curtin.edu.au

18-Sep-2018

Name: Penelope Hasking
Department/School: School of Psychology
Email: Penelope.Hasking@curtin.edu.au

Dear Penelope Hasking

RE: Ethics approval
Approval number: HRE2018-0615

Thank you for submitting your application to the Human Research Ethics Office for the project **The experience of self-injury**.

Your application was reviewed by the Curtin University Human Research Ethics Committee at their meeting on **04-Sep-2018**.

The review outcome is: **Approved**.

Your proposal meets the requirements described in National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*.

Approval is granted for a period of one year from **18-Sep-2018** to **18-Sep-2019**. Continuation of approval will be granted on an annual basis following submission of an annual report.

Personnel authorised to work on this project:

Name	Role
Hasking, Penelope	CI
Boyes, Mark	Co-Inv
Lewis, Stephen	Co-Inv

Standard conditions of approval

1. Research must be conducted according to the approved proposal
2. Report in a timely manner anything that might warrant review of ethical approval of the project including:
   - proposed changes to the approved proposal or conduct of the study
   - unanticipated problems that might affect continued ethical acceptability of the project
   - major deviations from the approved proposal and/or regulatory guidelines
   - serious adverse events

Appendix D

Chapter 3 Participant Information Sheet

The Experience of Self-Injury
Professor Penelope Hasking & Dr Mark Boyes (Curtin University)
A/Prof Stephen Lewis (University of Guelph)

What is this study about?
Non-suicidal self-injury is a behaviour that is confusing to many people. Usually used to help manage overwhelming emotions, self-injury can seem counter-intuitive to the tendency to avoid pain and injury. While a significant amount of work has been done to better understand why people self-injure, less work has focused on the experience of self-injury, as voiced by people with experience of self-injury. In this project we are particularly interested in your experiences of stigma associated with self-injury, your experiences of disclosing your self-injury to someone else (or reasons you have not disclosed your history of self-injury), and the effect of any self-injury-related scars on various aspects of your life.

What will you be asked to do?
In completing this survey you will be asked a number of questions about your experiences of self-injury, including the nature and extent of your history of the behaviour. The survey should take approximately 30 minutes of your time. You will also be asked to comment on what you think the general public think about both mental illness in general, and self-injury specifically. We will ask you about any experiences you have had that might reflect any stigma associated with self-injury. Finally we will ask you about whether you have ever told anyone about your self-injury, and your experiences to do with disclosing self-injury to someone else.

Are there any risks or benefits?
We appreciate that reflecting on your history of self-injury could be confronting, or could bring back some unpleasant memories. Remember that you can take a break at any time, or stop doing the survey by simply closing your browser. You can come back to finish the survey anytime within a 2-week period (after 2 weeks you would need to start from the beginning). If you wish to talk to anyone about any of the topics raised in this survey we suggest one of these Useful resources. You can download this list to refer to later.

Students recruited through SONA (the School of Psychology online sign up system for research participation) will receive 2 SONA points for completing the survey. Participants recruited through other means will not be reimbursed for their time. However, people have also told us that they value the opportunity to express their views, and to help others who might be self-injuring. As such, your participation will benefit others. However, the choice to participate or not is completely up to you.

Is my data secure?
All responses you provide are anonymous. Students recruited through SONA will be directed to a separate site to add their name and student ID for the purpose of awarding SONA points - at no time will your name be linked to the responses you provide. We will ask you at the end of the survey if you are interested in being interviewed about your experiences of self-injury. If you are interested in an interview you will also be directed to an external site to enter your contact details.

Data will be stored in an electronic file, on a secure server, accessible only via a password protected computer. Only the Chief Investigators will have access to the raw data. In accordance with the WA University Sector Disposal Authority, data will be kept for up to 8 years after publication and then destroyed.

Aggregate data will be used in peer-reviewed journal articles, conferences, and other publications (e.g., books), but at no point will anyone be able to identify your individual responses. We may also use direct quotes from open ended responses in publications, but will use a pseudonym so you can never be identified.

At the end of the survey we will ask if you are interested in participating in an interview about self-injury. If you are, you will be directed to a separate site to add your contact details. This means we cannot link your contact details to your survey responses.

What if I have questions?
If you have any questions about the project feel free to contact either:

Penelope Hasking: Penelope.Hasking@curtin.edu.au
Mark Boyes: Mark.Boyes@curtin.edu.au

Can I see the results?
If you are interested in seeing the aggregate research findings, please contact us in December 2019.

Thank you for taking the time to consider participating in our research.

Penny Hasking, Mark Boyes, & Stephen Lewis

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2018-0615). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Appendix E

Chapter 3 Consent

I have read the information above and agree to participate in this anonymous survey about my experience of self-injury.

- ○ Yes, I would like to complete the survey
- ○ No, I am not interested

Appendix F

Chapter 3 Study Advertisements

SONA Advert

Study name: The experience of self-injury

Description: Non-suicidal self-injury is a behaviour that is perplexing to many people. Usually used to help manage overwhelming emotions, self-injury appears to counter the human instinct to avoid pain and injury. While a significant amount of work has been done to better understand why people self-injure, less work has focused on the experience of self-injury, as voiced by people with experience of self-injury. In this project we are particularly interested in your experiences of stigma associated with self-injury, your experiences of disclosing your self-injury to someone else (or reasons you have not disclosed your history of self-injury), and the effect of any self-injury-related scars on various aspects of your life.

If you choose to participate in the study you will be asked to complete an anonymous questionnaire about your experience of self-injury, stigma, and disclosure of self-injury

Eligibility: Any student with lived experience of self-injury

Duration: 30 minutes

Points: 2 points

Preparation: None

Researchers: A/Prof Hasking, Dr Mark Boyes, A/Prof Stephen Lewis (U of Guelph), Lexy Staniland
HREC Approval Number: HRE2018-0615

Example Social Media Advert

Non-suicidal self-injury is a behaviour that is perplexing to many people. Usually used to help manage overwhelming emotions, self-injury appears to counter the human instinct to avoid pain and injury. While a significant amount of work has been done to better understand why people self-injure, less work has focused on the experience of self-injury, as voiced by people with experience of self-injury. In this project we are particularly interested in people's experiences of stigma associated with self-injury, and the impact of any self-injury-related scars. If you have ever engaged in self-injury we want to hear your story. To read more about the study and participate in the anonymous online survey click here.

This study has been approved by the Curtin University Human Research Ethics Committee (HRE2018-0615). If you are experiencing any distress and wish to talk to someone about these feelings remember you can always call: Lifeline: 13 11 14 or BeyondBlue: 1300 22 4636.

Appendix G

Chapter 3 Questionnaire

Demographics

Before we get started we just need some background information about you.

What is your gender?

- ◯ Male
- ◯ Female
- ◯ Another gender

How old are you?

What is your postcode?

What country were you born in?

Do you identify as Aboriginal or Torres Strait Islander?

- ◯ Yes
- ◯ No

Are you a university student?

- ◯ Yes
- ◯ No

Which university are you enrolled in?

Are you a Curtin undergraduate psychology student participating for SONA points?

- ◯ Yes
- ◯ No

Are you an undergraduate or postgraduate student?

- ◯ Undergraduate (including Honours)
- ◯ Postgraduate

What year of your degree are you in?

Are you studying full time or part time?

- ◯ Full time
- ◯ Part time

Where are you living?

- ◯ At home with parents/family
- ◯ In university accommodation
- ◯ With flatmates
- ◯ On your own
- ◯ With a partner
- ◯ Other (please specify)

Have you ever been diagnosed with a mental illness? (if yes, please specify)

- ◯ Yes
- ◯ No

At what age were you first diagnosed with a mental illness?

What was the mental illness?

How old were you when first diagnosed?

How old were you when you last experienced this mental illness?

NSSI

Now we are going to ask questions about your experiences of self-injury, and any history of suicidal thoughts and behaviours. Remember you can take a break or stop doing the questionnaire at any time. If you wish to talk to someone about feelings that may come about through doing this questionnaire remember you can call:

Lifeline: 13 11 14
BeyondBlue: 1300 22 4636

Nonsuicidal Self-Injury
Nonsuicidal self-injury is defined as the deliberate damage to one's body that is not associated with conscious suicidal intent. This does not include socially acceptable forms of tissue damage such as tattooing and body piercing.

Have you ever thought about engaging in self-injury?

- ◯ Yes
- ◯ No

Have you ever engaged in nonsuicidal self-injury?

- ◯ Yes
- ◯ No

How many times have you self-injured in the last year?

None	Once	Twice	Three times	Four times	5 or more times
◯	◯	◯	◯	◯	◯

Please only select a behaviour if you have done it intentionally (i.e., on purpose) and without suicidal intent (i.e., not for suicidal reasons).

Please estimate the number of times in your life you have intentionally (i.e., on purpose) performed each types of nonsuicidal self-injury (please write a number)

	Click to write
Cutting	
Biting	
Burning	
Carving	
Pinching	
Pulling hair	

Severe scratching	
Banging or hitting yourself	
Interfering with wound healing	
Rubbing skin against rough surface	
Sticking yourself with needles	
Swallowing dangerous substances	
Other	

If you feel that you have/had a *main* form of self-injury, please indicate from the list below the behaviour you consider to be your main form of self-injury

- ◯ Cutting
- ◯ Biting
- ◯ Burning
- ◯ Carving
- ◯ Pinching
- ◯ Pulling hair
- ◯ Severe scratching
- ◯ Banging or hitting yourself
- ◯ Interfering with wound healing
- ◯ Rubbing skin against rough surface
- ◯ Sticking yourself with needles
- ◯ Swallowing dangerous substances
- ◯ Other

At what age did you (please write a number):

	Click to write
First injure yourself?	
Most recently injure yourself?	

Do/did you experience physical pain during self-injury?

- ◯ Yes
- ◯ Sometimes
- ◯ No

When you self-injure are/were you alone?

- ◯ Yes
- ◯ Sometimes
- ◯ No

Typically, how much time elapses(d) from the time you have the urge to self-injure until you act on the urge?

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

Do/did you want to stop self-injuring?

- ◯ Yes
- ◯ No

This inventory was written to help us better understand the experience of nonsuicidal self-injury. Below is a list of statements that may or may not be relevant to your experience of self-injury.
Please indicate how relevant each statement is to your experience of self-injury.

When I self-injure I am/was...

	Not relevant	Somewhat relevant	Very relevant
calming myself down	○	○	○
creating a boundary between myself and others	○	○	○
punishing myself	○	○	○
giving myself a way to care for myself (by attending to the wound)	○	○	○
causing pain so I will stop feeling numb	○	○	○
avoiding the impulse to attempt suicide	○	○	○
doing something to generate excitement or exhilaration	○	○	○
bonding with peers	○	○	○
letting others know the extent of my emotional pain	○	○	○
seeing if I can stand the pain	○	○	○
creating a physical sign that I feel awful	○	○	○
getting back at someone	○	○	○
ensuring I am self-sufficient	○	○	○
releasing emotional pressure that has built up inside of me	○	○	○
demonstrating that I am separate from other people	○	○	○
expressing anger towards myself for being worthless or stupid	○	○	○
creating a physical injury is easier to care for than my emotional distress	○	○	○
trying to feel something (as opposed to nothing) even if it is physical pain	○	○	○
responding to suicidal thoughts without actually attempting suicide	○	○	○
entertaining myself or others by doing something extreme	○	○	○

	Not relevant	Somewhat relevant	Very relevant
fitting in with others	○	○	○
seeking care or help from others	○	○	○
demonstrating I am tough or strong	○	○	○
proving to myself that emotional pain is real	○	○	○
getting revenge against others	○	○	○
demonstrating that I do not need to rely on others for help	○	○	○
reducing anxiety, frustration, anger, or other overwhelming emotions	○	○	○
establishing a barrier between myself and others	○	○	○
reacting to feeling unhappy with myself or disgusted with myself	○	○	○
allowing myself to focus on treating the injury, which can be gratifying or satisfying	○	○	○
making sure I am alive when I don't feel real	○	○	○
putting a stop to suicidal thoughts	○	○	○
pushing my limits in a manner akin to skydiving or other extreme activities	○	○	○
creating a sign of friendship or kinship with friends or loved ones	○	○	○
keeping a loved one from leaving or abandoning me	○	○	○
proving I can take the physical pain	○	○	○
signifying the emotional distress I'm experiencing	○	○	○
trying to hurt someone close to me	○	○	○
establishing that I am autonomous/independent	○	○	○

Have you ever experienced stigma as a result of mental illness?

- ◯ Yes
- ◯ No

If you would like to, please tell us about your experience with stigma

Have you ever experienced stigma as a result of your self-injury?

- ◯ Yes
- ◯ No

If you would like to, please tell us a little bit about your experiences of stigma.

Have you ever heard anyone talking about self-injury in a way that made you feel uncomfortable, angry, or upset?

- ◯ Yes
- ◯ No

Think of the time you were most uncomfortable/angry/upset by something you overheard.
Can you recall what they said that made you feel that way? Please write below.

Could you please expand on how this made you feel?

What was your response to this situation?

Has anyone ever said anything directly to you, regarding self-injury, that made you feel uncomfortable, angry, or upsetting?

- ◯ Yes
- ◯ No

Think of the time you were most uncomfortable/angry/upset by something someone said to you.
Can you recall what they said that made you feel that way? Please write below.

Could you please expand on how this made you feel?

What was your response to this situation?

Finally, please enjoy this brief clip from Finding Nemo which people say they find amusing (feel free to skip this and go straight to the end of the survey).

FN from Emotion Research on Vimeo.

Please watch the short video clip and then click the "NEXT" button

FN

from Emotion Research

Self injury fact sheet
Shedding light on self-injury
Self-injury and recovery resources
Self-injury outreach and support
Stress management

Would you be interested in participating in an interview about your experiences of self-injury? If you are, please leave your contact details here. These details will only ever be used to contact you if we are conducting an interview study and will be stored on a password protected computer, completely separate from your survey responses.

Email address

Phone number

Appendix H

Chapter 4 Journal Permission

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Appendix I

Chapter 4 Reflexive Journaling Excerpts

26/3/21

Everything is everything.

I'm talking about self-harm threats, "dramatic scenes unfolded as a man threatened self harm outside parliament house", then there's the restraint and tasering of people who have threatened or engaged in self-harm, and the self-harm legitimises the practice, like a person dying from a taser is better than them ending their own life or harming themselves, then there's the danger aspect of arresting someone who is threatening self-harm.

24/8/20

The sense I am having about the way self-harm is often portrayed - particularly when identified as an outcome or consequence, is that it is non-voluntary, as thought people have no control or agency over their behaviour - it is a very simplistic and un-nuanced view/approach/take/expression. And that in prison/detention/refugee contexts, "self-harm" is an indication of trouble and problems. Perhaps the "context" for prison/detention/refugee/state care could be referred to as "facilities"?

The couple suing the school over fees really irritates me, because self-harm is used to heighten the severity of the situation, as though self-harm is this worst outcome ever things, I dunno how to articulate this... Like, the focus is on her academic performance, but the self-harm sort of flavours the article with a sense that the school did real harm. Maybe my anger is misplaced here, perhaps I am looking for ways in which the media has failed - that's certainly accurate, I need to be looking at this more objectively. How does the media frame NSSI? How is self-injury portrayed? Is it my own bias that is construing the articles to have this flavour of invoking self-injury imagery to further a particular vantage point? What am I even saying here?

21/8/20

I think one of the issues about how self-harm is handled by the media, is that it is spoken about in varying terms and with varying connotations. In contexts where it is used to demonstrate the seriousness of a particular issues, for example, in article 09-284, the authors include the following, "The inquiry said Veterans Affairs should deal separately with veterans submitting mental health claims because problems some found when dealing with the department may lead to negative reactions or "in the worst possible case, self-harm"". The attempt appears to be to highlight the importance of dealing sensitively with mental health difficulties faced by veterans, and that is legitimate. However, because self-

harm in this context likely refers to suicide or suicide attempts, and not to self-injury, it is difficult to see how readers assimilate this information. We need to know more about how people differentiate these things and whether the inconsistent terminology has any impact of stigma, treatment, service-delivery etc.

18/2/20

The other thing I am wondering is whether my time frame is ambitious... I have decided to continue with the time frame we used in the content analysis, however, this is returning a lot of results, which may leave me with a data set that is unsuitable for a media framing analysis. Perhaps I will need to block the articles into time points, like 2007-2012 and then 2013-2019, as a comparison in line with the DSM-V release... I'll continue collating and then decide this once I can see what my data set it like. This particular aspect may also change my research question, because if I am comparing these time point, my research question is actually "How does media framing of NSSI change over time?" Or something like that...

17/2/20

Day one of article collation. Some issues that I seem to be running into include some confusion around what articles can answer my research question, and whether my research question is enough. My question is: "How does the news media represent people who have a history of nonsuicidal self-injury?" This question is specific and discrete, the population is clearly articulated, and the types of stories that will be relevant is clear. I guess, as I am going through the list of articles and reviewing their content, other questions come to mind. The question "How does the news media represent nonsuicidal self-injury?" captures more information about the behaviour, whereas I want to know about how the people who engage in self-injury are framed. My research question is informed by a desire to understand how NSSI stereotypes develop, which necessitates an investigation of how people who self-injure are portrayed. But, these other questions that are coming to mind as I screen the articles are important, too. How the media discusses the rates of NSSI is also very interesting, because it likely informs people's understanding of the so-called NSSI "epidemic". But I need to maintain focus on the people.

Appendix J

Chapter 5 Initial Item Pool

Table J.1

Initial Item Pool

Public Stigma Scale	Personal Stigma Scale	Self-Stigma Scale	Anticipated Stigma Scale	Enacted Stigma Scale
People who have self-injured are to blame for their problems (1)	People who have self-injured are to blame for their problems (1)	I am to blame for my problems (1)	People will blame me for my problems (1)	People have said that I brought this upon myself (1)
People who have self-injured do not deserve sympathy (2)	People who have self-injured do not deserve sympathy (2)	I do not deserve sympathy for my problems (2)	People will tell me I don't deserve sympathy (2)	People have said that I do not deserve sympathy (2)
People who self-injured are dysfunctional (3)	People who self injured are dysfunctional (3)	I am dysfunctional (3)	People will think I am dysfunctional (3)	People have said that I am dysfunctional (3)
People who have self-injured should just get over it (4)	People who have self-injured should just get over it (4)	I should just get over my problems (4)	People will tell me to just get over it (4)	People have said that I should just get over it (4)
People who have self-injured are pathetic (5)	People who have self-injured are pathetic (5)	I am pathetic (5)	People will think I am pathetic (5)	People have said that I am pathetic (5)
People who have self-injured are weak (6)	People who have self-injured are weak (6)	I am weak (6)	People will think I am weak (6)	People have said that I am weak (6)
People who have self-injured are crazy (7)	People who have self-injured are crazy (7)	I am crazy (7)	People will think I am crazy (7)	People have said that I am crazy (7)
People who have self-injured are emotionally unstable (8)	People who have self-injured are emotionally unstable (8)	I am emotionally unstable (8)	People will think I am emotionally unstable (8)	People have said that I am emotionally unstable (8)
People who have self-injured are manipulative (9)	People who have self-injured are manipulative (9)	I am manipulative (9)	People will think I am manipulative (9)	People have said that I am manipulative (9)
People who have self-injured can't help it (10)	People who have self-injured can't help it (10)	I can't help it (10)	People will think I can't help it (10)	People have said that I can't help it (10)
People who have self-injured can't cope with life (11)	People who have self-injured can't cope with life (11)	I can't cope with life (11)	People will think I can't cope with life (11)	People have said I can't cope with life (11)
People who have self-injured are emotionally damaged (12)	People who have self-injured are emotionally damaged (12)	I am emotionally damaged (12)	People will think I am emotionally damaged (12)	People have said that I am emotionally damaged (12)
People who have self-injured are failures (13)	People who have self-injured are failures (13)	I am a failure (13)	People will think I am a failure (13)	People have said I am a failure (13)
People who have self-injured are attention seeking (14)	People who have self-injured are attention seeking (14)	I'm an attention-seeker (14)	People will think I am attention-seeking (14)	People have said I am attention-seeking (14)
People who have self-injured deserve the pain (15)	People who have self-injured deserve the pain (15)	I deserve pain (15)	People will think that I deserve pain (15)	People have said that I deserve pain (15)
People who have self-injured have a mental illness (16)	People who have self-injured have a mental illness (16)	I have a mental illness (16)	People will think I have a mental illness (16)	People have said I have a mental illness, despite not knowing whether that was true (16)
People who have self-injured have no self-control (17)	People who have self-injured have no self-control (17)	I have no self-control (17)	People will think I have no self control (17)	People have said I have no self-control (17)
People who have self-injured did it because their friends did (18)	People who have self-injured did it because their friends did (18)	I am not normal (18)	People will think I have done it to fit in (18)	People have said I have done it just to fit in (18)
People who have self-injured copied it from social media/internet (19)	People who have self-injured copied it from social media/internet (19)	I don't really have anything to complain about (19)	People will think I just copied it from social media/internet (19)	People have said I just copied it from social media/internet (19)

People who have self-injured copied it from TV/Movies (20)	People who have self-injured copied it from TV/Movies (20)	I am stupid (20)	People will think I copied it from TV/movies (1)	People have said I copied it from TV/movies (1)
People who have self-injured are not normal (21)	People who have self-injured are not normal (21)	*I am resilient (21)*	People will think I am not normal (2)	People have said I am not normal (2)
People who have self-injured don’t really have anything to complain about (1)	People who have self-injured don’t really have anything to complain about (22)	*I am capable (22)*	People will think I don't really have anything to complain about (3)	People have said I don't really have anything to complain about (3)
Self-injury is a stupid thing to do (2)	Self-injury is a stupid thing to do (1)	*I can fight through adversity (23)*	People will think my self-injury is a stupid thing to do (4)	People have said that my self-injury is a stupid thing to do (4)
People who have self-injured are resilient (3)	*People who have self-injured are resilient (2)*	*I can overcome challenges (24)*	*People will think I am resilient (5)*	*People have said that I am resilient (5)*
People who have self-injured are capable (4)	*People who have self-injured are capable (3)*	*I am coping as best I can (25)*	*People will think I am capable (6)*	*People have said that I am capable (6)*
People who have self-injured can fight through adversity (5)	*People who have self-injured can fight through adversity (4)*	*I am strong (26)*	*People will think I can fight through adversity (7)*	*People have said I an fight through adversity (7)*
People who have self-injured can overcome challenges (6)	*People who have self-injured can overcome challenges (5)*	*I can manage my emotions (27)*	*People will think I can overcome challenges (8)*	*People have said I can overcome challenges (8)*
People who have self-injured are coping as best they can (7)	*People who have self-injured are coping as best they can (6)*	*I am only human (28)*	*People will think I am coping as best I can (9)*	*People have said I am coping as best I can (9)*
People who have self-injured are strong (8)	*People who have self-injured are strong (7)*	*I can get through things (29)*	*People with think I am strong (10)*	*People have said I am strong (10)*
People who have self-injured can manage their emotions (9)	*People who have self-injured can manage their emotions (8)*	I am childish (30)	*People will think I can manage my emotions (11)*	*People have said that I can manage my emotions (11)*
People who have self-injured are only human (10)	*People who have self-injured are only human (9)*	I should keep my self-injury hidden (1)	*People will think I am only human (12)*	*People have said I am only human (12)*
People who have self-injured can get through things (11)	*People who have self-injured can get through things (10)*	I should not let others know about my self-injury (2)	*People will think I can get through things (13)*	*People have said I can get through things (13)*
People who have self-injured are just trying to be different/special (12)	People who have self-injured are just trying to be different/special (11)	I should not let others see my self-injury (3)	People will think I am just trying to be different/special (14)	People have said that I am just trying to be different/special (14)
People who have self-injured are childish (13)	People who have self-injured are childish (12)	I should cover up my self-injury (4)	People will think I am childish (15)	People have said that I am childish (15)
People who have self-injured are masochistic (14)	People who have self-injured are masochistic (13)	My problems are not "real" problems (5)	People will think I am masochistic (16)	People have said I am masochistic (16)
People who have self-injured are "emo" or "goth" (15)	People who have self-injured are "emo" or "goth" (14)	I avoid talking about my self-injury (6)	People will call me names like "cutter" (17)	People have called me names like “cutter” (17)
People who have self-injured should keep their self-injury hidden (16)	People who have self-injured should keep their self-injury hidden (1)	*I talk about my self-injury (7)*	People will think I am "emo" or "goth" (18)	People have called me an “emo” or a “goth” (18)
People who have self-injured should not let others know about it (17)	People who have self-injured should not let others know about it (2)	I avoid discussing my experiences of self-injury online (8)	People will think I should keep my self-injury hidden (1)	
People who have self-injured should not let others see their self-injury (18)	People who have self-injured should not let others see their self-injury (3)	I avoid posting about my experiences of self-injury online (9)	People will think that I should not let others know about my self-injury (2)	People have told me I should not let others know about my self-injury (2)
People who have self-injured should cover up their self-injury (19)	People who have self-injured should cover up their self-injury (4)	I feel that I have to prove that I have self-injured when asked (10)	People will think I should not let others see my self-injury (3)	People have told me I should not let others see my self-injury (3)
People who have self-injured don’t have any “real” problems (20)	People who have self-injured don’t have any “real” problems (5)	I do not make an effort to hide my self-injury (11)	People will think I should cover up my self-injury (4)	People have told me to cover my self-injury (1)
People should avoid talking about self-injury (21)	People should avoid talking about self-injury (6)	I have to show my self-injury to prove I have done it (12)	People will think I don't have any real problems (5)	People have dismissed me as not having any real problems (5)
People who have self-injured should be allowed to talk about it (22)	*People who have self-injured should be allowed to talk about it (7)*	*I am able to talk about my experiences of self-injury (13)*	People will think I shouldn't talk about my self-injury (6)	People have told me not to talk about my self-injury (6)

People should not discuss self-injury online (23)	People should not discuss self-injury online (8)	I shouldn't need to talk about my self-injury (14)	*People will think it's okay to talk about my self-injury (7)*	*People have told me it's okay to talk about my self-injury (7)*
People should not post about self-injury online (24)	People should not post about self-injury online (9)	*I share my experiences of self-injury with other people (15)*	People will think I shouldn't discuss my experiences of self-injury online (8)	People have told me not to discuss my experiences of self-injury online (8)
People who have self-injured should show evidence of their self-injury when asked (1)	People who have self-injured should show evidence of their self-injury when asked (10)	*I am open about my experiences of self-injury (16)*	People will think I shouldn't post about my experiences of self-injury online (9)	People have told me not to post about my experiences of self-injury online (9)
People who have self-injured should not need to hide it (2)	*People who have self-injured shouldn't need to hide it (11)*	*I do not hide my self-injury (17)*	People will pressure me to show them my self-injury (10)	People have pressured me to show them my self-injury (10)
People who have self-injured should be forced to prove it (3)	People who have self-injured should be forced to prove it (12)	I should just toughen up (18)	People will think I don't need to hide it (11)	People have told me that I don't need to hide it (11)
People who have self-injured are able to talk about it (4)	*People who have self-injured are able to talk about it (13)*	I will never be free of self-injury (1)	People will force me to show them my self-injury (12)	People have forced me to show them my self-injury (12)
People who have self-injured don't need to talk about it (5)	People who have self-injured don't need to talk about it (14)	I cannot handle high stress situations (2)	*People will allow me to talk about my experiences of self-injury (13)*	*People have allowed me to talk about my experiences of self-injury (13)*
People who have self-injured can share their experiences with others (6)	*People who have self-injured can share their experiences with others (15)*	I should be forced to stop (3)	People won't want to hear about my experiences of self-injury (14)	People have told me they do not want to hear about my experiences of self-injury (14)
People who have self-injured are open about their experiences of self-injury (7)	*People who have self-injured are open about their experiences of self-injury (16)*	*I want to live (4)*	*People will let me share my experiences (15)*	*People have let me share my experiences of self-injury (15)*
People who have self-injured should not have to hide it (8)	*People who have self-injured should not have to hide it (17)*	I will never recover (5)	*People will invite me to share my experiences of self-injury (16)*	*People have invited me to share my experiences of self-injury (16)*
People who have self-injured should toughen up (9)	People who have self-injured should toughen up (18)	*I will recover/have recovered (6)*	*People will not think I should hide my self-injury (17)*	*People have not told me to hide my self-injury (17)*
People who have self-injured want to show off their scars (10)	People who have self-injured want to show off their scars (19)	I feel hopeless about my future (7)	People will think I should toughen up (18)	People have told me to toughen up (18)
People who have self-injured want people to see their scars (11)	People who have self-injured want people to see their scars (20)	I will never be able to cope (8)	People will think I am suicidal (1)	People have I must be suicidal (1)
People who have self-injured wouldn't talk about it if they weren't attention seeking (12)	People who have self-injured wouldn't talk about it if they weren't attention seeking (21)	*I can succeed in life (9)*	People will think I should just kill myself (2)	People have said that I should just kill myself (2)
Self-injury should be banned from social media (13)	Self-injury should be banned from social media (22)	*I feel hopeful about my future (10)*	People will think I will never be free of self-injury (3)	People have said I will never be free of self-injury (3)
People who have self-injured are suicidal (1)	People who have self-injured are suicidal (1)	I will never be able to manage my emotions (11)	People will think I can't handle high stress situations (4)	People have said I cannot handle high stress situations (4)
People who have self-injured don't have the guts to kill themselves (2)	People who have self-injured don't have the guts to kill themselves (2)	I am/was just going through a phase (12)	People will try to make me stop (5)	People have tried to force me to stop (5)
People who have self-injured will never be able to stop (3)	People who have self-injured will never be able to stop (3)	I deserve to have my body searched for signs of self-injury (13)	*People will think I want to live (6)*	*People have said that I want to live (6)*
People who have self-injured cannot handle high-stress situations (4)	People who have self-injured cannot handle high-stress situations (4)	*I am proud of myself (14)*	People will think I will never recover (7)	People have said I will never recover (7)
People who have self-injured should be forced to stop (5)	People who have self-injured should be forced to stop (5)	*I appreciate that recovery is not easy (15)*	*People will think I have recovered (8)*	*People have said I will recover (8)*
People who have self-injured want to live (6)	*People who have self-injured want to live (6)*	Recovery should be easy for me (16)	People will think I have a hopeless future (9)	People have said I have a hopeless future (9)
People who have self-injured will never recover (7)	People who have self-injured will never recover (7)	I am impulsive (1)	People will think I will never be able to cope (10)	People have said I will never be able to cope (10)
People who have self-injured will recover (8)	*People who have self-injured will recover (8)*	I am unpredictable (2)	*People will think I can succeed in life (11)*	*People have said I can succeed in life (11)*
People who have self-injured have a hopeless future (9)	People who have self-injured have a hopeless future (9)	I want to die (3)	*People will feel hopeful about my future (12)*	*People have said they feel hopeful about my future (12)*

People who have self-injured will never be able to cope (10)	People who have self-injured will never be able to cope (10)	I will always be at risk of suicide (4)	People will think I will never be able to manage my emotions (13)	People have said I will never be able to manage my emotions (13)
People who have self-injured can succeed in life (11)	*People who have self-injured can succeed in life (11)*	I am a bad influence on others (5)	People will tell me self-injury is just a phase (14)	People have said my self-injury is just a phase (14)
People who have self-injured have a hopeful future (12)	*People who have self-injured have a hopeful future (12)*	*I don't want to die (6)*	People will search my body for signs of self-injury (15)	People have searched my body for signs of self-injury (15)
People who have self-injured will never be able to manage their emotions (13)	People who have self-injured will never be able to manage their emotions (13)	I am reckless (7)	*People will say they are proud of me (16)*	*People have said they are proud of me (16)*
People who have self-injured are just going through a phase (14)	People who have self-injured are just going through a phase (14)	*I have a lot to offer to others (8)*	*People will acknowledge that recovery is not easy (17)*	*People have acknowledged that recovery is not easy (17)*
People who have self-injured should be checked for signs of self-injury (15)	People who have self-injured should be checked for signs of self-injury (15)	*I am careful (9)*	People will tell me recovery is easy (18)	People have said that recovery is easy (18)
People who have self-injured should be proud (16)	*People who have self-injured should be proud (16)*	I am dangerous (10)	People will think I copied it from someone else, even if I didn't (1)	People have said I must have copied it from someone else, even if I didn't (1)
People who have self-injured don't necessarily find recovery easy (17)	*People who have self-injured don't necessarily find recovery easy (17)*	I should be forced to see a mental health professional (11)	People will think I am impulsive (2)	People have said I am impulsive (2)
People who have self-injured should be able to easily recover (18)	People who have self-injured should be able to easily recover (18)	*I should be in control of my recovery (12)*	People will think I am unpredictable (3)	People have said I am unpredictable (3)
People who have self-injured copied the behaviour from someone else (1)	People who have self-injured copied the behaviour from someone else (1)	I should be put on suicide watch (13)	People will assume I learnt about it online, even if I didn't (4)	People have said I must have learnt about it online, even if I didn't (4)
People who have self-injured are impulsive (2)	People who have self-injured are impulsive (2)	I belong in a mental institution (14)	People will think I share pictures of my self-injury online, even if I don't (5)	People have said I share pictured of my self-injury online, even if I haven't (5)
People who have self-injured are unpredictable (3)	People who have self-injured are unpredictable (3)	I should be locked up (15)	People will think I want to die (6)	People have said I want to die (6)
People who have self-injured learnt about it online (4)	People who have self-injured learnt about it online (4)	My problems are not important (16)	People will think I am trying to kill myself (7)	People have said I am trying to kill myself (7)
People who have self-injured share pictures of their self-injury online (5)	People who have self-injured like sharing pictures of their self-injury online (5)	My self-injury is not important (17)	People will think I am at risk of suicide (8)	People have said I am at risk of suicide (8)
People who have self-injured want to die (6)	People who have self-injured want to die (6)	I should minimise contact with friends (18)	People will say I am a bad influence on others (9)	People have said I am a bad influence on others (9)
People who have self-injured are trying to kill themselves (7)	People who have self-injured are trying to kill themselves (7)	I should not be allowed around children (19)	*People will think I do not want to die (10)*	*People have said I do not want to die (10)*
People who have self-injured will always be at risk of suicide (8)	People who have self-injured will always be a risk of suicide (8)	I do not care about my appearance (1)	People will think I am reckless (11)	People have said I am reckless (11)
People who have self-injured are a bad influence on others (9)	People who have self-injured are a bad influence on others (9)	I am unattractive (2)	*People will think I have a lot to offer others (12)*	*People have said I have a lot to offer others (12)*
People who have self-injured don't want to die (10)	People who have self-injured don't want to die (10)	I have ruined my body (3)	*People will think I am careful (13)*	*People have said that I am careful (13)*
People who have self-injured are reckless (11)	People who have self-injured are reckless (11)	I am repulsive (4)	People will think I am dangerous (14)	People have said they think I am dangerous (14)
People who have self-injured have a lot to offer others (12)	*People who have self-injured have a lot to offer others (12)*	My self-injury is ugly (5)	People will think I need to see a mental health professional (15)	People have forced me to see a mental health professional (15)
People who have self-injured are careful (13)	*People who have self-injured are careful (13)*	My self-injury represents strength (6)	*People will allow me to control my recovery (16)*	*People have allowed me to control my recovery (16)*
People who have self-injured are dangerous (14)	People who have self-injured are dangerous (14)	*I do care about my appearance (7)*	I will be put on suicide watch, even if I am not suicidal (17)	People have put me on suicide watch, even though I was not suicidal (17)
People who have self-injured should be forced to see a mental health professional (15)	People who have self-injured should be forced to see a mental health professional (15)	*I am attractive (8)*	People will think I belong in a mental institution (18)	People have said that I belong in a mental institution (18)

People who have self-injured should be in control of their recovery (16)	People who have self-injured should be in control of their recovery (16)	*I am beautiful (9)*	People will say I should be locked up (19)	People have said I should be locked up (19)
People who have self-injured should be put on suicide watch (17)	People who have self-injured should be put on suicide watch (17)	*I haven't ruined my body (10)*	People will dismiss my problems (20)	People have dismissed my problems (20)
People who have self-injured belong in a mental institution (18)	People who have self-injured belong in a mental institution (18)	I don't deserve intimacy with others (11)	People will dismiss my self-injury (21)	People have dismissed my self-injury (21)
People who have self-injured should be locked up (19)	People who have self-injured should be locked up (19)	I am not capable of looking after others (1)	People will not want me around their friends (22)	People have said that do not want me around their friends (22)
People who have self-injured do not have important problems (20)	People who have self-injured do not have important problems (20)	I cannot maintain close relationships (2)	People will stop me from being around children (23)	People have stopped me from being around children (23)
Self-injury is not important (21)	Self-injury is not important (21)	I am not/would not be a suitable romantic partner (3)	People will think I don't care about my appearance (1)	People have said I don't care about my appearance (1)
People who have self-injured should minimise contact with friends (22)	People who have self-injured should minimise contact with friends (22)	I am not/would not be a suitable parent (4)	People will think I am unattractive (2)	People have said that I am unattractive (2)
People who have self-injured should not be allowed around children (23)	People who have self-injured should not be allowed around children (23)	I waste valuable medical resources (5)	People will think I have ruined my body (3)	People have said that I have ruined my body (3)
People who have self-injured do not care about their appearance (1)	People who have self-injured do not care about their appearance (1)	I don’t deserve medical treatment for my self-injury (6)	People will think I am repulsive (4)	People have said that I am repulsive (4)
People who have self-injured are unattractive (2)	People who have self-injured are unattractive (2)	I waste my friends' time (7)	People will stare at my self-injury (5)	People have stared at my self-injury (5)
People who have self-injured have ruined their body (3)	People who have self-injured have ruined their body (3)	I am a drain on the health system (8)	People will think my self-injury is ugly (6)	People have said my self-injury is ugly (6)
People find self-injury scars repulsive (4)	People find self-injury scars repulsive (4)	I don't care if I upset friends and family (9)	*People will think my self-injury represents strength (7)*	*People have said that my self-injury represents strength (7)*
People can’t help but stare when they see self-injury (5)	People can’t help but stare when they see self-injury (5)	I am unlovable (10)	*People will think self-injury scars are no different to other types of scars (8)*	*People have said that self-injury scars are no different to other types of scars (8)*
Self-injury is ugly (6)	Self-injury is ugly (6)	*I am caring (11)*	*People will think I care about my appearance (9)*	*People have said I do care about my appearance (9)*
Self-injury scars represent strength (7)	*Self-injury scars represent strength (7)*	I am selfish (12)	*People will think I am attractive (10)*	*People have said that I am attractive (10)*
Self-injury scars are no different to other types of scars (8)	*Self-injury scars are no different to other types of scars (8)*	I drain loved ones of emotional resources (13)	*People will think I am beautiful (11)*	*People have said that I am beautiful (11)*
People who have self-injured care about their appearance (9)	*People who have self-injured care about their appearance (9)*	*I can maintain close relationships (14)*	*People will think I have not ruined my body (12)*	*People have said that I have not ruined my body (12)*
People who have self-injured are attractive (10)	*People who have self-injured are attractive (10)*	I deserve to be asked uncomfortable questions about my self-injury (15)	People won't want to be intimate with me (13)	People have not wanted to be intimate with me (13)
People who have self-injured are beautiful (11)	*People who have self-injured are beautiful (11)*	*I am dependable (16)*	People will think I am not capable of looking after others (7)	People have said I am not capable of looking after others (1)
People who have self-injured have not ruined their body (12)	*People who have self-injured have not ruined their body (12)*	*I am selfless (17)*	People will not want to be close to me (8)	People have not wanted to be close to me (2)
People who have self-injured do not deserve intimacy with others (13)	People who have self-injured do not deserve intimacy with others (13)	I don't deserve to have friends (1)	People will think I am not a suitable romantic partner (9)	People have told me I am not a suitable romantic partner (3)
People who have self-injured are not capable of looking after others (1)	People who have self-injured are not capable of looking after others (1)	I am angry with myself (2)	People will think I am not/would not be a suitable parent (10)	People have told me I am not/would not be a suitable parent (4)
People who have self-injured cannot maintain close relationships (2)	People who have self-injured cannot maintain close relationships (2)	I need to be controlled (3)	People will think I waste valuable medical resources (11)	People have told me I waste valuable medical resources (5)
People who have self-injured are not suitable romantic partners (3)	People who have self-injured are not suitable romantic partners (3)	I cannot be trusted to be alone (4)	People will think I don't deserve medical treatment (12)	People have said I don't deserve medical treatment (6)

People who have self-injured are not suitable parents (4)	People who have self-injured are not suitable parents (4)	*I should be treated as I am usually treated (5)*	People will think I am a waste of time (13)	People have said I am a waste of time (7)
People who have self-injured waste valuable medical resources (5)	People who have self-injured waste valuable medical resources (5)	I should be avoided (6)	People will think I am a drain on the health system (14)	People have said I am a drain on the health system (8)
People who have self-injured don’t deserve medical treatment (6)	People who have self-injured don’t deserve medical treatment (6)	I deserve poor treatment (7)	People will think I don't care if I upset them (15)	People have said I don't care if I upset them (9)
People who have self-injured waste their friends’ time (7)	People who have self-injured waste their friends’ time (7)	I should not have children (8)	People will think I refuse to accept help (16)	People have said that I refuse to accept help (10)
People who have self-injured are a drain on the health system (8)	People who have self-injured are a drain on the health system (8)	I am a time-waster (9)	People will think I am unlovable (17)	People have said I am unlovable (11)
People who have self-injured don’t care if they upset their friends and family (9)	People who have self-injured don’t care if they upset their friends and family (9)	I do not deserve support for my self-injury (11)	*People will think I am caring (18)*	*People have said I am caring (12)*
People who have self-injured refuse to accept help (10)	People who have self-injured refuse to accept help (10)	People should stay away from me (12)	People will think I am selfish (19)	People have said I am selfish (13)
People who have self-injured are unlovable (11)	People who have self-injured are unlovable (11)	I do not care about others (13)	People will think I drain loved ones of emotional resources (1)	People have said that I am a drain on their emotional resources (14)
People who self-injure are caring (12)	*People who have self-injured are caring (12)*	I am a burden to loved ones (14)	*People will think I can maintain close relationships (2)*	*People will say that I can maintain close relationships (15)*
People who self-injure are selfish (13)	People who have self-injured are selfish (13)	*I am compassionate (15)*	People will ask me uncomfortable questions about my self-injury that I do not want to answer (3)	People have asked me uncomfortable questions about my self-injury that I did not want to answer (16)
People who have self-injured drain loved ones of emotional resources (14)	People who have self-injured drain loved ones of emotional resources (14)	I should be ignored (16)	*People will think I am dependable (4)*	*People have said I am dependable (17)*
People who have self-injured can maintain close relationships (15)	*People who have self-injured can maintain close relationships (15)*	I should not be allowed to talk about my self-injury (17)	*People will think I am selfless (5)*	People have said I am selfless (18)
People who have self-injured should answer questions about self-injury, even if they are uncomfortable (16)	People who have self-injured should answer questions about self-injury, even if they are uncomfortable (16)	I should avoid talking about my self-injury (18)	People will not want to be friends with me (6)	People have not wanted to be friends with me (19)
People who have self-injured are dependable (17)	*People who have self-injured are dependable (17)*		People will be angry with me (1)	People have been angry with me (1)
People who have self-injured are selfless (18)	*People who have self-injured are selfless (18)*		People will try to control me (2)	People have tried to control me (2)
People who have self-injured don't deserve to have friends (1)	People who have self-injured don't deserve to have friends (19)		People will not trust me to be alone (3)	People did not trust me to be alone (3)
People who have self-injured deserve anger (2)	People who have self-injured deserve anger (1)		People will "walk on eggshells" around me (4)	People have "walked on eggshells" around me (4)
People who have self-injured need to be controlled (3)	People who have self-injured need to be controlled (2)		*People will treat me as they usually do (5)*	*People have treated me as they usually do (5)*
People who have self-injured cannot be trusted to be alone (4)	People who have self-injured cannot be trusted to be alone (3)		People will avoid me (6)	People have avoided me (6)
People who have self-injured need to be treated delicately (5)	People who have self-injured need to be treated delicately (4)		People will treat me poorly (7)	People have treated me poorly (7)
People who have self-injured should be treated as they are usually treated (6)	*People who have self-injured should be treated as they are usually treated (5)*		People in the health care profession will treat me poorly (8)	I have been treated poorly by health care professionals (8)
People who have self-injured should be avoided (7)	People who have self-injured should be avoided (6)		People will tell me I should not have children (9)	People have said that I should not have children (9)
People who have self-injured deserve poor treatment (8)	People who have self-injured deserve poor treatment (7)		People will tell me I am a time-waster (10)	People have said I am a time-waster (10)

People who have self-injured deserve to be treated poorly by health care professionals (9)	People who have self-injured deserve to be treated poorly by health care professionals (8)	People will think I do not deserve medical treatment for my self-injury (11)	People have said I do not deserve medical treatment for my self-injury (11)
People who have self-injured should not have children (10)	People who have self-injured should not have children (9)	People will think I do not deserve support for my self-injury (12)	People have said I do not deserve support for my self-injury (12)
People who have self-injured are time-wasters (11)	People who have self-injured are time-wasters (10)	People will stay away from me (13)	People have stayed away from me (13)
People who have self-injured do not deserve medical treatment for self-injury (12)	People who have self-injured do not deserve medical treatment for self-injury (11)	People will think I do not care about others (14)	People have told me I do not care about others (14)
People who have self-injured do not deserve support for self-injury (13)	People who have self-injured do not deserve support for self-injury (12)	People will think I am a burden to loved ones (15)	People have said I am a burden on loved ones (15)
I should stay away from people who self-injure (14)	I should stay away from people who self-injure (13)	*People will think that I am compassionate (16)*	*People have said that I am compassionate (16)*
People who have self-injured do not care about others (15)	People who have self-injured do not care about others (14)	People will ignore my self-injury (17)	People have ignored my self-injury (17)
People who have self-injured are a burden to loved ones (16)	People who have self-injured are a burden to loved ones (15)	People will refuse to talk to me about my self-injury (18)	People have refused to talk to me about my self-injury (18)
People who have self-injured are compassionate (17)	*People who have self-injured are compassionate (16)*	People will avoid talking about self-injury with me (19)	People have avoided talking about self-injury with me (19)
People who have self-injured should be ignored (18)	People who have self-injured should be ignored (17)		
People who have self-injured should not be allowed to talk about their self-injury (19)	People who have self-injured should not be allowed to talk about their self-injury (18)		
People who have self-injured should avoid talking about it with others (20)	People who have self-injured should avoid talking about it with others (19)		

Note. Italicised items are positively worded and reflect an absence of stigma.

Appendix K

Chapter 5 Ethical Approval

Research Office at Curtin

GPO Box U1987
Perth Western Australia 6845

Telephone +61 8 9266 7863
Facsimile +61 8 9266 3793
Web research.curtin.edu.au

27-May-2020

Name: Penelope Hasking
Department/School: School of Psychology
Email: Penelope.Hasking@curtin.edu.au

Dear Penelope Hasking

RE: Ethics approval
Approval number: HRE2020-0267

Thank you for submitting your application to the Human Research Ethics Office for the project **Validating a Self-Injury Stigma Questionnaire**.

Your application was reviewed by the Curtin University Human Research Ethics Committee at their meeting on .

The review outcome is: **Approved**.

Your proposal meets the requirements described in National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*.

Approval is granted for a period of one year from **27-May-2020** to **26-May-2021**. Continuation of approval will be granted on an annual basis following submission of an annual report.

Personnel authorised to work on this project:

Name	Role
Hasking, Penelope	Supervisor
Staniland, Alexandra	Student
Boyes, Mark	Supervisor
Lewis, Stephen	Supervisor

Standard conditions of approval

1. Research must be conducted according to the approved proposal
2. Report in a timely manner anything that might warrant review of ethical approval of the project including:
    - proposed changes to the approved proposal or conduct of the study
    - unanticipated problems that might affect continued ethical acceptability of the project
    - major deviations from the approved proposal and/or regulatory guidelines
    - serious adverse events
3. Amendments to the proposal must be approved by the Human Research Ethics Office before they are implemented (except where an amendment is undertaken to eliminate an immediate risk to participants)
4. An annual progress report must be submitted to the Human Research Ethics Office on or before the anniversary of approval and a completion report submitted on completion of the project
5. Personnel working on this project must be adequately qualified by education, training and experience for their role, or supervised

6. Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, that bears on this project
7. Changes to personnel working on this project must be reported to the Human Research Ethics Office
8. Data and primary materials must be retained and stored in accordance with the Western Australian University Sector Disposal Authority (WAUSDA) and the Curtin University Research Data and Primary Materials policy
9. Where practicable, results of the research should be made available to the research participants in a timely and clear manner
10. Unless prohibited by contractual obligations, results of the research should be disseminated in a manner that will allow public scrutiny; the Human Research Ethics Office must be informed of any constraints on publication
11. Ethics approval is dependent upon ongoing compliance of the research with the Australian Code for the Responsible Conduct of Research, the National Statement on Ethical Conduct in Human Research, applicable legal requirements, and with Curtin University policies, procedures and governance requirements
12. The Human Research Ethics Office may conduct audits on a portion of approved projects.

Special Conditions of Approval

It is the responsibility of the Chief Investigator to ensure that any activity undertaken under this project adheres to the latest available advice from the Government or the University regarding COVID-19.

This letter constitutes ethical approval only. This project may not proceed until you have met all of the Curtin University research governance requirements.

Should you have any queries regarding consideration of your project, please contact the Ethics Support Officer for your faculty or the Ethics Office at hrec@curtin.edu.au or on 9266 2784.

Yours sincerely

Sharyn Burns

Associate Professor Sharyn Burns
Chair, Human Research Ethics Committee

Appendix L

Chapter 5 Factor Structure Output for NSSI Social Exposure Scale

Total Variance Explained

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.168	51.678	51.678	4.792	47.918	47.918
2	1.489	14.892	66.570	1.144	11.442	59.360
3	.799	7.989	74.559			
4	.556	5.560	80.119			
5	.478	4.781	84.900			
6	.411	4.113	89.014			
7	.334	3.343	92.357			
8	.288	2.877	95.234			
9	.255	2.550	97.783			
10	.222	2.217	100.000			

Total Variance Explained

Factor	Rotation Sums of Squared Loadings[a]
	Total
1	4.092
2	3.980
3	
4	
5	
6	
7	
8	
9	
10	

Extraction Method: Maximum Likelihood.

a. When factors are correlated, sums of squared loadings cannot be added to obtain a total variance.

Factor Matrix[a]

	Factor	
	1	2
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 1. I am personally familiar with individuals who engage/have engaged in some form of NSSI	.748	-.347
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 2. I have seen internet forums or blogs about NSSI	.668	.145
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 3. I have heard references to NSSI in music lyrics	.714	.263
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 4. I have seen references to different forms of NSSI in movies	.759	.465
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 5. I have seen, heard, or read news reports about NSSI	.611	.356

Factor Matrix[a]

	Factor	
	1	2
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 6. I have seen references to NSSI on TV (sitcoms, dramas, serials - not movies on TV or news programs)	.674	.457
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 7. I have friends who engage in NSSI	.718	-.330
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 8. I have observed someone engage in a form of NSSI (in person, not on TV or in a movie)	.428	-.164
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 9. I have talked about NSSI with other people (regardless of whether they engaged in the behaviour)	.752	-.243
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 10. I have talked about NSSI with people who have done it	.780	-.433

Extraction Method: Maximum Likelihood.

a. 2 factors extracted. 4 iterations required.

Appendix M

Chapter 5 Participant Information Sheets

Study One

HREC Project Number:	HRE2020-0267
Project Title:	*Attitudes Toward Self-Injury*
Chief Investigator:	*Prof Penelope Hasking*
Associate Investigator(s):	*Dr Mark Boyes & A/Prof Stephen Lewis (U of Guelph)*
Student researcher:	*Alexandra (Lexy) Staniland*
Version Number:	*1*
Version Date:	*15/05/2020*

What is the Project About?
Attitudes play an important role in how we think and feel about mental illness and other related issues. In this project, we are interested in understanding people's attitudes toward and experiences with nonsuicidal self-injury. Nonsuicidal self-injury refers to deliberating damaging one's body without intending to end one's life.

In this study, we will ask you to complete an online survey about your attitudes toward and experience of self-injury. The data we collect will be used to develop an accurate measure of attitudes toward self-injury and help us understand how these attitudes relate to a range of psychological outcomes, such as self-esteem. We will also look at how people's experiences relate to their attitudes.

Who is doing the Research?
This project is being conducted by a team of researchers, including Prof Penelope Hasking, A/Prof Stephen Lewis, Dr Mark Boyes, and PhD candidate Alexandra (Lexy) Staniland. This study will be used as part of the requirements to obtain a Doctor of Philosophy in Psychology at Curtin University, Western Australia, and is funded by the Australian Government.

Why am I being asked to take part and what will I have to do?
You are being invited to complete an online survey about attitudes toward self-injury. If you choose to participate, you will be asked a series of questions relating to mental health, self-injury, and your attitudes relating to self-injury. We are interested to hear from people who do and do not have a lived experience of mental illness and/or self-injury.

Are there any benefits' to being in the research project?
Apart from your time, there will be no direct cost to you to participate in this study. If you are completing this survey as a worker on Amazon's Mechanical Turk platform, then you will be paid in accordance with the information on the page that linked you here. You must complete the entire survey before payment will be made. If you only complete part of the survey, you will not be paid for the part you have completed.

While there may be no direct benefits to participating in this research, some people find it helpful to share their thoughts about mental health issues. Furthermore, you will be contributing to a vital area of research interested in improving the wellbeing of people with a history of self-injury.

Are there any risks, side-effects, discomforts or inconveniences from being in the research project?

We have been careful to make sure the questions in this survey cause minimal distress, however you may still experience some discomfort while completing the survey. This discomfort should not be long-lasting and we encourage you to reach out to the supports provided if you feel this would be of use. You may take a break from the survey and return to it at any time within 14 days of starting, and you can choose to stop completing the survey at any time simply by closing your browser. The data you have provided up until that point may be used in our analyses.

Sometimes just thinking about mental health and self-injury can be upsetting. If you choose not to be in this research but feel distressed from considering participation, please visit: https://checkpointorg.com/global/ for contact details of mental health supports in your area.

Who will have access to my information?

If you are completing this survey as a worker on Amazon's Mechanical Turk platform, you will need to provide your 12-digit MTurk ID at the end of the survey so that we can process payment. This ID will be stored alongside your data so that we can ensure that you have completed to entire survey prior to payment. Your data will be confidential and only accessible by the research team. After the survey has closed, and payment has been processed, your ID will be removed from the data set and your data will become anonymous.

Any information we collect may be used in this and other similar projects. The following people will have access to the information we collect in this research: the research team and, in the event of an audit or investigation, staff from the Curtin University Office of Research and Development.

Electronic data will be stored on Curtin's secure research hard drive and will be password protected. This information will be kept for up to 9 years and will be stored on Curtin's secure Research Drive.

The results of this research may be presented at conferences or published in professional journals. You will not be identified in any results that are published or presented.

Will you tell me the results of the research?

If you are interest in obtaining a summary of the results of this research, please contact the researchers after October 2020.

Do I have to take part in the research project?

Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project at any time simply by closing your browser. We may use any data you have entered prior to this point.

What happens next and who can I contact about the research?

If you have questions or concerns relating to this project, or if you have any issues accessing the survey or research material, please contact Alexandra Staniland at alexandra.staniland@postgrad.curtin.edu.au.

Curtin University Human Research Ethics Committee (HREC) has approved this study (*HRE2020-0267*). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Study Two

HREC Project Number:	HRE2020-0267
Project Title:	*Validating a Self-Injury Stigma Questionnaire*
Chief Investigator:	*Prof Penelope Hasking*
Associate Investigator(s):	*Dr Mark Boyes & A/Prof Stephen Lewis (U of Guelph)*
Student researcher:	*Alexandra (Lexy) Staniland*
Version Number:	*1*
Version Date:	*17/03/2020*

What is the Project About?

Attitudes play an important role in how we think and feel about mental illness and other related issues. Attitudes also play an important role in how we think and feel about ourselves and others. In this project, we are interested in understanding people's experiences with mental illness and self-injury as well as how attitudes toward mental illness and self-injury may relate to psychological health.

In this study, we will ask you to complete an online survey about your attitudes toward and experience of mental illness and self-injury. The data we collect will be used to develop an accurate measure of attitudes toward self-injury and help us understand how these attitudes relate to a range of psychological outcomes, such as self-esteem. We will also look at how people's experiences relate to their attitudes.

Who is doing the Research?

This project is being conducted by a team of researchers, including Prof Penelope Hasking, A/Prof Stephen Lewis, Dr Mark Boyes, and PhD candidate Alexandra (Lexy) Staniland. This study will be used as part of the requirements to obtain a Doctor of Philosophy in Psychology at Curtin University and is funded by the Government.

There will be no cost to you to participate in this study. If you are an undergraduate student recruited through the SONA pool, you will receive 3 SONA points for participating. If you are recruited through another source (e.g., Facebook), you will not be reimbursed for your time. Your participation is vital to our understanding of the relationships between attitudes, mental health, and self-injury.

Why am I being asked to take part and what will I have to do?

You are being invited to complete an online survey that should take no longer than 45 minutes to complete. If you choose to participate, you will be asked a series of questions relating to your attitudes toward and experience of mental illness and self-injury. We are interested to hear from people who do and do not have a lived experience of mental illness and/or self-injury.

Are there any benefits' to being in the research project?
While there may be no direct benefits to participating in this research, some people find it helpful to share their thoughts about mental health issues. Furthermore, you will be contributing to a vital area of research interested in improving the wellbeing of people with mental illness and/or a history of self-injury.

Are there any risks, side-effects, discomforts or inconveniences from being in the research project?
We have been careful to make sure the questions in this survey cause minimal distress, however you may still experience some discomfort while completing the survey. This discomfort should not be long-lasting and we encourage you to reach out to the supports provided if you feel this would be of use. You may take a break from the survey and return to it at any time within 14 days of starting, and you can choose to stop completing the survey at any time simply by closing your browser. The data you have provided up until that point may be used in our analyses.

Sometimes just thinking about mental health and self-injury can be upsetting. If you choose not to be in this research but feel distressed from considering participation, please contact Lifeline 13 11 14, Beyond Blue 1300 224 636, or Kids Helpline (<25 years old) 1800 551 800. If you are a Curtin student or staff member, you also have access to on-campus counselling, which you can contact on 9266 7850.

If you are completing this outside of Australia, please head to: https://checkpointorg.com/global/ for contact details of mental health supports in your area.

Who will have access to my information?
If you are completing this survey in return for SONA points, we will ask you to record your student ID number so that your points can be awarded. At the end of the survey you will be directed to a new webpage to enter these details, and they not be linked to the data you provide in answering the survey. The information will remain confidential, and will be deleted after your points have been allocated in the SONA system. If you are not completing this survey in return for SONA points, no identifying information will be collected, and your data will be anonymous. We will not be able to identify you from the information collected.

Any information we collect will be treated as confidential and will be used in this and other similar projects. The following people will have access to the information we collect in this research: the research team and, in the event of an audit or investigation, staff from the Curtin University Office of Research and Development.

Electronic data will be stored on Curtin's secure research hard drive and will be password protected. This information will be kept for up to 9 years and will be stored on Curtin's secure Research Drive.

The results of this research may be presented at conferences or published in professional journals. You will not be identified in any results that are published or presented.

Will you tell me the results of the research?
If you are interest in obtaining a summary of the results of this research, please contact the researchers after October 2020.

Do I have to take part in the research project?
Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project at any time simply by closing your browser. We may use any data you have entered prior to this point. If you choose not to take part or start and then stop the study, it will not affect your relationship with the University, staff or colleagues.

What happens next and who can I contact about the research?
If you have questions or concerns relating to this project, or if you have any issues accessing the survey or research material, please contact Alexandra Staniland at alexandra.staniland@postgrad.curtin.edu.au.

Curtin University Human Research Ethics Committee (HREC) has approved this study (*HRE2020-0267*). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Appendix N

Chapter 5 Consent

Study One

I have read the information above and agree to participate in this anonymous survey about my experience of self-injury.

- Yes, I would like to complete the survey
- No, I am not interested

Study Two

We just want to double check you understand what we are asking you to do.

What is this study about?

- Attitudes toward mental illness and self-injury
- Attitudes toward politics
- Self-injury and social media

What will you be asked to do if you participate?

- Participate in an interview
- Complete an online questionnaire
- Post messages online

True of false?
All response provided are confidential.

- True
- False

I have read the information sheet and understand what participating in this study involves.

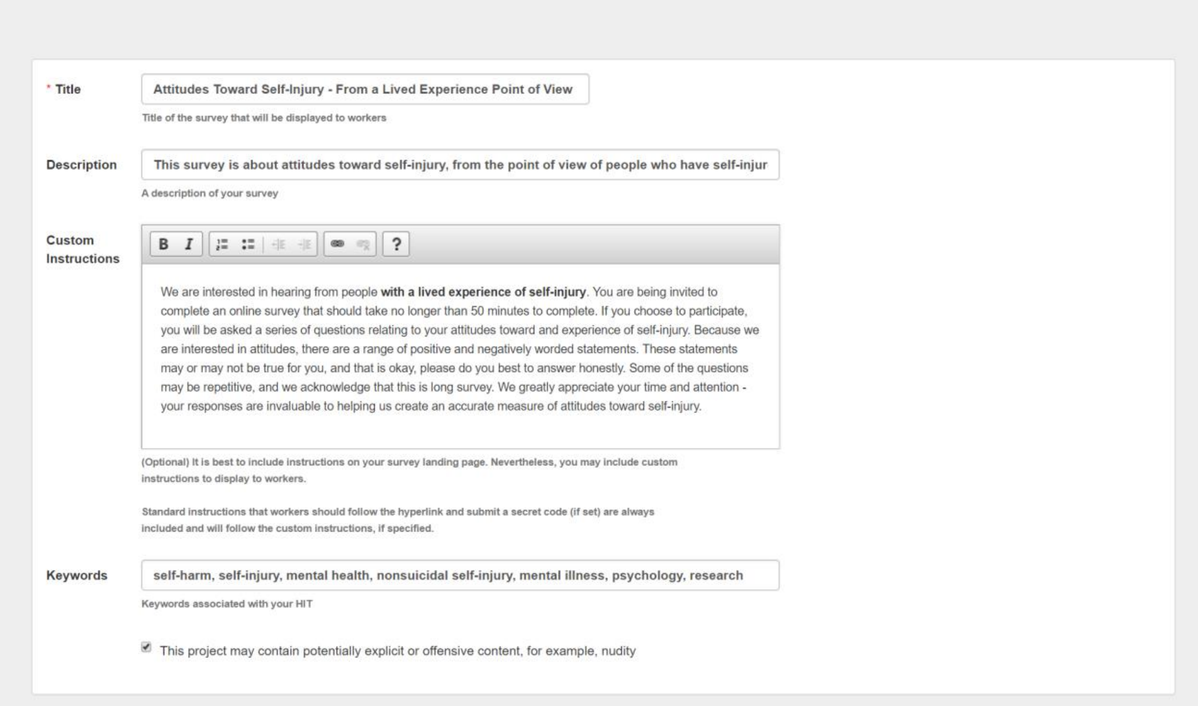
- I consent to completing the questionnaire
- I do not want to complete the questionnaire

Appendix O

Chapter 5 Study Advertisements

Study One

Description for Individuals with Lived Experience


* Title: Attitudes Toward Self-Injury - From a Lived Experience Point of View
Title of the survey that will be displayed to workers

Description: This survey is about attitudes toward self-injury, from the point of view of people who have self-injur
A description of your survey

Custom Instructions: We are interested in hearing from people **with a lived experience of self-injury**. You are being invited to complete an online survey that should take no longer than 50 minutes to complete. If you choose to participate, you will be asked a series of questions relating to your attitudes toward and experience of self-injury. Because we are interested in attitudes, there are a range of positive and negatively worded statements. These statements may or may not be true for you, and that is okay, please do you best to answer honestly. Some of the questions may be repetitive, and we acknowledge that this is long survey. We greatly appreciate your time and attention - your responses are invaluable to helping us create an accurate measure of attitudes toward self-injury.

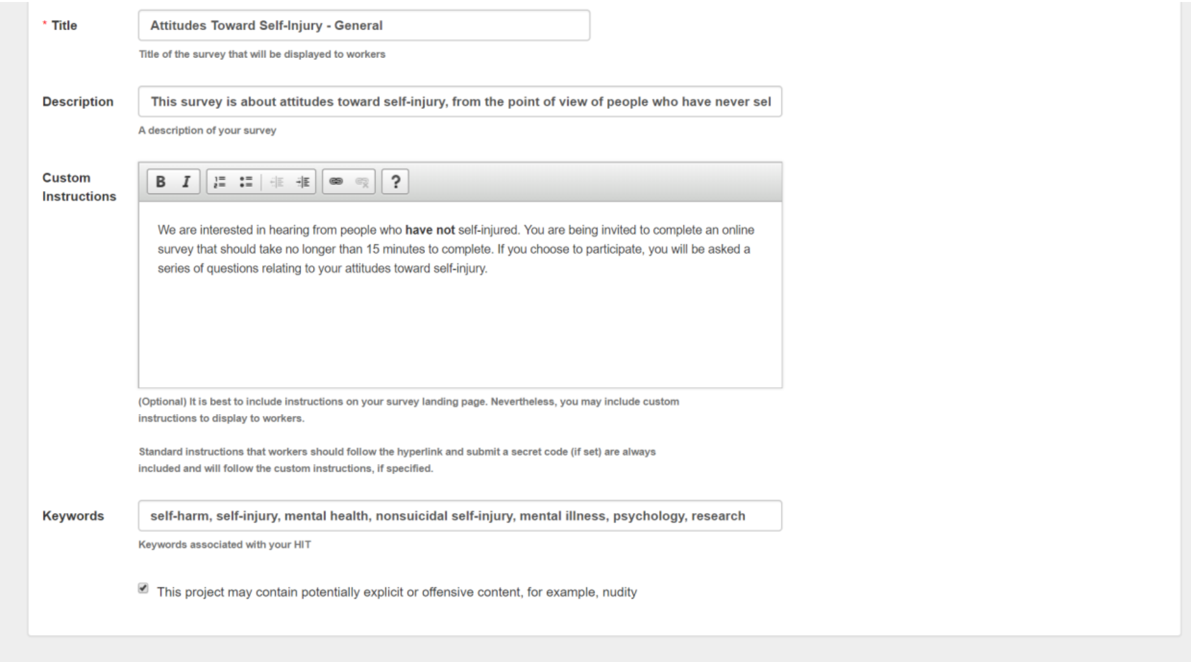
(Optional) It is best to include instructions on your survey landing page. Nevertheless, you may include custom instructions to display to workers.

Standard instructions that workers should follow the hyperlink and submit a secret code (if set) are always included and will follow the custom instructions, if specified.

Keywords: self-harm, self-injury, mental health, nonsuicidal self-injury, mental illness, psychology, research
Keywords associated with your HIT

This project may contain potentially explicit or offensive content, for example, nudity

Description for Individuals with No Lived Experience


* Title: Attitudes Toward Self-Injury - General
Title of the survey that will be displayed to workers

Description: This survey is about attitudes toward self-injury, from the point of view of people who have never sel
A description of your survey

Custom Instructions: We are interested in hearing from people who **have not** self-injured. You are being invited to complete an online survey that should take no longer than 15 minutes to complete. If you choose to participate, you will be asked a series of questions relating to your attitudes toward self-injury.

(Optional) It is best to include instructions on your survey landing page. Nevertheless, you may include custom instructions to display to workers.

Standard instructions that workers should follow the hyperlink and submit a secret code (if set) are always included and will follow the custom instructions, if specified.

Keywords: self-harm, self-injury, mental health, nonsuicidal self-injury, mental illness, psychology, research
Keywords associated with your HIT

This project may contain potentially explicit or offensive content, for example, nudity

Study Two

SONA

Study name: Attitudes, mental health, and non-suicidal self-injury
Description: If you choose to participate in the study, you will be asked to complete an online survey asking about your about mental health, self-injury and some of your attitudes about these things. We are interested to hear from people who do and do not have a lived experience of self-injury. If you have engaged in self-injury, you will be asked about that experience. The questionnaire should take no longer than 40 minutes to complete.
Eligibility: All students are eligible
Duration: 40 minutes
Points: 3 points
Preparation: No preparation required.
Researchers: Prof Penelope Hasking, Dr Mark Boyes, A/Prof Stephen Lewis (U of Guelph), PhD Candidate Alexandra Staniland
HREC Approval Number: HRE2020-0267
Curtin University Human Research Ethics Committee (HREC) has approved this study (HRE-XXXX). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Reddit

Reddit is an online forum where people can create "threads" that are themed (also called "SubReddits"). People can post to these threads with text and photos. The content found on Reddit varies widely and covers both entertainment and education. There is an existing SubReddit called "StopSelfHarm" which has 7,677 followers. This thread is aimed at peer support. Other researchers are taking advantage of this platform to share their online questionnaires (see Figure 5). Reddit allows post such as these. We plan to post the following information to the "StopSelfHarm" thread and the "PsychologicalResearch/Surveys" thread: Nonsuicidal self-injury (NSSI) refers to the deliberate damage caused to oneself without suicidal intent. People have a range of thoughts and beliefs about NSSI that we are interested to learn more about. The School of Psychology at Curtin University is conducting a study to better understand people's attitudes toward self-injury. If you would like to share your views, we invite you to take part in a series of online questionnaires. You will be asked about how you experience emotion, your attitudes toward self-injury and mental illness, and whether you have any experience with self-injury. We are interested to hear from people who do and do not have a lived experience of NSSI.

Twitter

Twitter is an online information sharing platform that allows people to share messages with others. These messages are capped at 280 characters, and only seen by people who follow the profile. A number of NSSI support groups exist on Twitter. We aim to contact these groups to ask permission for posting our advert for participant recruitment. Our research team has an existing Twitter account called NSSI_RG. Twitter's terms of service allow sharing of promotional material. See https://help.twitter.com/en/rules-and-policies/twitter-rules for more information. We plan to post a link to our Survey with a short description, which will be seen by our followers: *We are conducting a study to explore attitudes toward nonsuicidal self-injury and mental illness. If you are interested in taking part, please go to [survey link].*

Facebook

Facebook is a platform allowing individuals to create an account where they can post information including status updates, photos, videos and links. Posts can be shared by other individuals or groups, where a replication of the original post appears on another individual's page. Adaptable privacy settings mean that information posted may be available to the public, or to a selection of individuals as chosen by the owner of the account. Groups can be created which allow information to be accessible only from individuals eligible for inclusion. There are a number of self-injury support groups and education pages available. We aim to advertise for participants on such pages following permission from the pages administration. We have a dedicated Facebook page for self-injury research and will use that page for this study. All utilised forms of social media will be linked directly to our Facebook page, which will hold the link to the online survey itself. Advertisements are permissible by Facebook, given they adhere to the guidelines stated in their policies. See https://www.facebook.com/policies/ads/?ref=u2u for more information. The following will be posted as an advertisement for recruitment:
Nonsuicidal self-injury (NSSI) refers to the deliberate damage caused to oneself without suicidal intent. People have a range of thoughts and beliefs about NSSI that we are interested to learn more about these. The School of Psychology at Curtin University is conducting a study to better understand people's attitudes toward self-injury. If you would like to share your views, we invite you to take part in a series of online questionnaires. You will be asked about how you experience emotion, your attitudes toward self-injury and mental illness, and whether you have any experience with self-injury. We are interested to hear from people who do and do not have a lived experience of NSSI.

Instagram

Instagram is an image-based social media platform. People using this platform share photographs or other images, including text and quotes, to their feed, and other users can interact with these posts by liking them or commenting on them. Posts can be shared by other individuals or groups, where a replication of the original post appears on another individual's page. People find post by using hashtags (e.g., #mentalhealth) which are used like keywords to help users find content they might be interested in. Advertisements are permissible by Instagram, provided they adhere to the guidelines stated in their policies. See https://help.instagram.com/537518769659039?helpref=page_content for more information. An NSSI research page has been established, with the view to post intermittent content including links to the survey alongside motivational and positively valanced content. Instagram has made some recent changes to their policies disallowing images related to self-harm. Although we do not intend to ever post any images of self-harm, this policy change limits our ability to use hashtags related to the topic. Therefore, we will not use the terms "self-injury" or "self-harm" in our posts at all and refer only to "mental health-related difficulties". A similar procedure has been followed by other PhD students within the School, and we plan to follow a similar posting plan (see https://www.instagram.com/overcomingperfectionism/). The following will be posted as an advertisement for recruitment:
We are interested to hear about your thoughts and feelings about mental health, emotions and other mental-health related issues. If you'd like to share your views, please head to the link in our bio to find out more. #mentalhealth #depression #anxiety #psychology #research

Appendix P

Chapter 5 Questionnaire

Study One

Due to the length of the questionnaire, I had chosen to exclude a copy of it from the thesis; however, it can be viewed here:

https://osf.io/mdcu2/?view_only=6c82200a85b240cbae7706a5dbbccf1

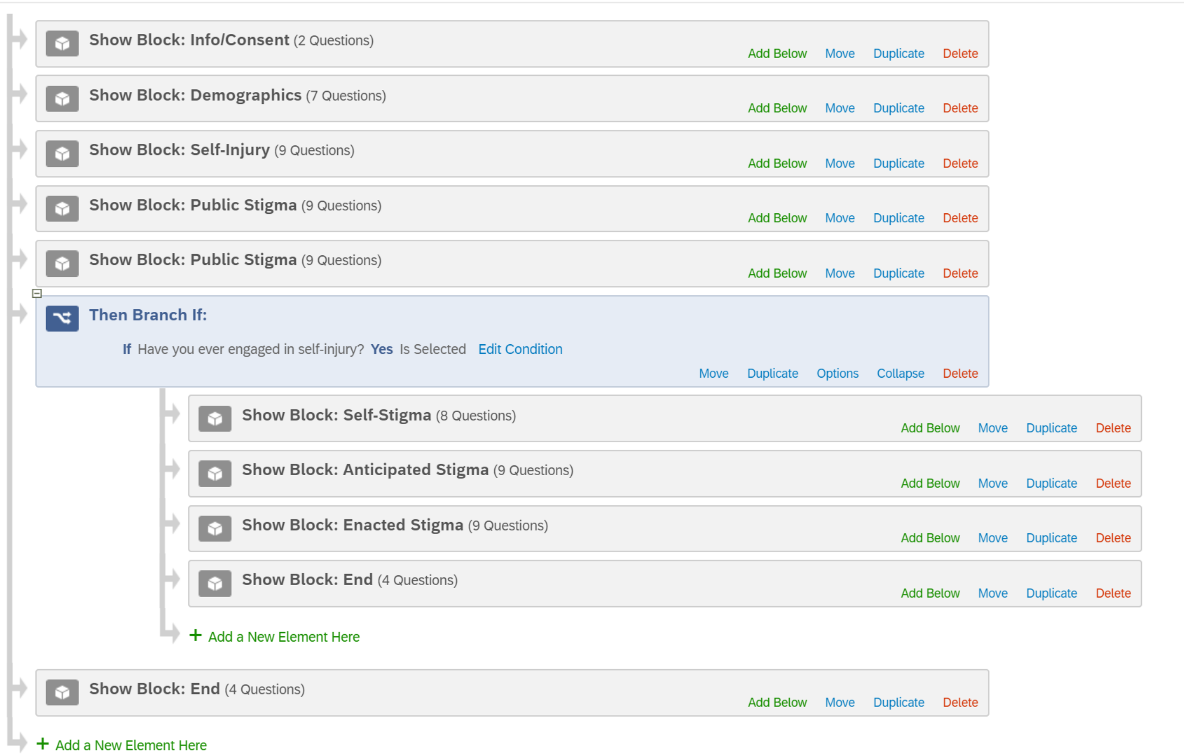
Study Two

Due to the length of the questionnaire, I had chosen to exclude a copy of it from the thesis; however, it can be viewed here:

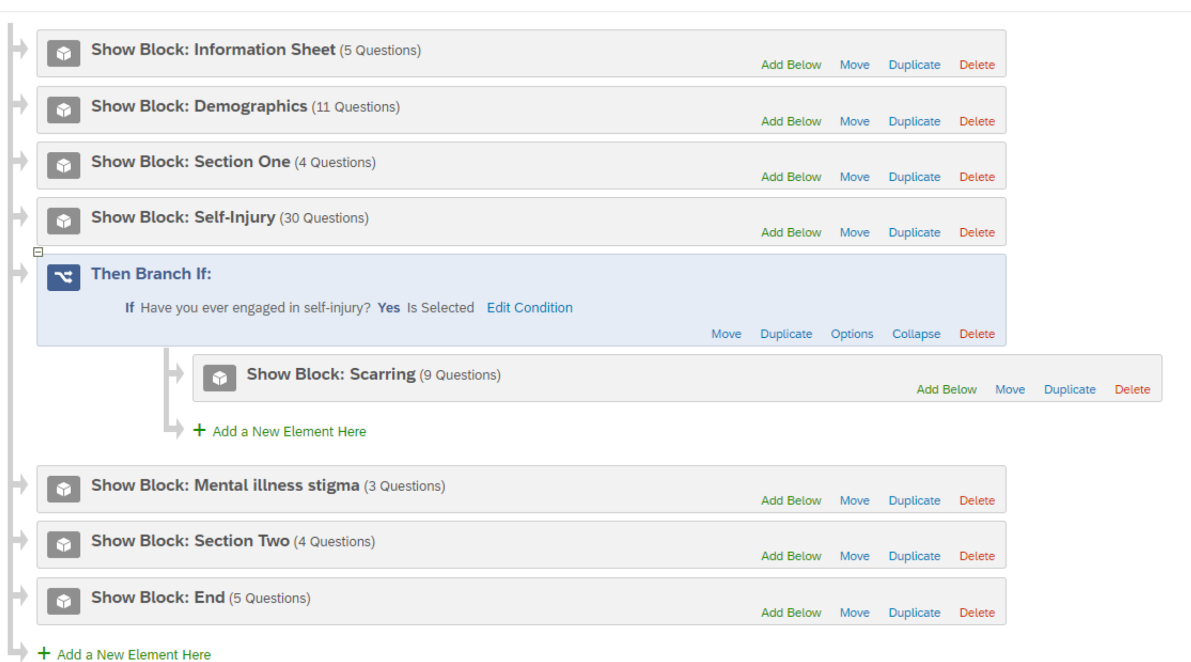
https://osf.io/kx7tv/?view_only=6c82200a85b240cbae7706a5dbbccf1

Appendix Q
Chapter 5 Study Flow

Study One



Study Two



Declaration

Originality

To the best of my knowledge and belief, this thesis contains no material previously published by any other person except where due acknowledgment is made. This thesis contains no material that has been submitted or accepted for the award of any other degree or diploma at any university.

Human Ethics

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2014). Human research ethics approval from the Curtin University Human Research Ethics Committee (HREC) was obtained for the studies presented in Chapter 3 (HRE2018-0615) and Chapter 5 (HRE2020-0267). Ethical approval was not required for the studies in Chapter 2 or Chapter 4 as neither study involved collecting data from any humans.

1st April 2022

Acknowledgments

I am honoured and privileged to have completed my PhD on Whajuk booja, unceded by the Noongar custodians of Country. I pay my respects to Elders past and present, and to all Indigenous peoples across Australia, whose strength, resilience, and creativity is an inspiration, and whose culture is ongoing and everlasting.

I extend my whole-hearted gratitude to my supervision team: Professor Penny Hasking, Professor Stephen Lewis, and Associate Professor Mark Boyes. Penny and Stephen, together you have cultivated a sense of safety and security regarding my lived experience of self-injury. The support you have offered as I explored how to navigate this in the context of my research has been invaluable. You have been an ongoing source of inspiration and strength. Mark, you have been a pillar during turbulent times, and I appreciate your unrelenting concern for my wellbeing. When my hyperactive or self-defeating brain was too loud, you were a source of stability and calm. Penny, Stephen, Mark - your combined passion, expertise, and genuine care made doing a PhD as a first-generation university student possible, even enjoyable! Thank you for being present, compassionate, and most of all, for believing in me. I could not have done this without you.

There are a host of other people who made this wild journey possible. My partner Andre, who has accepted his life as a parttime boyfriend. Your commitment to and support of me has been a source of great comfort. My best friend, Caity, who left for Ireland just after we reached Candidacy. Somehow, we have managed to stay close and connected, and even though you're forever away, it always feels like you're right by my side. The Hubbies gang, who have been a source of hilarity, distraction, knowledge, and understanding. Every PhD Candidate needs a group like you. I've had the pleasure of powering through this last year alongside Nikki, Kirsty, Sophie, Sylvanna, and Adie, and in the earlier days I cut my teeth alongside Emily, Caitlin, Jess, Dan, Ash, and Kate. It's been such a pleasure to commiserate and laugh with you all. You made the rollercoaster feel more stable.

I also want to acknowledge everyone who has championed me throughout these years. The Trio, for having my back and loving me even when I don't speak to them for weeks on end. Lloyd at Working Life, for the opportunities to grow and constant celebration of me. My new colleagues, who have been so encouraging and supportive. And the endless line of friends who can almost stop asking me, "Are you a Dr yet?"

Finally, I acknowledge the Australian Government for supporting this research through the Research Training Program (RTP) Scholarship and RTP Living Stipend.

Dedication

In the final days of writing my thesis discussion and formatting this extraordinarily long document, I got a call from a close friend whose partner had just self-injured. I could hear them both on the call, my friend seeking advice, their partner sobbing, “I didn’t mean to.” I know you didn’t, honey. She was terrified. Scared she’d be yelled at by the nurses, scolded for hurting herself on purpose when other people need help; afraid of being forced into a mental health ward under suicide watch. She wasn’t suicidal. She accidentally cut deeper than she meant to. I helped them understand the process they’d experience going to the emergency department, reassuring them that it would be okay, meanwhile fearing she’d be judged, dismissed, or stitched with no pain relief.

In a way that might seem peculiar to some, I felt a deep honour in being the recipient of that call. Throughout my PhD I have become a person others feel comfortable to talk to about self-injury. I’ve heard many stories, some hard, some horrific, but always deeply moving. I wanted to avoid the “to all the people who self-injure” dedication, which has always seemed hollow to me, but I truly dedicate this work to all individuals who have self-injured. We are resilient, we are capable, we are strong, and we keep ourselves alive even in moments when we desperately don’t want to be. It is my never-ending hope that my current and continued work helps to strengthen your hope and diminish the obstacles you face.

Journal Articles

Published

1. Hasking, P., Lewis, S. P., **Staniland, L.,** & Boyes, M. (in press). Adding insult to injury: The accumulation of stigmatizing language on individuals with lived experience of self-injury. *Journal of Nervous and Mental Disease*.
2. ***Staniland, L.,** Hasking, P., Lewis, S. P., & Boyes, M. (2022). News media framing of self-harm in Australia. *Stigma and Health*, *7*, 35–44. https://doi.org/10.1037/sah0000350
3. ***Staniland, L.,** Hasking, P., Lewis, S. P., Boyes, M., & Mirichlis, S. (2022). Crazy, weak, and incompetent: A directed content analysis of self-injury stigma experiences. *Deviant Behavior*, Advanced online publication. https://doi.org/10.1080/01639625.2022.2038022
4. ***Staniland, L.,** Hasking, P., Boyes, M., & Lewis, S. P. (2021). Stigma and nonsuicidal self-injury: Application of a conceptual framework. *Stigma and Health*, *6*, 312-323. https://doi.org/10.1037/sah0000257

Under Review

1. ***Staniland, L.,** Hasking, P., Boyes, M., & Lewis, S. (2022). Development and validation of the Self-Injury Stigma Questionnaire (SIS-Q).
2. Hasking, P., Lewis, S. P., **Staniland, L.,** Mirichlis, S., Hird, K., Gray, N., Arai, M., Pemberton, E., Preece, D., & Boyes, M. (2021). Further silencing the voiceless: The role of gatekeepers in accessing information about self-injury.
3. Lewis, S. P., Hasking, P., **Staniland, L.,** Boyes, M., Collaton, J., & Bryce, L. (2020). Self-Injury in the News: A Content Analysis.
4. **Staniland, L.,** Gray, N., Boyes, M., & Hasking, P. (2020). Digital self-harm and nonsuicidal self-injury: Functional, cognitive, and psychosocial comparisons.

Conference Presentations

1. Lewis, S. P., Hasking, P., **Staniland, L.,** Boyes, M., Collaton, J., & Bryce, L. (2019). Self-injury in the news: A content analysis. *International Society for the Study of Self-Injury*.
2. ***Staniland, L.,** Hasking, P., Boyes, M., & Lewis, S. P. (2020). A theoretical framing of NSSI stigma. *Mark Liveris Research Student Seminar*.
3. ***Staniland, L.,** Hasking, P., Boyes, M., & Lewis, S. P. (2020). A theoretical framing of NSSI stigma. *International Society for the Study of Self-Injury*.
4. ***Staniland, L.,** Hasking, P., Lewis, S. P., Boyes, M., Mirichlis, S. (2021). Application of the NSSI stigma framework: A directed content analysis. *International Society for the Study of Self-Injury*.
5. ***Staniland, L.,** Hasking, P., Lewis, S. P., Boyes, M., Mirichlis, S. (2021). Application of the self-injury stigma framework. *Australian Association for Cognitive and Behaviour Therapy*.
6. Moullin, J, Velure Uren, H., **Staniland, L.,** Glazier, C., O'Callaghan, S., Mackrill, M., Thorp, E., Shand, F., & McGoldrick, J. (2021). Exploring practices of staged supply as a suicide prevention intervention among Tasmanian pharmacists: The barriers. *Pharmaceutical Society of Australia*.
7. Moullin, J, Velure Uren, H., **Staniland, L.,** Glazier, C., O'Callaghan, S., Mackrill, M., Thorp, E., Shand, F., & McGoldrick, J. (2022). Optimising staged supply of medication as a suicide prevention intervention in community pharmacy. *Society for Mental Health Research*.

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Thesis Abstract

Non-suicidal self-injury (NSSI; self-injury) is a highly stigmatised behaviour. The intentional damage to oneself without suicidal intent, self-injury typically involves cutting, burning, and/or hitting oneself. In this way, self-injury appears to violate our innate desire to avoid pain and harm, and can therefore be difficult to understand. A lack of understanding may inform the stigmatisation of self-injury; indeed, unnuanced assumptions about self-injury (e.g., that it is ultimately attention-seeking) are relatively common. However, the composition, manifestation, and impact of self-injury stigma has yet to be thoroughly investigated. The aim of this thesis is to develop a better understanding of self-injury stigma.

The first study in this thesis involved a review of the literature and subsequent development of a theoretical framework through which self-injury stigma can be conceptualised. Developing the NSSI Stigma Framework was an important first step, as no models of stigma yet existed in the self-injury context. Drawing on work by Jones et al. (1984), Corrigan and Watson (2002), and Quinn and Chaudoir (2009), I proposed that self-injury stigma is a function of six domains that manifest across four social levels. Each domain contributes to explaining why self-injury is stigmatised: *origin*, beliefs about why a person self-injures; *concealability*; the visibility of self-injury; *course*, perceptions of how self-injury changes over time; *peril*, the perceived dangerousness of self-injury; *aesthetics*, evaluations of self-injury's appearance; and *disruptiveness*, how self-injury is thought to impact relationships. These domains of stigma emerge across the following levels: *public*, the attitudes and beliefs about self-injury held by the general public; *self*, the internalisation of public stigma (i.e., agreeing with and applying attitudes and beliefs to oneself); *enacted*, the direct and indirect experiences of prejudice and discrimination; and *anticipated*; the expectation of enacted stigma. While the NSSI Stigma Framework offers a theoretically grounded approach to the study of self-injury stigma, its applicability to lived experiences of self-injury stigma required validation, which led me to the second study in this thesis.

In study two, the applicability of NSSI Stigma Framework was examined using data obtained from a series of open-ended questions relating to stigma. I conducted a directed content analysis of 99 responses, using the Framework as the coding rubric. I found support for the Framework, with 19 of the 24 rubric cells represented by participants' experiences. Because I asked participants to describe their experiences of NSSI stigma, the enacted stigma level had the most support. While more research is required to further assess the applicability of the public, self, and anticipated levels, the NSSI Stigma Framework offers a useful guide to developing relevant research questions that further our understanding of self-injury stigma.

Such questions can be derived at specific cells within the Framework, for example, "how does concealability inform self-stigma?". Questions relating to specific domains regardless of level could also be generated, with the view to better understand how particular domains manifest. Likewise, questions at the broader levels regardless of domain can be generated. Given the incipient nature of NSSI stigma research, wide scope research questions allow us to explore the phenomenon flexibly, and potentially illuminate previously unconsidered facets. Therefore, in Study Three, I sought to explore NSSI stigma at the public level.

It is well-established that stigma is proliferated through mass media. In particular, news media are a prominent source of stigma due to perceptions that news media are representing the "truth". Thus, news media portrayals of self-injury[1] are likely key to the development and maintenance of public NSSI stigma. To investigate how news media portray self-injury, I conducted a media framing analysis of 545 news article published in Australia during 2019. Within an overarching theme of pathology, instability, and damage, six media frames were generated: *Inevitably Suicidal*, *A Tragic Outcome*, *Mentally Unwell*, *An Epidemic*, *Threatening and Dangerous*, and *A Manipulative Tactic*.

Each frame contributes to NSSI stigma in unique ways. *Inevitably Suicidal* captured a lack of distinction between suicidal and non-suicidal self-injury, which may lead to confusion about what constitutes self-injury, informing misconceptions about why people self-injure. *A Tragic Outcome* described the positioning of self-injury as an indication of impact. In stories about abuse, discrimination, detention, bullying and social, school, and work pressures, self-injury was referenced to demonstrate how impactful the experience was. The *Mentally Unwell* frame captured portrayals that synonymised self-injury with mental illness and/or portrayed self-injury as the behaviour of someone who was "unstable". Rates of self-injury were often portrayed as increasing, as indicated by the *An Epidemic* frame, whereby language such as "shocking" and "disturbing" was used to support the notion that self-injury is an epidemic. *Threatening and Dangerous* included articles that framed self-injury as an act of violence, or criminalised individuals who indicated intent to self-injure in public. The final frame, *A Manipulative Tactic*, related to portrayals of self-injury as a tool to manipulate circumstance and people for one's own gain. Taken together, these frames point to news media as a likely source of public NSSI stigma; however, the extent to which such messaging is internalised requires further investigation. Such investigation necessitates a measure of

[1]For consistency, I use the term "self-injury" here; however, in Study Three, I use the term "self-harm" because that is the common vernacular in Australia.

self-injury stigma. Therefore, the final study in this thesis was the development and validation of the Self-Injury Stigma Questionnaire.

I developed the Self-Injury Stigma Questionnaire in two parts. In the first part, I used the NSSI Stigma Framework to generate a large pool of items (approximately 150 per level). I then piloted these items with a sample of 316 (M^{age} = 32.1, 68% male, 40% with a history of self-injury) participants recruited via MTurk. I then conducted item reduction using bivariate correlations and exploratory factor analyses before administering the reduced item pool to 722 (M^{age} = 29.2, 27.3% male, 55.7% with a history of self-injury) participants recruited via social media, my university's participant pool, and MTurk. Due to its theoretically informed nature, I used confirmatory factor analyses to assess the structure of the Self-Injury Stigma Questionnaire. Four factors were generated: *Origin*, *Concealability*, *Peril*, and *Disruption*. While I expected six factors to mirror the NSSI Stigma Framework, the four-factor solution was conceptually sound. I then demonstrated internal consistency, convergent and divergent validity, and measurement invariance. The Self-Injury Stigma Questionnaire offers a comprehensive measure of self-injury stigma that can be used in future research to assess the extent and impact of self-injury stigma, and evaluate the effectiveness of NSSI stigma reduction efforts.

Taken together, the four studies presented in this thesis demonstrate self-injury stigma as a phenomenon requiring targeted investigation. Through the development and application of the NSSI Stigma Framework and the development and validation of the Self-Injury Stigma Questionnaire, this thesis contributes to a better understanding of self-injury stigma and offers a foundation to inform future self-injury research.

Author's Note

Thesis Format

As a hybrid thesis, the following chapters comprise both published and unpublished research. In published (Chapters 2, 3, and 4) and submitted papers (Chapter 5), I use the pronoun "we", as these papers are authored by myself and others. Relevant attributions and permissions are included at the beginning of each chapter. Due to the hybrid nature of this thesis, some repetition across Chapters is inevitable; however, I have tried to limit this where possible. Furthermore, I have combined the references for all chapters into a single list following the final chapter for brevity.

Nomenclature

Non-suicidal self-injury (NSSI) refers to harming oneself on purpose without intent to die (Butler & Malone, 2013), while *self-harm* refers to harming oneself on purpose, regardless of intent (Skegg, 2005). In this thesis, the phrases non-suicidal self-injury, self-injury, and NSSI are used predominantly, as these are the most accurate terms in the context of this program of research. However, there are instances where the phrase self-harm is used. While the field of NSSI research is an international one, the present research was conducted in an Australian context. Australian researchers, clinicians, journalists, and general public predominantly used the term self-harm to refer to NSSI (despite the complications that arise from this), and where necessary or relevant (i.e., Chapter 3 and 4) I use the term self-harm. Unless otherwise specified, when I use the term self-harm, I am still referring to NSSI.

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Chapter 1

Introduction to Thesis

In this chapter, I introduce the thesis topic. First, I provide an overview of non-suicidal self-injury and why it may be stigmatized. I then provide a description of stigma and summarize what is known about non-suicidal self-injury stigma. I finish this chapter with an outline of the thesis.

Non-Suicidal Self-Injury

Non-suicidal self-injury (NSSI; self-injury) is the intentional damage of one's own body enacted without suicidal intent (International Society for the Study of Self-Injury [ISSS], 2022). Usually done by cutting, hitting, and/or burning oneself, the most common motivation for self-injury is emotion regulation (Taylor et al., 2018). Accordingly, individuals who have self-injured tend to experience greater psychological distress than individuals who have never self-injured (Buelens et al., 2019). Despite being non-suicidal in nature, self-injury confers increased risk for suicidal thoughts and behaviours (Kiekens et al., 2018).

While self-injury is reported across identities, individuals identifying as lesbian, gay, bisexual, and/or transgender (LGBT) are more likely than their cisgender and heterosexual peers to engage in self-injury (Liu et al., 2019). In some research, the features of self-injury are similar for males and females, with females more likely than males to scratch themselves and injure on the stomach/abdomen and legs, and males more likely than females to burn themselves and injure on the chest/torso (Victor et al., 2018). NSSI can begin at any age, however, onset is most common during adolescence between 14 and 15 years of age, and early adulthood between 20 and 24 years of age (Gandhi et al., 2018). Self-injury is relatively common, with approximately 17% of adolescents, 13% of young adults, and 5% of adults reporting a lifetime history (Swannell et al., 2014). There are some indications that rates of NSSI are increasing, particularly among adolescents (Hiscock et al., 2018); however, it is not yet clear whether such increases are attributable to changes in hospital recording of self-injurious behaviours, ambiguity in distinguishing between suicidal and nonsuicidal self-injury, or actual changes in behaviour. Furthermore, emerging evidence suggests an increase in NSSI following the onset of the COVID-19 pandemic (Zetterqvist et al., 2021).

Despite being a relatively common behaviour, individuals are unlikely to disclose their self-injury to others (Simone & Hamza, 2020). Given that people who have self-injured are vulnerable to psychological distress and suicidality, it is vital that individuals who wish to seek support can do so; however, shame, fear of rejection or judgement, the potential for

disclosure to impact opportunities (e.g., career choices), and the possibility of losing control over future disclosures are prominent barriers to NSSI disclosure (Simone & Hamza, 2020). Removing these barriers is therefore critical to improving the wellbeing of individuals with lived experience of self-injury. Understanding the origin of those barriers is a key first step, and the aforementioned barriers likely stem from a single problem: stigma.

Stigma

Goffman (1963) described stigma as the mark or attribute an individual carries that leads to social rejection. Since Goffman's early works, psychologists have endeavoured to conceptualise, understand, and reduce stigma, proposing various social psychological models to do so (Corrigan, 2014). Common to many of these models are the following constructs: stereotype, prejudice, and discrimination. Stereotypes are culturally developed knowledge structures about individuals and groups that serve to categorise people in the least cognitively taxing way (Corrigan & Kosyluk, 2014). Stereotypes are unavoidable, as they represent automatic processes designed to increase cognitive efficiency; however, when such stereotypes are endorsed, prejudice can arise. Prejudices are the emotional responses elicited by belief in and exposure to a stereotype, and can take many forms, including anger, pity, and disgust. Prejudices can then lead to discrimination – the actions taken against a stereotyped group or individual that result in some form of social, structural, economic, or emotional disadvantage (Corrigan & Kosyluk, 2014).

Unsurprisingly, stigma has significant adverse impacts. Mental illness stigma diminishes self-esteem and self-efficacy, thwarts help-seeking and treatment adherence, interferes with coping and resilience, and is associated with fewer opportunities in relationships, housing, and employment (Sickel et al., 2014). Consequently, individuals experiencing mental health difficulties tend to conceal such difficulties to avoid stigmatisation, leading to ineffective treatments, isolation, and worsening of symptoms (Isaksson et al., 2018). Similar impacts may be related to self-injury stigma.

Self-Injury Stigma

The stigmatisation of self-injury is a topic of emerging scholarly attention. In line with a broader shift in the field toward better understanding the lived experiences of NSSI (e.g., Lewis & Hasking, 2021; Long, 2018; Victor et al., 2022), there is increasing recognition of how stigma negatively impacts individuals who have self-injured. Much of our understanding of self-injury stigma is drawn from qualitative work, which has provided insight into experiences of NSSI stigma, demonstrating that it is a significant barrier to support seeking and negatively impacts wellbeing (e.g., Hodgson, 2004; Kendall et al., 2021; Long, 2018;

Long, 2021; Mitten et al., 2016). Limited quantitative research has been done to investigate the predictors, correlates, and outcomes of self-injury stigma, possibly due to the absence of NSSI-specific models and measure of stigma.

In the absence of an existing model specific to self-injury stigma, researchers have drawn on Corrigan et al.'s (2003) Attribution Model of mental illness stigma to investigate NSSI stigma. This model proposes that stigma is driven by attributions of responsibility, suggesting that prejudice and discrimination are a function of perceptions and assumptions about why an individual has engaged in a behaviour (the cause) and whether they can control that behaviour (the controllability). If the cause is attributed to the individual engaging in the behaviour and that behaviour is seen to be controllable by the individual, then the responsibility for the behaviour will be attributed to the individual. When attributions of responsibility are made, prejudice and discrimination are more likely (Corrigan et al., 2003). Therefore, beliefs about why an individual has self-injured are important to understanding NSSI stigma.

This has been demonstrated in experimental studies (Burke et al., 2019; Law et al., 2009; Lloyd et al., 2018), whereby vignettes depicting a fictional character who has self-injured for various reasons are presented to participants. Characters who self-injured for controllable reasons (e.g., drug misuse) were rated less favourably than characters who had self-injured for uncontrollable reasons (e.g., history of abuse). Apart from attributions of responsibility, however, little is known about why self-injury stigma occurs. Indeed, there are aspects of self-injury that are likely not fully captured by mental illness stigma models. While self-injury likely incurs mental illness stigma due to its empirical (Keikens et al., 2018) and assumed (Newton & Bale, 2012) associations with mental illness, self-injury is also a behaviour that is enacted by the individual themselves, and often leaves marks in the form of wounds and scars.

Research by Piccirillo et al. (2020) and Kendall et al. (2021) demonstrates the importance of scarring in NSSI stigma. Piccirillo et al. examined participants' implicit and explicit evaluations of self-injury scars compared to scars from "non-intentional disfigurement" or tattoos, finding that self-injury scars were rated most negatively, both implicitly and explicitly. Kendall et al. examined 60 blog entries posted by individuals who had a history of self-injury and found that NSSI scarring has expansive implications. Most notably, participants were concerned their self-injury scars would preclude them from job opportunities and invite stigma. These concerns motivated scar concealment, interfering with daily life, such as avoiding holidays or wearing uncomfortable clothing. Clearly, the visible

aspect of self-injury is crucial to understanding self-injury stigma. Yet, we still know little about how, why, and where self-injury stigma manifests.

This knowledge is critical to the development and evaluation of effective stigma reduction programs and interventions. Ill-conceived interventions can be detrimental, inadvertently worsening stigma or harming the individuals the intervention was designed to help (Corrigan, 2016; Stuart, 2016). Therefore, NSSI stigma reduction efforts should be theoretically informed and designed in accordance with the priorities and concerns of individuals with lived experience (Corrigan, 2016; Stuart, 2016). In absence of a self-injury specific conceptualisation of stigma, efforts to reduce NSSI stigma may be ineffective, inadequate, and/or harmful. In this thesis, I contribute to the field's understanding of self-injury stigma in two ways. First, I propose and assess a theoretical framework of self-injury stigma; second, I develop and validate a measure of self-injury stigma.

Aims and Outline of the Thesis

The central aim of this thesis was to develop a better understanding of non-suicidal self-injury stigma. Four objectives fulfil this aim:

1. Collate existing knowledge to propose a comprehensive theoretical framework of NSSI stigma (Chapter 2).
2. Explore the utility and validity of the NSSI Stigma Framework (Chapter 3).
3. Explore a potential mechanism of NSSI stigma by analysing news media framing of self-injury (Chapter 4).
4. Develop and validate a comprehensive measure of NSSI stigma, informed by the NSSI Stigma Framework (Chapter 5).

The contents of each chapter are detailed below.

Chapter 2

In Chapter 2, I present the first study, *Application of a conceptual framework of non-suicidal self-injury stigma*, which provides an empirically derived theory for how to identify, explore, and explain self-injury stigma. Drawing together stigma models proposed by Jones et al. (1984), Corrigan and Watson (2002), and Quinn and Chaudoir (2009), I developed a holistic framework that considers how self-injury stigma manifests across multiple social contexts, and the domains that underly why self-injury is stigmatised.

Chapter 3

In Chapter 3, I present the second study, *Crazy, weak, and incompetent: A directed content analysis of self-injury stigma experiences*, where I assess the applicability of the NSSI Stigma Framework. Using the Framework as a rubric, I conducted a directed content

analysis of responses from 99 participants to a series of online, open-ended questions about their experiences of stigma. This study provided preliminary empirical support for the NSSI Stigma Framework.

Chapter 4

Chapter 4 comprises the third study, *News media framing of self-harm in Australia*. This study represents an example of how the self-injury stigma framework can be used to generate and answer a relevant research question. I sought to understand how the news media portray self-injury by conducting a media framing analysis on 545 news articles published in 2019. I found that self-injury framing was largely negative, with common stereotype perpetuation and use of stigmatising language. This study provided insight into how self-injury stigma may manifest at the public stigma level proposed in the NSSI Stigma Framework.

Chapter 5

The fourth study is presented in Chapter 5. Comprising two parts, this study involved the development and validation of the Self-Injury Stigma Questionnaire, which are a set of four 18-itme scales (public, self, anticipated, and enacted stigma), each comprising four factors (origin, concealability, peril, disruption). In part one of the study, I developed a large pool of potential items using the NSSI Stigma Framework as a guide. Using correlational and exploratory factor analyses, I reduced the item pool before piloting it to a new sample in part two of the study. I then conducted psychometric evaluations. Using a series of confirmatory factor analyses, I established the factor structure and examined measurement invariance. I then assessed reliability and convergent and divergent validity. The results demonstrated that the Self-Injury Stigma Questionnaire are psychometrically sound.

Chapter 6

Chapter 6 comprises a discussion of the limitations and contributions of the present work and their implications for future research.

Chapter 7

In the final chapter, I conclude the thesis with a critical reflexivity statement, where I reflect on my experience conducting this research as an individual with lived experience of self-injury.

Chapter 2

Stigma and NSSI: Application of a Conceptual Framework

As alluded to in the introduction, self-injury stigma comprises the interaction of mental illness-related, behavioural, and physical stigma elements. Therefore, existing theories of stigma may not adequately capture self-injury stigma and therefore limit our understanding of the phenomenon. The aim of the first study was to develop a theoretical framework of NSSI stigma that incorporated the elements unique to self-injury stigma. To do so, I conducted a literature review of self-injury stigma research and integrated multiple conceptualisations of stigma to form an integrated model of NSSI stigma.

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Attributions

Author	Contribution	Acknowledgement
Lexy Staniland	Development of research question and methodology, collection and management of data, collation and integration of theoretical components, manuscript preparation	
Penelope Hasking Mark Boyes Stephen Lewis	Assisted with development of research question and methodology, collation and integration of theoretical components, and manuscript preparation	
Journal permission for article inclusion can be found in Appendix A.		

Abstract

Nonsuicidal self-injury (NSSI) is a stigmatized behaviour that involves intentionally damaging one's own body, usually by cutting or burning the skin. Despite evidence that NSSI is stigmatized, the processes underlying NSSI stigma and associated outcomes are poorly understood. Given associations between NSSI and mental illness, NSSI may incur mental illness–related stigma. Additionally, NSSI is self-inflicted, which violates societal expectations of self-preservation, resulting in stigmatization. Finally, NSSI leaves physical marks in the form of wounds and scars that are subject to stigmatization. These behavioural and physical aspects of NSSI mean that a mental illness stigma lens may not holistically capture the experience and process of NSSI stigma. Understanding the manifestation and experience of NSSI stigma is a critical step toward stigma reduction. Given the incipient nature of research in this area, we have a unique opportunity to provide a theoretically grounded foundation to stimulate future work. In this article, we draw on theoretical perspectives to demonstrate the complexity of NSSI stigma and identify possible constructs that may underlie the development and experience of NSSI stigma. We then provide a theoretically and empirically informed framework to guide future work in this area.

Introduction

Nonsuicidal self-injury (NSSI) is damage caused to one's body without suicidal intent (International Society for the Study of Self-Injury, 2022), and is a relatively common behaviour, with prevalence rates of 17.2% for adolescents, 12.5% for young adults, and 5.5% for adults (Swannell et al., 2014). NSSI is most often used as a way to manage painful and/or unwanted emotions, and typically takes the form of cutting, burning, or hitting oneself (Cipriano et al., 2017). While not always coinciding with a mental illness diagnosis, NSSI may be related to mental health difficulties and is associated with heightened psychological distress (Bentley et al., 2015). Although enacted without intent to die, NSSI confers significant risk for immediate physical harm and later suicidal thoughts and behaviour (Kiekens et al., 2018).

Despite advancements in understanding the behaviour, NSSI is highly stigmatised and often misunderstood. Common misconceptions include that it is an attention-seeking or manipulative behaviour (Lewis et al., 2014; Lloyd et al., 2018; Sandy, 2013; Scourfield et al., 2011), circumscribed to teenagers (Hughes et al., 2017; Oldershaw et al., 2008) or girls (Lewis et al., 2014), that it is suicidal (Kumar et al., 2004), or superficial and transitory (Mitten et al., 2016; Oldershaw et al., 2008). These misconceptions generate stereotypes about NSSI that may result in prejudice and discrimination in the form of negative judgements (Long, 2018), reduced access to services (Anonymous, 2016), or removal of autonomy (Parker, 2018). People who self-injure may internalise NSSI stereotypes, resulting in diminished self-esteem and a reluctance to seek support (Chandler, 2014; Long, 2018), despite the potential benefits of doing so (Hasking et al., 2015). These experiences are consistent with stigma, and while the process and experience of stigma are well-documented in other fields (e.g., HIV, mental illness; Jackson-Best & Edwards, 2018), surprisingly little is known about how stigma develops and occurs in the context of NSSI.

NSSI stigma likely comprises an interaction of behavioural, physical and mental illness stigma. Self-injury is a behaviour often associated with mental illness that may leave physical evidence in the form of wounds and scars. Because NSSI is self-inflicted, it violates society's understanding of self-preservation and may be stigmatised for being a socially "deviant" behaviour (Adler & Adler, 2007). Additionally, due to associations between NSSI and mental illness, it is likely that NSSI attracts mental illness stigma. Finally, NSSI often results in wounds or scars that can be long-lasting and visible to others (Lewis, 2016; Lewis & Mehrabkhani, 2016), which adds an additional layer of complexity to the stigma experience

for people with lived experience. Therefore, a holistic understanding of the process and experience of NSSI stigma must be approached with these three components in mind.

In the following paper, we provide a brief description of stigma, drawing on established theoretical perspectives. We then explore how NSSI stigma may be evident at a broad public level and at an individual level, including experiences of self-directed, anticipated, and enacted stigma. Using Jones and colleagues' (1984) model, we then identify constructs that may underlie the development of NSSI stigma. Finally, we propose a theoretically informed framework that considers the unique interplay of behavioural, physical, and mental illness stigma. This framework can be used guide future theoretical developments and empirical work in this area.

NSSI Stigma

Conditions, behaviours, personal characteristics, and other marks deemed to be socially unacceptable are frequently subject to stigmatisation (Goffman, 1963). Stigmatisation occurs through a process of labelling, stereotyping, separation, and discrimination (Link et al., 2004). A person is first identified on the basis of a mark and labelled accordingly. A set of usually negative characteristics known as stereotypes are then applied to the individual (e.g., "dangerous", "unpredictable") and symbolic separation is made possible, whereby a labelled person becomes an "other." An emotional response is subsequently elicited (e.g., fear, pity), which contributes to discrimination. Discriminatory behaviours may be overt (e.g., rejection of job application) or subtle (e.g., reduced funding for the relevant condition) and may operate through external forces or arise within the self.

As a phenomenon that emerges within social interactions, stigma is inexorably embedded within social structures such as gender, class, and ethnicity (Scambler, 2006). Understanding stigma must therefore be informed by an acknowledgement of the power and privilege associated with these social structures, as well as a critical evaluation of the social institutions that allow, perpetuate, or even encourage stigma (Scambler, 2004). A multi-level approach to conceptualising stigma in any given context may help to direct attention to these macro issues while simultaneously appreciating lived experience.

At the broadest level, public stigma emerges in the stereotypes about a given mark and gives rise to a range of stigmatising experiences, including prejudice and discrimination (Corrigan & Watson, 2002). These experiences of prejudice and discrimination are referred to as enacted stigma and may manifest in experiences such as being denied access to a service due to mental illness (Scambler, 1998). The expectation of such experiences may result in anticipated stigma (Quinn & Chaudoir, 2009), and the internalisation of stereotypes can result

in self-stigma (Corrigan & Watson, 2002). In the context of NSSI, there is a small but developing body of work demonstrating that NSSI stigma is present across public, self, enacted, and anticipated levels (Breen et al., 2013; Burke et al., 2019; Lloyd et al., 2018; Mitten et al., 2016; Piccirillo et al., 2020; Rosenrot & Lewis, 2018).

Public NSSI Stigma

Public NSSI stigma is reflected in the attitudes of some healthcare workers, teachers, parents, and members of the general public. Negative attitudes toward NSSI have been reported by medical staff, particularly within emergency departments (Karman et al., 2015; Saunders et al., 2012), with nurses sometimes perceiving people who self-injure as "time-wasters" and less deserving of care than other patients (Cook et al., 2004; Gibb et al., 2010; Sandy & Shaw, 2012). Similar views are also expressed by some psychologists (Gagnon & Hasking, 2012), teachers (Berger et al., 2014; Berger et al., 2015; Heath et al., 2011), and vocational rehabilitation providers (Lund et al., 2018). Attitudes such as these may impact care provision and/or rapport, and potentially result in a reduced likelihood that an individual will seek support for self-injury in the future. People with lived experience may internalise these attitudes, possibly leading to self-stigma (Long, 2018).

Some parents of adolescents who have self-injured report negative reactions to NSSI, describing emotions of horror, shock, and devastation to finding out their child has self-injured (Hughes et al., 2017; Kelada et al., 2016; Oldershaw et al., 2008). Parents may express beliefs that NSSI is manipulative and transitory, a behaviour that adolescents use to get their own way, and/or one that they will simply outgrow (Hughes et al., 2017; Oldershaw et al., 2008). While these reactions and attitudes may reflect concern for their child's wellbeing, they can also reflect judgment and prejudice, which may lead to poor interactions and the child feeling unsupported (Wadman et al., 2017). Peers of young people who have self-injured may also express negative attitudes, describing their peers as "attention-seeking", or believing that they waste doctors' time (Klineberg et al., 2013, p. 7). In a qualitative investigation of public attitudes to self-harm (which, unlike NSSI, encapsulates both suicidal and non-suicidal actions; Kapur & Gask, 2009) participants largely expressed sympathy toward people who self-injure, however, when describing societal attitudes toward self-injury, participants suggested that society perceives people who self-injure negatively (e.g., as "nut jobs") and that society endorses common misconceptions about NSSI (e.g., goth/emo stereotypes, behaviour isolated to teenagers). The latter attitudes may be a more accurate representation of participants' views toward self-injury, given that people tend to downplay negative attitudes when asked directly (Scocco et al., 2012).

Recent quantitative work has also demonstrated stigma toward NSSI. Lloyd et al. (2018) found that participants were likely to express negative emotional reactions (e.g., anger) toward people who have self-injured, especially if the participant attributed blame toward the individual. Additionally, participants tended to perceive NSSI as manipulative, particularly if the person who had self-injured discloses their self-injury (Lloyd et al., 2018). NSSI stigma has been further evidenced in recent experimental research. Burke et al. (2019) compared implicit and explicit attitudes toward NSSI scarring, nonintentional scarring, and tattoos using self-report measures and an Implicit Association Test. A significant negative bias toward people with self-injury scars was found across both implicit and explicit measures, suggesting that these scars may be more stigmatised than other types of scars (Burke et al., 2019). Participants were also more likely to rate people with self-injury scars as bad, rejection-worthy, and dangerous, and less likely to accept people with self-injury scars as a friend, roommate, or romantic partner. Taken together, these works demonstrate empirical evidence of public NSSI stigma.

Finally, stigma is a socially communicated phenomenon informed by multiple complex representations of perceived normalcy (Bos et al., 2013). Public NSSI stigma is likely embedded within a shared ideology that is subtly proliferated across multiple modes of communication, such as direct social interactions, inadvertent observations, and mass media (Stangor & Crandall, 2000). There is evidence to suggest that mass media plays a significant role in the propagation of negative attitudes toward people with mental illness (Chan & Yanos, 2018), and the same may be true in the context of NSSI (Newton & Bale, 2012). More work is needed to understand how public NSSI stigma is generated and maintained across multiple modes of communication.

Self NSSI Stigma

Self-stigma is the awareness of, agreement with, and application of stigma to self that results in harm (e.g., diminished self-esteem; Corrigan & Rao, 2012). Self-stigma is evident in the context of NSSI through the narratives of those with lived experience. People with a history of self-injury describe feelings of guilt, shame, and embarrassment (Chandler, 2014; Lesniak, 2010; Long, 2018), and may perceive the self as disgusting, stupid, and abnormal (Chandler, 2014; Fortune et al., 2008; Straiton et al., 2013; Wadman et al., 2017). Confusion and self-doubt are also commonly experienced, whereby people who have self-injured worry that NSSI stereotypes (e.g., attention-seeking) are true for them and mean they do not deserve help (Long et al., 2015). These experiences may contribute to diminished self-esteem. People who have a history of self-injury report lower self-esteem than people without (Forrester et

al., 2017), and self-stigma often coincides with poor self-esteem (Corrigan, Larson, et al., 2009); however, the role of self-stigma in this association has yet to be explicitly explored.

Enacted NSSI Stigma

Across multiple settings, people who have a history of self-injury have described both overt and subtle stigma experiences. At hospitals, people have described being reprimanded for the cost of dressings or refused analgesia (Anonymous, 2016). People have faced "freak out" reactions (Long, 2018), been doubted (Lindgren et al., 2004), or labelled as a "freak" or "crazy" (Mitten et al., 2016). People have also faced disparaging comments, such as being described as attention-seeking and stupid (Brown & Kimball, 2012; Klineberg et al., 2013). At school, people have described loss of autonomy (Parker, 2018) or having their disclosure choices removed from them, with their NSSI shared to others without permission (Klineberg et al., 2013). People have also described experiencing unnecessary pity, being treated like they had a disability (Klineberg et al., 2013), or as though they were now "damaged" (Mitten et al., 2016). Experiences of enacted stigma are identified as damaging and reduce future support-seeking (Long, 2018). It is also likely that these experiences have impacts beyond what research has thus far investigated in the context of NSSI (e.g., self-esteem, self-efficacy).

Anticipated NSSI Stigma

Because stereotypes are socially learned scripts, people are aware of them regardless of their relevance to self (Quinn & Chaudoir, 2009). Therefore, when a stereotype becomes relevant to the self (i.e., after a person has engaged in self-injury), an individual may subsequently anticipate negative experiences. Consistent with anticipated stigma, people with a history of NSSI avoid disclosure or support-seeking for fear of judgement or other adverse reactions (Fortune et al., 2008; Hodgson, 2004; Klineberg et al., 2013; Long, 2018; Lund et al., 2018; Rosenrot & Lewis, 2018; Wadman et al., 2017). Anticipated stigma is also evident in efforts to conceal wounds and scars, and attempts to explain them as non-self-injurious (Chandler, 2014; Hodgson, 2004; Long, 2018). Concerns of experiencing stigma, and preoccupation with avoiding stigma have a detrimental effect on an individual's quality of life (Corrigan, Kerr, et al., 2005). Given the perceived need to actively avoid stigmatisation, anticipated stigma may be a more significant barrier to support-seeking than public stigma in the context of NSSI.

The Constructs Underlying NSSI Stigma

Stigma is associated with multiple negative outcomes, including diminished self-esteem and self-efficacy (Corrigan & Rao, 2012; Lannin et al., 2016), reduced help-seeking (Clement

et al., 2015), poor treatment outcomes (Oexle et al., 2018), social isolation (Link et al., 1989), and reduced opportunities across a number of life domains including relationships, employment, and education (Lasalvia et al., 2013). Similar outcomes have been observed for people who have a history of self-injury (Victor & Klonsky, 2014), however, before exploring the impacts of NSSI stigma, we must first understand how and why NSSI is stigmatised, and what characterises stigmatising experiences for people who self-injure. Jones and colleagues (1984) proposed six stigma constructs that underlie the stigmatisation of a mark: origin, concealability, course, peril, disruptiveness, and aesthetics. This model has conceptual value for elucidating which aspects of NSSI are stigmatised and can inform our understanding of the cognitive and emotional processes that may underpin public, enacted, self, and anticipated stigma. In the following section we describe each construct in the context of NSSI to demonstrate the complexities of NSSI stigma.

Origin

Origin relates to how a mark came to exist and is closely tied to controllability. When a mark is perceived as onset-controllable (avoidable or acquired through one's own actions) the person is perceived to be responsible for that mark and is subsequently more stigmatised than if they possessed a mark perceived as uncontrollable (Weiner et al., 1988). For that reason, physical illnesses that are perceived to be behaviourally generated (e.g., lung cancer perceived to be caused by smoking) incur greater stigma than those that are not within a person's control (e.g., Alzheimer's disease; Crandall & Moriarty, 1995). It is likely that origin is a particularly relevant construct in the stigmatisation of NSSI due to its volitional nature. Like other socially rejected behaviours (e.g., drug use; Corrigan, Kuwabara, et al., 2009), NSSI incurs stigma due to perceptions of responsibility - an individual who has brought a circumstance upon themselves is considered undeserving of help (Weiner, 1995). Perceptions of origin seem to directly relate to service provision, especially in a medical setting. People describe being dismissed as low-priority due to the volitional nature of their injuries, even when severe (Brown & Kimball, 2012).

Stereotypes of attention-seeking and manipulation may stem directly from misunderstandings of NSSI origin (Borrill et al., 2012). People tend to perceive self-injury as directly the fault of the person engaging in it (Newton & Bale, 2012). While NSSI is ultimately volitional, a lack of understanding about why people self-injure may inform the tendency to assign blame that allows judgement and discrimination. Indeed, people tend to be less stigmatising when provided with an explanation for NSSI (Borrill et al., 2012; Law et al., 2009; Newton & Bale, 2012; Nielsen & Townsend, 2018). Despite a tendency to perceive

NSSI as having a person-centred origin, people may also believe NSSI to originate from mental illness. In Newton and Bale's (2012) interviews with members of the general public, people expressed mixed opinions on the relevance of mental illness to self-injury. People seemed to reject the notion that NSSI is a mental illness, but endorsed the idea that emotional difficulties must be present (Newton & Bale, 2012). Participants were also inclined to use mental illness narratives in a derogatory manner. For example, one person stated "...it's gotta be something mentally wrong with somebody to do it [self-injure]" (Newton & Bale, 2012, p. 111). Nonetheless, it was evident that sympathy may increase toward people who have self-injured if there was evidence of mental illness; participants seemed to hold an individual less responsible for their self-injury if they could attribute the reason to mental illness.

The origin construct is complicated in the context of NSSI due to the interaction of behavioural and mental components. NSSI is enacted directly toward the self and may therefore be perceived as controllable, and it has connotations of mental illness that may or may not alter perceptions of responsibility. Based on the findings outlined, people seem to have limited understanding of why a person may self-injure and as a result, default to a cognitively simpler explanation - the person who self-injured is to blame and therefore does not deserve help.

Concealability

Concealability refers to the degree to which a mark may be hidden, with some marks completely unconcealable, others concealable sometimes or partially, and some completely concealable. An unconcealable mark is one that is visibly or audibly obvious to others and might include marks such as wheelchair use and skin colour, whereas concealable marks are those that can be withheld or hidden, such as mental illness or HIV status (Quinn & Earnshaw, 2013). Some marks are easier to conceal than others; a person who exclusively uses a wheelchair cannot hide this mark as easily as a person who sometimes uses a walking aid. Similarly, a physical stigma, such as wheelchair use, is more difficult to conceal than a symbolic stigma like mental illness (Corrigan, Kuwabara, et al., 2009). An unconcealable mark may be more readily susceptible to stigma, as it is observable (Quinn & Earnshaw, 2013); however, a concealable mark may be stigmatised due to a perception that it is not a "genuine" illness (Jutel & Conrad, 2011). In the context of NSSI, this means that marks caused by self-injury may be subject to stigma because they are visible, however, the connotations of mental illness that coincide with self-injury may incur stigma associated with it being perceived as an illegitimate concern.

NSSI often leaves marks in the form of bruising, burns, scratches or cuts that can result in scarring (Lewis, 2016; Lewis & Mehrabkhani, 2016). Many people with a history of self-injury report at least one permanent scar (Burke et al., 2016), and scarring caused by cutting the skin tends to be easily recognisable (Ho et al., 2018). The concealability of scars may vary person to person, depending on variables such as location on the body and severity of the injury, which may give rise to different stigma experiences. A person may be at greater risk of experiencing stigma if their scarring is located in a highly visible area (e.g., forearms) compared to a more easily concealed location (e.g., upper thighs), or if the scarring is severe (e.g., raised) or populous (Lewis, 2016; Lewis & Mehrabkhani, 2016).

A person may be more likely to be labelled an attention-seeker if they have more visible scarring due to assumptions that location is related to attention-seeking intentions (Crouch & Wright, 2004; Scourfield et al., 2011) and an expectation that unless NSSI is kept hidden, it is attention-seeking (Klineberg et al., 2013; Scourfield et al., 2011). In addition to the likelihood that objective visibility relates to public and enacted NSSI stigma (e.g., Klineberg et al., 2013), the perception of visibility for a person who has self-injured is likely important for consideration of self-stigma (Burke et al., 2017; Lewis & Mehrabkhani, 2016). Indeed, subjective ratings of scar severity are associated with psychosocial distress for a range of scar types, including those from self-injury (Brown et al., 2010).

Concealability in the context of NSSI is further complicated by the conflation between NSSI and mental illness. While mental health difficulties are, for the most part, invisible, self-injury is often not, and while self-injury may be concealable, it could act as a visible marker for mental illness (Burke et al., 2017). A person who self-injures is therefore at risk of experiencing mental illness stigma (even if they do not have a mental illness) due to the potential perception that self-injury is a “physical manifestation of mental illness” (Burke et al., 2017, p. 546). Interestingly, while mental illness may incur stigmatisation due to its lack of visibility (seen as “less real” due to its invisibility; Jutel & Conrad, 2011, p. 13), self-injury as a marker for mental illness may not improve perceptions of mental illness. Instead, self-injury is likely doubly stigmatised, both for being indicative of a mental health difficulty and for being an onset-controllable behaviour. Thus, NSSI stigma is complicated by the simultaneously visible/hideable nature of self-injury, and its association with mental illness.

Course

Course refers to how a mark is perceived to change over time. A person may be held responsible for the course of their condition through the process of offset-attribution (stigmatisation for not taking necessary action to alleviate their condition; Weiner, 1995).

However, the course of self-injury is unlikely to be a linear process, and cessation may be indefinite or temporary (Kelada et al., 2018; Lewis et al., 2019). In the context of NSSI, the volitional nature of the behaviour is likely to generate strong offset-attributions that may lead to stigmatising responses towards people who have not stopped self-injuring. This can be seen in some nursing contexts in which nurses experience greater frustration toward patients who have sought medical assistance on multiple occasions for self-injury (Sandy & Shaw, 2012).

The relevance of course to NSSI stigma may differ depending on whether a person has ceased self-injury. To be self-injuring may carry the stigma of being somebody who hurts themselves intentionally and the stigma of having scars from such injuries. A person who no longer self-injures may be able to shed the stigma of current self-injury yet carry the self-stigma of having done so, and the potential ongoing stigma of NSSI scarring. As such, the experience of stigma does not necessarily dissipate once an individual stops self-injuring. Indeed, this expectation is evident in concerns that NSSI may impact future career prospects (Long, 2018), particularly given self-injury scars are more stigmatised than other scars (Burke et al., 2019), and may signal stereotypes regardless of whether the individual still engages in self-injury. An additional complication, which has implications for ongoing enacted and self-stigma, is that the often permanent nature of scars could also, perhaps inaccurately, signal ongoing mental illness.

Peril

Peril traditionally refers to the level of danger a person poses to others. The more dangerous a mark is perceived to be, the more stigmatised the marked person tends to be. For physical stigmas, social avoidance stems from the fear that the mark poses the risk of infection, even for marks that are not contagious (Oaten et al., 2011). For symbolic stigmas, peril relates to fear for personal safety, and social avoidance stems from inaccurate perceptions that people who have mental illness are dangerous and unpredictable (Corrigan & Watson, 2002). There appears to be a dichotomy in the way potential peril associated with NSSI is viewed. Some see NSSI as inherently related to suicidal behaviour and thus highly perilous (Kumar et al., 2004; Long, 2018), while others tend to dismiss the behaviour as attention-seeking and inconsequential (Long, 2018; Newton & Bale, 2012).

Damage to the body can be seen as inherently perilous. People may injure themselves more severely than intended (Rissanen et al., 2009), and NSSI can result in accidental death (Lofthouse & Yager-Schweller, 2009). For this reason, NSSI is sometimes perceived as dangerous, or associated with high peril (Lloyd et al., 2018). While marks that are associated

with higher levels of peril tend to be more highly stigmatised, the understatement of the importance of NSSI may, in fact, reflect stigma. Refusal (or inability) to perceive NSSI as a significant health concern renders it illegitimate, which translates to discrimination in the form of poor treatment and support across multiple settings (Anonymous, 2016; Berger et al., 2014; Karman et al., 2015; Mitten et al., 2016).

Additionally, fear of "social contagion" of NSSI is rife, with many believing that NSSI "spreads" through peer groups, being passed on from one person to another. While social influences may be involved in NSSI, the notion that it is a "contagious" behaviour perpetuates harmful stereotypes that NSSI is attention seeking, enacted for peer approval, or isolated to certain sub-cultures (for a detailed commentary, see Hasking & Boyes, 2018). Teachers and parents in particular tend to perceive NSSI as a "contagious" behaviour (Berger et al., 2014; Rissanen et al., 2009). This fear of "contagion" leads to policies to avoid talking about NSSI (Parker, 2018) and encouraging people who self-injure to conceal their scars (despite evidence that acceptance of scars can be part of the healing process; Bachtelle & Pepper, 2015; Lewis et al., 2019), which may perpetuate stigma and reduce help-seeking (Parker, 2018).

Aesthetics

Aesthetics refers to how visibly displeasing a mark is. People tend to equate attractiveness with morality, meaning that if a person is perceived to be unattractive, they may be perceived as bad or immoral (Jones et al., 1984). Aesthetics is most commonly associated with physical stigmas, and marks that cannot be hidden, although a concealable stigma is still subject to an aesthetics evaluation when it is revealed. Physical marks that are considered to be visibly displeasing are more highly stigmatised than those that are not considered to be visibly displeasing. Therefore, NSSI is likely to incur stigma as a result of the displeasing appearance of injuries and scars. It follows that more evident or extensive injuries are likely to incur more stigma. People who self-injure have reported that others find their scars "ugly" and "gross" (Mitten et al., 2016) or describe NSSI as a "disgusting" behaviour (Rissanen et al., 2009). People who have a history of self-injury have discussed feelings of ambivalence, acceptance, and shame when discussing their scars (Chandler, 2014; Lewis & Mehrabkhani, 2016), meaning that others' perceptions of scarring may or may not be internalised.

The subjective aesthetic quality of self-injury and its resulting scars is important to consider because the physical component of NSSI is potentially the most salient and stigma-provoking attribute of the behaviour. The interaction between aesthetics and concealability

may add an additional complexity to NSSI stigma. For example, a person who perceives their scars as beautiful and representative of strength may experience less self-stigma than a person who sees their scars as ugly and shameful (Mitten et al., 2016). Efforts to conceal scars may directly relate to these aesthetic evaluations, which may then give rise to different experiences of enacted or anticipated stigma. Someone who accepts their scars may be less likely to cover them and thus more likely to be exposed to stereotype, prejudice, and discrimination. In contrast, someone who does not accept their scars may be more likely to conceal them, decreasing risk of exposure.

Disruptiveness

Disruptiveness refers to the impact a mark has upon relationships, and according to Jones and colleagues (1984) is the least clearly demarcated construct, as it tends to capture evidence of stigma rather than reasons for it. Marks that interfere with relationships tend to be more highly stigmatised than those that have limited impact on personal interactions. In the context of NSSI, disruptiveness likely varies depending on the nature of the relationship. NSSI is unlikely to cause major disruption to general interactions, given its capacity to be concealed; however, it may cause significant disruption to close or romantic relationships. Impacts to close relationships may stem from concern for the person who has self-injured that plays out in a damaging way. For example, a parent may respond to a child's NSSI by removing autonomy or expressing anger, which may cause the child to withdraw, disrupting feelings of trust and safety (Ferrey et al., 2016; Hughes et al., 2017). Within the broader family dynamic, NSSI may catalyse sibling tensions (Tschan et al., 2019) or elicit judgment and blame from extended family (Ferrey et al., 2016). Within friendships and romantic relationships, avoiding conversations about NSSI has been described as a common response to disclosure, which can lead to an individual feeling unsupported (Rosenrot & Lewis, 2018). Yet, when a loved one is urging an individual to stop self-injuring - and they do not - this can put pressure on the relationship.

Disruptiveness may also be relevant beyond interpersonal interactions and extend to activity choices that indirectly impact socialisation. For example, people trying to conceal evidence of self-injury may avoid going to the beach, playing sport, or entering romantic relationships (Hodgson, 2004). Anticipation of social disruption may motivate avoidance of certain activities or disclosure reluctance; indeed, fear of burdening family has been cited as a barrier to disclosure (Rosenrot & Lewis, 2018). NSSI may also disrupt relationships with the self, possibly generating self-hatred (Breen et al., 2013). Both anticipated and enacted experiences of disruption are likely to be particularly relevant to self-stigma.

A Framework for NSSI Stigma

NSSI is subject to public, self, enacted, and anticipated stigma. The reasons for this stigmatisation are complex due to the presence and interaction of the physical, behavioural, and mental illness components of stigma. NSSI is typically perceived to be a mental health difficulty (Newton & Bale, 2012) and therefore incurs mental illness stigma, it is self-inflicted and therefore incurs behavioural stigma, and it frequently leaves evidence in the form of wounds and scars (Lewis & Mehrabkhani, 2016), therefore incurring physical stigma. NSSI stigma is further complicated by the interactions between, and tensions within, each stigma construct, meaning that the application of existing conceptualisations may not be able to capture important aspects of how NSSI stigma operates or is experienced. For example, a mental illness stigma lens may not capture the complexities found within the origin construct, where responsibility and blame are complicated by the behavioural and mental components of NSSI.

While research suggests that NSSI stigma is widely expressed and experienced, most of these findings are ancillary and emerge from work investigating other elements of NSSI (e.g., recovery, scarring). There has been relatively little attention directed at understanding the processes underlying the stigmatisation of NSSI, much less an evaluation of how the field should approach such a task. Exploring the constructs underlying stigma, and the many ways in which it may be experienced, begins to paint a picture of the complex nature of NSSI stigma. In line with the levels of stigma (i.e., public, enacted, self, anticipated), we have provided theoretically and empirically driven examples of how each stigma construct may manifest in the context of NSSI (see Table 2.1). For example, when considering NSSI origin, public stigma is evidenced in the tendency to blame an individual for their self-injury without considering precipitating reasons.

Within the same construct, self-stigma is evidenced by negative views toward the self in relation to the origin of self-injury; for example, shame and embarrassment are common. Then, at the level of anticipated stigma, concerns about how others will perceive NSSI origin emerge in expectations of being blamed or labelled as an attention-seeker (Lesniak, 2010). Finally, at the level of enacted stigma, beliefs about the origin of NSSI inform poor treatment, such as denying a person who has self-injured analgesia due to the belief that self-injury was motivated by a desire for pain (Anonymous, 2016). In providing examples at each level of stigma and within each stigma construct, we have presented a holistic conceptualisation of how NSSI stigma manifests within a framework that can direct relevant research questions and guide future work.

Table 2.1
A Framework for Conceptualising NSSI Stigma

	Public Stigma	Self-Stigma	Anticipated Stigma	Enacted Stigma
Origin	*What the public think about the origin of NSSI*	*What an individual thinks/feels about the origin of their own NSSI*	*What an individual expects from others re: the origin of their NSSI*	*How people are treated as a result of beliefs about NSSI origin*
	"It's their own fault"[1(pg. 110)] Belief that only those with mental illness self-injure[1] Belief that people who self-injure enjoy pain[2]	Shame, guilt, embarrassment "I've felt it was inconceivably pathetic of me to do it"[3(pg. 81)]	Expectations of blame "I felt as though … they would think I was being a stupid attention-seeker, or it was just my hormones"[4(pg. 7)] Falsifying origin of wounds/scars[5,6]	Being denied analgesia[2] "… is it just you attention seeking?"[7(pg. 124)]
Concealability	*How concealability influences public attitudes toward NSSI*	*How NSSI concealability influences an individual's perceptions of self*	*How concealability influences an individual's expectations of others*	*How people are treated as a result of beliefs about NSSI concealability*
	NSSI scars tend to be recognisable as self-inflicted[8] Marker for mental illness[9] Visible = attention seeking or manipulative[10,11] Not a "real" problem[12]	Feelings of shame[6,13] Falsifying narratives[5,6] Negative feelings toward scars[14,15]	Hiding/covering/removing scars[14,5,6] Avoiding activities (e.g., swimming)[5] Injuring concealable areas of the body[6,13,7]	Being instructed to hide/cover scars or being forced to prove NSSI[16] Labelled as attention-seeking due to visibility of scarring[10,17]
Course	*What the public think about the course of NSSI*	*How an individual perceives the course of their own NSSI*	*What an individual expects others to think about the course of their NSSI*	*How people are treated as a result of beliefs about the course of NSSI*
	Belief that NSSI is suicidal[1,16] Belief that NSSI can easily be stopped[7] Frustration with continued self-injury[18]	Ongoing urges, notions of recovery[7,19] Visible scars as triggering[9]	Fear of impact to career prospects[20] Scars do not necessarily indicate current self-injury[14]	"Just stop it" Judgement from others leading to continued self-injury[21] Being told how expensive dressings are[1]
Peril	*What the public think about the peril of NSSI*	*How an individual perceives the peril of their own NSSI*	*What an individual expects others to think about the peril of their NSSI*	*How people are treated as a result of beliefs about the peril of NSSI*

	Conflation of NSSI and suicide[16] Belief that NSSI is contagious[22,23]	Possible self-directed beliefs about one's own "contagion" or mental stability	Fear of being labelled/perceived as suicidal[6,20] "I did not feel it was serious enough for help"[4(pg. 6)]	Not talking about it; being forced to cover scars[16] Being forced to admit to being suicidal, even when not[6] Being put on suicide watch[24] Lack of follow-up due to perception that NSSI is nonserious[21]
Aesthetics	*What the public think about the aesthetics of NSSI*	*What an individual thinks/feels about the aesthetics of their own NSSI*	*What an individual expects others to think about the aesthetics of their NSSI*	*How people are treated as a result of beliefs about the aesthetics of NSSI*
	"…you know big gashes down their arm, you'd think oh my God"[1(pg. 110)]	Feeling disgust toward own scars[12,23] Scarring as a trigger for continued self-injury[14]	Hiding/covering/removing scars[5]	Aversive reactions to scars "…oh that's so gross"[12(pg. 9)]
Disruptiveness	*How the public believe NSSI disrupts relationships*	*How an individual perceives their NSSI has disrupted relationships*	*How an individual expects their NSSI to disrupt relationships*	*How NSSI disrupts relationships*
	"Wasting doctor's time"[10(pg. 7)] Using ED resources (e.g., time, dressings)[2]	May disrupt relationship with self[25] Feeling isolated/unsupported[13]	Change in activities/ behaviours (e.g., no longer going to the beach)[5] Avoiding disclosure to avoid disruption[7] Pretending to be okay[20]	Arguments with loved ones[7] Impact to family dynamics[26,27] Increased bullying or social isolation[12]

References: [1]Newton & Bale, 2012; [2]Anonymous, 2016; [3]Straiton et al., 2012; [4]Fortune et al., 2008; [5]Hodgson, 2004; [6]Lesniak, 2010; [7]Wadman et al., 2017; [8]Ho et al., 2018; [9]Burke et al., 2017; [10]Klineberg et al., 2013; [11]Lloyd et al., 20128; [12]Mitten et al., 2016; [13]Rosenrot & Lewis, 2018; [14]Chandler, 2014; [15]Lewis & Mehrabkhani, 2016; [16]Parker, 2018; [17]Crouch & Wright, 2004; [18]Sandy & Shaw, 2012; [19]Lewis et al., 2019; [20]Long, 2018; [21]Long et al., 2015; [22]Berger et al., 2014; [23]Rissanen et al., 2008; [24]Kumar et al., 2004; [25]Breen et al., 2013; [26]Ferrey et al., 2019; [27]Tschan et al., 2019.

Limitations

In synthesising multiple conceptualisations of stigma, we acknowledge that there are potential theoretical gaps in our framework. Because we were guided by a psychological lens, the behavioural and physical components of the framework may be limited. Given that this framework is a first attempt at combining these perspectives in the context of NSSI, we have no doubt that the framework will evolve over time as the more research is generated. Additionally, while the framework is theoretically robust and grounded in available evidence, it is limited by a sparsity of NSSI stigma research. Further empirical work is required to validate this framework and determine whether the components operate in the proposed manner. Finally, while we have acknowledged the importance of power in our overview of stigma theory, further research is required to understand how power contributes to NSSI stigma within the proposed framework.

Future Directions

A fruitful starting point may be to investigate the types of messages that are conveyed about self-injury at a broad societal level, given that stereotypes are socially learned scripts that inform prejudice and discrimination (Corrigan, 2000). Mass media can be a vehicle for the communication of stereotypes (Frankham, 2019), and presents an important avenue for investigating messaging about NSSI. Exploring how NSSI is portrayed by news and other popular media may give important insights into the development of public NSSI stigma. For example, if media consistently purports NSSI to be “contagious”, this may inform public notions of origin and peril, which contribute to harmful stereotypes and generate public stigma. This may also inform understanding of the development of self-stigma; if people who self-injure are exposed to stigmatising attitudes through mass media, these attitudes may be internalised, contributing to self-stigma. While media representations of self-injury are beginning to be explored (e.g., movies; Trewavas et al., 2010, online; Brown et al., 2018; Lewis & Seko, 2016), more work in this area is needed.

Investigating if media messages about NSSI translate into attitudes and beliefs at a community level will be an important next step, if we are to understand the extent of public NSSI stigma and how it develops and functions. While some research has investigated public attitudes towards NSSI (Law et al., 2009; Lloyd et al., 2018; Nielsen & Townsend, 2018), important constructs (e.g., aesthetics, peril, concealability) may not be captured within the attribution-affect framework used, leaving facets of NSSI stigma uninvestigated. Other research (e.g., Newton & Bale, 2012) has focused on self-harm more broadly, which tends to encompass both suicidal and nonsuicidal actions, meaning a clear picture of NSSI stigma

cannot emerge. To understand, and ultimately reduce NSSI stigma, research with the general community needs to be informed by questions specific to NSSI that draw on the complexities discussed here, and focus on constructs relevant to self-injury, such as aesthetics, peril, and concealability.

Explicitly exploring the experiences of NSSI stigma for people with a history of self-injury is vital. While stigma experiences have emerged in other work (e.g., Mitten et al., 2016), these findings are ancillary and limited in scope. Understanding which stigma constructs are most salient for people who self-injure can inform directions for future research. From this we can also gain a better understanding of the differentiation between self, enacted, and anticipated stigma for people with lived experience, and how each may be associated with outcomes such as support-seeking, recovery, and self-esteem. Additionally, the development and evaluation of efforts to reduce NSSI stigma will need to occur. Programs designed to improve attitudes toward self-harm have demonstrated efficacy for nurses (Gibson et al., 2019), and the utility of NSSI-specific stigma reduction programs should be investigated.

Conclusion

The model proposed by Jones et al. (1984) provided a conceptually sound and empirically supported scaffold for us to build upon in the context of NSSI (Pachankis et al., 2018). By considering how the constructs of NSSI stigma manifest at various levels (i.e., public, enacted, self, and anticipated), we have proposed a multi-level framework that encourages a holistic investigation of NSSI stigma. The growing awareness of intersectional stigma (Turan et al., 2019) points to the importance of considering multiple facets of a single stigma experience, and there is scope to introduce additional layers of complexity to this framework, such as the influence of culture or gender on NSSI stigma.

This framework may also have utility beyond a research context. While there are some interventions available to address self-stigma of mental illness (Corrigan & Rao, 2012), this framework may provide guidance as to where clinicians could direct attention when working with clients who have self-injured. An understanding of how anticipated and self-stigma influence lived experience may therefore inform better outcomes for people with lived experience of self-injury seeking therapeutic support. Additionally, this framework may be able to inform the reduction of stigma. While educational programs exist to reduce NSSI stigma in a medical context (e.g., Gibson et al., 2019), addressing the specific constructs underlying NSSI stigma may yield more efficacious stigma reduction efforts that could be broadened to the wider public.

Despite the multifarious impact of stigma, research investigating and addressing NSSI stigma is lacking. Given the sparse nature of this research, we have a unique opportunity to establish a theoretically grounded foundation that can guide meaningful research questions. By incorporating robust conceptualisations of stigma, the framework we have presented offers a holistic approach that illuminates both procedural and experiential facets of NSSI stigma. We hope that this paper acts as a call-to-action for fellow researchers interested in improving the lives of people with lived experience of NSSI.

Chapter 3

Crazy, Weak, and Incompetent: A Directed Content Analysis of Self-Injury Stigma Experiences

In the previous chapter, I proposed an empirically informed and theoretically grounded framework through which to understand and investigate self-injury stigma. While the framework was developed based on existing research and an integration of existing stigma models, the applicability of the framework to lived experiences of self-injury stigma was unknown. In this chapter, I apply the NSSI Stigma Framework to a set of responses to open-ended questions relating to stigma, using a directed content analysis. This chapter provides preliminary evidence for the applicability and utility of the NSSI Stigma Framework in conceptualising NSSI stigma.

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Attributions

Author	Contribution	Acknowledgement
Lexy Staniland	Development of research question and methodology, data management and analysis, interpretation of results, and manuscript preparation	
Penelope Hasking Stephen Lewis Mark Boyes	Assisted with development of research question, interpretation of results, and manuscript preparation	
Sylvanna Mirichlis	Assisted in data analysis, and establishing inter-rater reliability	
Permission for inclusion can be found in Appendix B.		

Abstract

Despite significant impacts to mental health and support-seeking, nonsuicidal self-injury (NSSI) stigma remains under-studied and poorly understood. Recently, Staniland et al. (2021) conceptualized NSSI stigma as comprising six constructs (origin concealability, course, peril, aesthetics, disruptiveness) that manifest across four perspectives (public, self, anticipated, enacted). The present study investigates the extent to which this framework can account for individuals' NSSI stigma experiences using a directed content analysis. Written responses from 99 university undergraduates (Mage = 21.5, SD = 3.7; 83.8% female) generated 731 data units for analysis, of which 299 (40.9%) were coded.

Results demonstrated support for the public and enacted contexts, with participants describing stigma experiences within friendships, families, schools, and workplaces. Data pointed to both direct and indirect experiences of public stigma, suggesting a more nuanced understanding of this context is required. While there was sufficient support for a majority of elements, more work is needed to verify the applicability of the self and anticipated contexts. Our findings contribute to a growing body of research investigating NSSI stigma and provide preliminary support for the utility of the NSSI Stigma Framework in identifying multiple facets of NSSI stigma. Implications for intervention and future research are discussed.

Introduction

Nonsuicidal self-injury (NSSI) is the intentional, self-directed damage done to one's own body without suicidal intent (ISSS, 2022), and can take many forms, including skin cutting or burning, breaking bones, and self-battery, excluding socially (e.g., piercing) or religiously (e.g., self-flagellation) sanctioned practices (ISSS, 2022). NSSI is relatively prevalent, with 17.2% of adolescents, 13.4% of young adults, and 5.5% adults reporting lifetime prevalence (Swannell et al., 2014), and is engaged in for both intrapersonal (e.g., emotion regulation) and interpersonal reasons (e.g., signaling distress; Klonsky & Olino, 2008). Notwithstanding potential physical damage, NSSI is associated with mental illness and heightened psychological distress, and is a reliable predictor of suicidality (Kiekens et al., 2018). As such, it is important that people who have self-injured feel comfortable and able to access physical, psychological, and/or social support. Unfortunately, most people do not voluntarily disclose their NSSI (Simone & Hamza, 2020), with stigma cited as a significant barrier to disclosure (Staniland et al., 2021).

NSSI Stigma

Stigma is a social construct comprising the stereotype, prejudice, and discrimination of characteristics, conditions, and behaviors deemed socially unacceptable (Goffman, 1963). Conditions and behaviors of psychological origin are often subject to greater stigma than those of physical origin due to perceptions that they are controllable and, therefore, the fault of the individual experiencing them (Pachankis et al., 2018). Such is the case for mental illness (Michaels et al., 2012) and associated behaviors, such as alcohol and drug dependence (Corrigan, Kuwabara, et al., 2009; Schomerus et al., 2011), sexual deviance (Jahnke & Hoyer, 2013), and self-injury (Staniland et al., 2021).

Stigma is galvanized by misconceptions (Link & Phelan, 2001), and in the context of self-injury, these typically relate to who engages in the behaviour and why. For example, a pervasive belief is that NSSI is a form of attention-seeking (Wadman et al., 2017) or manipulation (Sandy, 2013), despite extensive evidence to the contrary (Taylor et al., 2018). Other misconceptions include that NSSI is always suicidal (Kumar et al., 2004), a phase people will "grow out of" (Klonsky et al., 2014), or isolated to teenagers (Hughes et al., 2017), girls/women, or people with mental illness (Lewis et al., 2014).

Despite a paucity of research directly investigating NSSI stigma, qualitative accounts of self-injury experiences often feature themes reflecting NSSI stigma (Hodgson, 2004; Long et al., 2015; Mitten et al., 2016), which is described as a significant barrier to support-seeking (Chandler, 2014; Long, 2018), fomenting shame (Lesniak, 2010) and social isolation

(Rosenrot & Lewis, 2018), potentially increasing frequency and severity of NSSI (Bachtelle & Pepper, 2015). The frequency with which stigma features in these narratives suggests it is a salient and important factor in lives of people who have self-injured. Despite this, only recently has there been an effort to theoretically conceptualize NSSI stigma.

The NSSI Stigma Framework

The NSSI Stigma Framework (Staniland et al., 2021) captures the unique ways in which NSSI stigma emerges, providing a template through which NSSI stigma can be identified, described, and explained. Drawing on two theoretical approaches, the framework is a matrix of intersecting components (Table 3.1). On the left side of the framework, six domains are proposed to underlie NSSI stigma. Drawn from work by Jones et al. (1984), these domains are the constituents of NSSI stigma and identifying what it is about self-injury that leads to stigma.

Origin relates to the onset of NSSI and deals with perceptions and beliefs about why a person has self-injured and who or what should be 'blamed' for it. Perceptions of responsibility lead to blame (Weiner, 1995), and this may inform misconceptions (e.g., that self-injury is manipulative), and discrimination (e.g., withholding treatment). Concealability relates to the visibility of NSSI, with greater visibility argued to lead to greater potential for stigmatization. Course relates to how self-injury changes over time, and includes genuine change as well as perceived and expected changes; for example, the assumption that only teenagers self-injure may inform the expectation that self-injury should cease in adulthood. Peril refers to the perceived lethality of self-injury and captures the paradoxical perceptions that self-injury is both insignificant (e.g., something an individual will 'grow out of') and highly dangerous (e.g., associated with suicide). Aesthetics refers to the subjective appearance of self-injury, with appraisals informing stigmatization. Lastly, disruptiveness refers to the degree to which self-injury impacts relationships. This domain is the least explicit and may differ in relevance depending on the condition or behavior of interest (Jones et al., 1984). In the context of NSSI, disruptions to relationships may arise because of NSSI stigma, rather than stigma arising due to disruptive qualities of NSSI. Across the top of the framework are four contexts within which NSSI stigma may manifest. Drawing on work by Corrigan and Watson (2002) and Quinn and Chaudoir (2009), it is proposed that stigma occurs at the public level (attitudes and beliefs held by the general public), at the self-level (internalization of public stigma), at the enacted level (actions and experiences driven by stigma), and at the anticipated level (expectations of enacted stigma).

Table 3.1
The NSSI Stigma Framework

	Public Stigma	Self-Stigma	Enacted Stigma	Anticipated Stigma
Origin	People who self-injure are just attention seeking.	I feel ashamed for needing to self-injure.	You are just an attention seeker.	I am worried people will think I am attention-seeking.
Concealability	People should not have their self-injury on display.	I must hide my self-injury from others.	You should cover your self-injury.	I cover my self-injury so others won't comment on it.
Course	People who self-injure should just stop doing it.	I am weak for continuing to think about self-injury.	Just stop self-injuring, it's that simple.	I am worried my scars will make people think I am still self-injuring.
Peril	Self-injury is definitely suicidal, even if the person doesn't realise it.	I don't want to end my life, so why am I self-injuring?	I don't believe you when you say you aren't suicidal, so we are sectioning you.	If I talk about my self-injury, people will assume I am suicidal.
Aesthetics	Self-injury is disgusting to look at.	My scars are disgusting to look at.	Wow, your scars are so gross.	I am worried about what people will say or think about my scars.
Disruptiveness	People who self-injure are wasting hospital resources.	I don't deserve medical help for this injury.	My mum said I can't be friends with you anymore because you self-injure.	I am worried that people will reject me if they find out I self-injure.

Note. From "Stigma and Nonsuicidal Self-Injury: Application of a Conceptual Framework" by Staniland et al., 2020.

While the NSSI Stigma Framework (Staniland et al., 2021) is theoretically and empirically grounded, the degree to which it can account for experiences of NSSI stigma has yet to be investigated. Using a directed content analysis (Hsieh & Shannon, 2005) of open-ended responses to an online questionnaire, we examined the extent to which the framework could account for university students' descriptions of NSSI stigma experiences. A directed content analysis is a deductive analytical approach using the proposed variables of a conceptual framework as coding categories (Hsieh & Shannon, 2005). Data is coded according to these categories to investigate the applicability of a framework to a set of data. In the present study, the 24 cells (6 domains x 4 levels of stigma) of Staniland et al.'s NSSI Stigma Framework formed 24 coding categories, which were used to code participants' data, allowing assessment of the framework's applicability.

Method

Measures

Participants completed a battery of measures and open-ended questions related to various NSSI and mental illness experiences. Only the measures used in the present study are reported here.

Demographics

Participants were asked to report their age, sex, whether they had a mental illness diagnosis, and if so, what the diagnosis was.

NSSI

The Inventory of Statements About Self-Injury (ISAS; Klonsky & Olino, 2008) was used to measure NSSI. This measure has good construct validity and test-retest reliability (r = .85), and asks participants whether they have ever self-injured, what their primary form of self-injury was/is, how often they self-injured during the past year, and at what age they first and most recently self-injured.

Stigma Experiences

Participants who reported a mental illness diagnosis or history of self-injury were asked whether they had experienced stigma related to their mental illness or self-injury. Those who answered 'yes' were invited to describe that experience by typing their response into a textbox with no character limit. All participants were asked whether they had overheard people talking about self-injury in a way that made them feel uncomfortable, angry, or upset. Those who answered 'yes' were invited to describe what they overheard, how it made them feel, and how they responded. All participants were asked whether anyone had ever said anything to them directly about self-injury that made them feel uncomfortable, angry, or

upset. Those who answered ‘yes’ were invited to describe what had been said to them, how it made them feel, and how they responded.

Procedure

After obtaining ethical approval (Appendix C) the study was advertised to an undergraduate psychology research participation pool. All students were eligible to participate, regardless of their personal experiences with mental illness or self-injury. Interested participants were directed to an information sheet on Qualtrics outlining participants’ rights and requirements. Participants provided consent by checking a box that routed them to the questionnaire. Part of a larger project about experiences with NSSI and mental illness the questionnaire took approximately 60 minutes to complete and course credit was awarded for participation.

Participants

Of the 239 university students who responded to the Qualtrics survey, 25 completed less than 75% of the survey and 60 did not respond to any of the open-ended questions of interest; these responses were removed. The final sample comprised 149 participants, aged 17-52 years (M = 22.31, SD = 5.31), with 116 females (77.9%), 24 males (16.1%), and two of another sex (1.0%). One-hundred and two (68.5%) participants reported a mental illness diagnosis, with the most common being comorbid anxiety and depression (n = 38, 37.3%). Reported age of NSSI onset ranged from three[2] to 41 (M = 13.50, SD = 3.68), with 13 being the most common. The most common form of self-injury was cutting (n = 82), followed by self-battery (n = 20). Most participants reported self-injuring within the last year between one (n = 19) and five or more times (n = 36).

Data Analysis

Data were exported from Qualtrics into SPSS for cleaning, and analysis of descriptive data. Each participant was assigned an identification code (e.g., P110) and their text responses to the open-ended questions were exported to Microsoft Excel. Each response was then segmented into units of codable data, which were interpreted in context before being quantitatively accounted for within the relevant framework element (see Table 3.2 for examples).

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[2] Documented age of onset tends to range between 12 and 16 years (Gholamrezaei et al., 2015), however, self-injury has been recorded among children as young as 3 years (Luby et al., 2019). It is possible that a response of *3* may have been in error (i.e., meant to be *13*), however, this cannot be known for sure. Therefore, participants’ responses are reported as they were entered into the survey.

A 'data unit' represents a shift in meaning within a sentence or statement (Campbell et al., 2013). A single sentence may comprise multiple sections of meaning that are distinct from one another in terms of how they contribute to an understanding of self-injury stigma. Take the following response for example, "They said the person who self-harmed was an idiot and just wanted attention". Here, "idiot" meaningfully differs from "just wanted attention" and should be separately codable; therefore, this response was segmented into two data units, each representing a piece of information that was distinct and whole in its meaning. Data units were identified within each response using brackets, allowing retention of the context from which the data unit was derived. A participant's responses across questions were considered in combination, meaning that interpretations could be informed by a participant's responses to the other open-ended questions. A data unit could be coded to multiple elements. The fourth example in Table 3.2 depicts an instance of this, whereby the data unit "suck it up and be stronger" captured the perception of self-injury as controllable and changeable (course) and the implication that a lack of strength is the reason for self-injuring (origin). Participants' responses were analysed verbatim, with errors in spelling and grammar retained.

Eight cases were used to operationalize the rubric, and two authors, one naive to the framework prior to undertaking analysis (Kolbe & Burnett, 1991), cross-coded 14 (10%) randomly selected cases in a stepwise manner (O'Connor & Joffe, 2020). Intercoder reliability was first assessed using Cohen's Kappa (κ; Cohen, 1960), calculated with the *irr package* for R (version 0.84.1; Gamer et al., 2019). Despite high percentage agreement, intercoder reliability remained low after round three of cross-coding, likely due to the Kappa paradox (Feinstein & Cicchetti, 1990). Gwet's first-order agreement coefficient (AC_1; Gwet, 2008), calculated with the *irrCAC package* for R (version 1.0; Gwet, 2019), was subsequently used and demonstrated high agreement. The lead author coded the remaining 99 cases.

Findings

Each of the 99 participants yielded between 0 and 55 (M = 7.31, SD = 7.86) data units, totalling 731 units for analysis. Each of the 85 (85.9%) participants whose data was coded into the framework contributed between 1 and 29 (M = 3.02, SD = 4.06) data units to the framework (see Tables 3.3 and 3.4).

Table 3.2

An Example of the Analytic Process

Response	Data Units	Code
The few close family members that found out I self-harmed reacted quite poorly. I was patronised and treated as if I was unpredictable or incapable. The experience was frustrating and made it extremely unlikely for me to tell anyone else.	[The few close family members that found out I self-harmed reacted quite poorly.]	Enacted Stigma - Disruption
	[I was patronised]	Enacted Stigma - Disruption
	[and treated as if I was unpredictable or incapable]	Enacted Stigma - Peril
	[The experience was frustrating]	Not coded.
	[and made it extremely unlikely for me to tell anyone else.]	Anticipated Stigma - Concealability
In High School, some of my friends were talking about someone else in our year who openly self-harmed. They were unaware I had experience with NSSI. They were talking about how she only did it for attention and had nothing to truly be sad about.	[In High School, some of my friends were talking about someone else in our year who openly self-harmed.]	Not coded.
	[They were unaware I had experience with NSSI.]	Not coded.
	[They were talking about how she only did it for attention]	Public Stigma - Origin
	[and had nothing to truly be sad about.]	Public Stigma - Origin
This made me feel frustrated, isolated and misunderstood. I knew if people reacted to others in that way then I could never disclose my NSSI.	[This made me feel frustrated,]	Not coded.
	[isolated]	Not coded.
	[and misunderstood.]	Not coded.
	[I knew if people reacted to others in that way then I could never disclose my NSSI.]	Anticipated Stigma – Concealability
That I should suck it up and be stronger and not attention seeking	[That I should suck it up and be stronger]	Enacted Stigma – Origin & Course
	[and not attention seeking]	Enacted Stigma - Origin

Public NSSI Stigma

Origin

Origin was the most prevalent domain in the public stigma level, with common references including that people who self-injure are attention-seeking, weak, cowardly, pathetic, stupid, silly, a freak, or crazy. Four responses related to perceived legitimacy of NSSI. For example, Participant 149 described, "*They were talking about how she only did it* [self-injured] *for attention and had nothing to truly be sad about*", and Participant 91

reported overhearing, "*self-injury is weak… people do it for no reason*." Further responses related to responsibility and blame, as evidenced by Participant 59 who overheard, "*they brought it on themselves*" and Participant 65 who overheard, "*It's the fault of the person themselves*." NSSI stereotypes were also present in participants' responses, with common NSSI myths evident. For example, the myth that only teenage girls self-injure was captured by Participant 127 who overheard, "*I swear self harmers are just angry 14 year old girls dying for attention*", and Participant 145 who overheard "*a joke about girls who 'act depressed, have a tumblr and slit their wrists'*." Likewise, the myth that people who self-injure belong to emo subgroups was evident in Participant 34's response: "*The 'emo' stereotype was commonly used throughout my highschool years by many of my peers, insinuating that self-injurers were within that group*."

Taken together, data units relating to NSSI origin captured (inaccurate) ideas about who self-injures and why. Attributions of responsibility were apparent, whereby perceptions that self-injury is a choice appeared to inform blame, and assumptions that self-injury is attention-seeking, or a sign of weakness appeared to inform dismissal. Blame and dismissal may legitimize stigmatizing responses.

Concealability

The data unit coded to concealability was provided by Participant 18, who wrote that someone had been "*mocking a person for having scars*." The visibility of NSSI scarring may give rise to stigma.

Course

The course domain captured assumptions that NSSI is transitory or that it can be easily stopped. Participant 59 overheard someone say that self-injury is "*just a phase*", Participant 100 overheard, "*They can stop if they want*", and Participant 65 overheard that people who self-injure "*just need to get over it*." These responses suggest that people have limited understanding of the function of self-injury, viewing it as a trivial behaviour that warrants dismissal, rather than as a strategy for dealing with difficult experiences. While these responses reflect minimization of self-injury, assumptions that self-injury leads to suicide were also evident. Participants 21, 97, and 119 reported overhearing variations on the comment that people who self-injure should "*just kill themselves*", with Participant 110 also overhearing, "*they're just cowards who can't reach for help or go all the way*." These statements may relate to an assumption that self-injury is a precursor to suicide.

Table 3.3
Quantitative Results from Directed Content Analysis

	Public Stigma		Self-Stigma		Anticipated Stigma		Enacted Stigma			
	Sum	*n*	Sum	*n*	Sum	*n*	Sum	*n*	Total Domain Units	Total *n* at Domain
Origin	77	57	8	6	4	3	60	33	149	73
Concealability	1	1	0	0	15	10	26	13	43	21
Course	13	9	2	1	2	2	10	7	27	20
Peril	18	14	0	0	0	0	15	10	33	28
Aesthetics	1	1	0	0	2	1	6	6	9	7
Disruption	1	1	2	2	2	1	33	18	38	24
Total	111	67	12	7	25	12	150	48		

Note. Sum = the sum of data units coded to the element, *n* = number of participants providing a data unit at the element. Total *n* = number of unique participant contributions.

Table 3.4

Qualitative Results from Directed Content Analysis

	Public Stigma	Self-Stigma	Anticipated Stigma	Enacted Stigma
Origin	"that if you cut, you're mentally crazy"[P136] "I swear self harmers are just angry 14 year old girls dying for attention"[P127] "People who hurt themselves are weak"[P131]	"I felt even worse about my Non-Suicidal Self Harm"[P110] "... questioning whether I was 'supposed' to be in that stereotype"[P34] "Ashamed"[P137]	"... I don't want to be seen as weak or incompetent"[P89] "… because I would be met with the same judgement"[P147]	"Comments from my mother about being untrustworthy delusional and incapable"[P149] "Yeah, you're only doing it for attention"[P122] "That I'm weak"[P43]
Concealability	"Mocking a person for having scars"[P18]	-	"They made it very awkward to reveal that I applied to a group that they were bashing, and insulting."[P111] "I could never possibly disclose my history of self-harm, because I would be met with the same judgement"[P147]	"That's disgusting."[P34] "Don't do that to yourself, imagine if your great-grandmother saw that"[P77] "Some people think because my scars are visible it's a green card to bring it up"[P89]
Course	"They can stop if they want"[P100] "They just need to get over it"[P65] "It's just a phase"[P59]	"Suddenly I thought that I was worse for not going 'all the way" to suicide."[P110]	"the only concern I have is in my career/professional life…"[P89] "... thinking about how upset my [family] would get… I really considered stopping the self-harm for good"[P77]	"That I should just stop cutting"[P43] "That I should suck it up and be stronger"[P71] "Oh my god not again… just stop it"[P89]

Peril	"assuming every self injury is an attempt to comit [*sic*] suicide "[P16] "people joking about slitting wrists][P47] "... treat it as if it was nothing"[P98]	-	-	"... stating to my face that I 'should have tried a bit harder to kill myself', adding that I 'clearly didn't do a good enough job'."[P34] "I was called immature"[P85] "... they were worried I would hurt them"[P110]
Aesthetics	"... and the scars it leaves are unattractive"[P118]	-	"worried about the image it [NSSI scars] might portray will be unprofessional or undesirable." "I worry about my scars in professional situations"[P89]	"They said it was disgusting"[P56] "Why would you ruin your arms like that"[P89] "just looks of disgust when they see scars"[P145]
Disruptiveness	"… that they didn't deserve sympathy."[P110]	"it made me feel worse about myself"[P138] " I felt even worse about my Non-Suicidal Self Harm" [P110]	"[I felt] like I could never say anything"[P130] "The harsh responses don't encourage me to open up to them."[P110] "... it made me realise that i couldn't trust [them] with vulnerable information about myself"[P88]	" told that I'm a waste to taxpayer dollars presenting at emergency for severe self harm requiring stitches."[P28] "Mum told me… it would be unfair for me to marry anyone."[P33] "they acted like I was a burden to them"[P89]

Peril

The peril domain captured the paradoxical perceptions that NSSI is both dangerous and insignificant. While Participant 21 overheard, "*If you're going to kill yourself, just do it, don't do a half arsed job*" and Participant 16 described, "*assuming every self injury is an attempt to comit [sic] suicide and saying 'they're doing it wrong'*," other participants overheard "jokes" or minimizing statements such as that reported by Participant 47: "*People are constantly joking about slitting their wrists if anything goes wrong.*" The assumption that NSSI is a suicide attempt may inadvertently foster dismissal. While counter-intuitive, this is apparent in the comment that NSSI is a "half arsed job" of suicide. The impact of dismissal was conveyed by Participant 98, who felt "*negative emotions when people wave off self-injury or treat it as if it was nothing*."

Aesthetics

Only one data unit was coded into the aesthetics domain at the public stigma level, which was provided by Participant 118, who overheard someone say that "*the scars it* [NSSI] *leaves are unattractive.*" Assessment of the aesthetic appearance of scarring likely inform NSSI stigma.

Disruptiveness

The only data unit coded in the disruptiveness domain at the public stigma level was provided by Participant 110, who overheard someone's opinion that people who have self-injured "*didn't deserve sympathy*". This speaks to the way in which NSSI stigma can manifest as disruption to relational care.

Self NSSI Stigma

Origin

Self-stigma related to participants' reactions to hurtful things said about NSSI, and included descriptors such as ashamed/shame, embarrassed, worthless, and guilty. While these types of descriptors are presented as examples of self-stigma in the NSSI Stigma Framework, it was rarely possible to determine whether they represented self-stigma for our participants. In the few instances that the phrase "*ashamed*" was categorized, the shame described clearly related to a stigmatizing experience, as evidenced by Participant 137, who described feeling "*ashamed*" after being told, "*I was attention seeking… that I was looking for attention*". While this participant's sense of shame does not necessarily reflect an internalization of the belief that the origin of NSSI is attention-seeking, it fits within the Framework that shame, guilt, and embarrassment represent an individual's thoughts and/or feelings about the origin of their own NSSI (Staniland et al., 2021).

Applying NSSI stereotypes to oneself may also reflect origin-related self-stigma. This was evident in Participant 34's response to being frequently described as *emo:* "*I was the furthest from said stereotype in every other sense and was internally invalidated on a regular basis, questioning whether I was 'supposed' to be in that stereotype due to my self-injury*." Persistent stereotyping appeared to foster doubt for this participant, who may have experienced confusion regarding the origin of their own self-injury as a result.

Concealability

No data units reflecting concealability were coded at the self-stigma level.

Course

Data units coded at course reflected internalization of a belief that NSSI is a "failed" suicide attempt. In response to overhearing people say, "*those who self harmed* [are] *'weak' and 'cowards' because they didn't have the guts to kill themselves*," Participant 110 wrote, "*Suddenly I thought that I was worse for not going 'all the way' to suicide. I was oddly stuck between being pathetic enough to self-harm but not good enough to commit suicide*." Misconceptions related to the course and peril of NSSI appear to foment confusion and negative self-perceptions.

Peril

No data units reflecting peril were coded at the self-stigma level.

Aesthetics

No data units reflecting aesthetics were coded at the self-stigma level.

Disruptiveness

Disruptiveness represented impact to participants' self-perceptions, as evidenced in Participant 110's response, "*I felt even worse about my* [NSSI]", and Participant 138's description that an overheard comment "*made me feel worse about myself*." NSSI stigma appeared to disrupt relationship with self, demonstrating how this domain represents outcomes of stigma rather than reasons for it.

Anticipated NSSI Stigma

Origin

One response comprising two data units was coded into the origin domain at the anticipated stigma level, provided by Participant 89: "*I don't want to be seen as weak or incompetent*". This response captures concern with the potential responses of others, who may hold assumptions regarding the origin of NSSI – that it is isolated to people who are "weak" or "incompetent". Another participant described concern disclosing their self-injury

"*because I would be met with the same judgement*." Here, the participant appears to be anticipating how others may interpret the origin of their self-injury.

Concealability

Concealability was the most prevalent domain within the anticipated stigma level, evidenced in participants' choices about where on their body to injure, what clothes to wear, and who to disclose NSSI to. Injuring concealable parts of the body may be motivated by avoiding the "attention-seeker" label, as evidenced by Participant 83 who wrote that remarks about NSSI being attention seeking "*made me sad because I have done it but no one knew about it so it obviously wasn't for attention* [I] *would do it in covered places*." Avoidance of stigma was also apparent in Participant 122's response: "*I came in to work one day wearing a jacket as I had self injuries (cuts) on my arms*." While not explicitly stated, it may be inferred that wearing a jacket (and therefore concealing NSSI) was informed by anticipated stigma. After removing their jacket, the manager "*saw my arms, she said 'Oh why do you have that? Are you crazy?'*" – a stigmatizing response the participant was likely trying to avoid by concealing their self-injury.

Regarding self-injury disclosure, hurtful comments may impact whether individuals feel they can talk about their self-injury or seek help. Participant 89 described, "*I have not experienced the stigma directly but I've seen it play around me so I try to keep things hidden in such situations*", and Participant 149 explained that comments about another's self-injury "*made me feel frustrated, isolated and misunderstood. I knew if people reacted to others in that way then I could never disclose my NSSI*." Experiences of stigma also informed future disclosure, as described by Participant 147, who, after negative responses from their parents, "*hid my self-harm*[3] *from everyone else to avoid judgment*." In these examples, participants chose to conceal their NSSI in anticipation of being stigmatized.

Course

Course related to expectations of stigma regardless of NSSI continuation or cessation, as evidence by Participant 89: "*the only concern I have is in my career/professional life*" and Participant 77, who "*considered stopping the self-harm for good*" when reflecting on "*how upset my [family] would get*." Anticipated responses may inform consideration of NSSI continuation, or prompt concern about future responses to past NSSI.

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[3] While the term "self-harm" may refer to both suicidal and nonsuicidal behaviors, it tends to be used to refer to non-suicidal self-injury in Australia.

Peril

No data units reflecting peril were coded into the anticipated level.

Aesthetics

Aesthetics at the anticipated domain appears linked with course, whereby concern about how NSSI scars may impact future experiences was reported. Participant 89 described they were "*worried about the image it [NSSI scars] might portray will be unprofessional or undesirable*."

Disruptiveness

Overlap between concealability and disruptiveness was apparent, with concealment possibly driven by fear of disruption to relationships. In response to overhearing their father state to their brother, "*It's not like you're cutting yourself*", Participant 130 described that they felt "*Lost, judged, like I could never say anything*," a response that reflects anticipated disruption to the relationship with their father if they disclosed their self-injury. Therefore, this response captures NSSI concealment due to anticipated disruptiveness. The two additional units centered on lost trust following a stigmatizing experience. After a close friend said that people who self-injure "*didn't deserve sympathy*," Participant 110 felt "*heartbroken because I thought this individual was someone I would eventually trust enough to disclose my self harming*" and Participant 111 described that "*harsh responses don't encourage me to open up to them*." While overlap with concealability is present (both participants refer to concealment), these responses focus on interpersonal impacts, thereby representing disruptiveness.

Enacted NSSI Stigma

Origin

Origin was the most prevalent domain at the enacted stigma level, emerging across various contexts, including the medical system, workplace, friendship groups, and the family. Hurtful comments centred on reasons for NSSI, or assumptions made based on NSSI history, including attention seeking, being crazy, weird, weak, incapable, stupid, manipulative, or lying. An assumption of attention-seeking was described by Participant 28, who described that mental health professionals "*focused on my self destructive behaviour as though I wanted attention*", pointing to potential misunderstanding of NSSI origins manifesting as inappropriate treatment of people seeking support. Participants also described being perceived as incapable due to their self-injury, as evidenced by Participant 147, whose parents "*automatically assumed I couldn't be trusted and that I wasn't capable,*" and Participant 30, who described that, "*I have had people assume I can't do stressful tasks after*

they've seen my scars". While "incapable" was not operationalized, participants may be referring to perceptions of incompetence or instability.

Perceptions of instability were also evident in responses related to mental health. Participant 33 relayed that "*Mum told me I was fucked in the head*", Participant 122 explained that "*people at work or my family thought that I was crazy*", and Participant 147 described her parents saying, "*oh she's self harming, she's completely lost it then*." These examples reflect an assumption that self-injury originates from or reflects mental instability. Paradoxically, participants also relayed experiences whereby their self-injury was not believed or was perceived as unwarranted. Participant 81 was asked "*why do you need to seek attention by hurting yourself?*", Participant 147 was told "*I didn't have enough bad things going on in my life to warrant it* [NSSI]", and Participant 122 was told, "*Yeah, you're only doing it for attention. Stop pretending something's wrong with you*." Within an assumption that self-injury represents a particular type of person or experience, it can be disbelieved or minimized.

Concealability

This domain often related to responses received when another person had seen evidence of their self-injury. Participant 88 described that "*they saw the cuts on my thigh and got angry*" and in Participant 34's experience, the visibility of their self-injury scars led to the following exchange on public transport:

> *The mother looked at my arm (with a couple of scars exposed due to my sleeve rolling up without my knowledge) and got my attention... She then proceeded to give me an angry look and say (quite loudly): That's disgusting; you really shouldn't be out in public with 'those' (pointing to my arm) exposed. It sends the wrong messages to children; what gives you the right to show something like that to innocent kids?*

The mother's statement taps into many domains of stigma but most clearly represents concealability due to her expression that NSSI scars should be concealed.

Course

The course domain captured assumptions about NSSI recovery, representing ideas about how self-injury should be stopped. Participant 43 described being told "*That I'm weak and I should just stop cutting*", and Participant 71 described that they were told "*I should suck it up and be stronger*". The assumption that self-injury should "just be stopped" reflects an expectation that the course of NSSI should (and can) be easily halted, which ignores lived experience perspectives of recovery (Lewis & Hasking, 2021). In contrast, Participant 136

wrote that someone had demanded, "*do it again, right in front of me*," perhaps to force proof of self-injury. It is possible that course captures complex and conflicting perceptions about changes in self-injury over time.

Also relevant to course is a consideration of how self-injury scars may elicit stigma, regardless of whether self-injury is past or present. This was evidenced in Participant 89's descriptions that living with self-injury scars means "*People don't realise I'm recovered*", and Participant 130's description that "*People who have been about to have sex with me have stopped because of it* [scarring]*, which is fair because consent is important, but also rude because my scars are an unfortunate part of my past*." These experiences demonstrate the ongoing nature of NSSI stigma, whereby residual NSSI scarring can lead to stigmatization despite self-injury cessation.

Peril

Perceptions of danger, suicide, or insignificance reflected the peril domain. Danger appeared in experiences of avoidance or ostracization due to self-injury, such as that described by Participant 110: "*I've been excluded from otherwise lovely friend groups because they were worried I would hurt them or 'lure' them into being mentally ill*." Such exclusion may be driven by an assumption that self-injury is "contagious", representing danger to others. Danger also emerged in perceptions of being "untrustworthy", as evidenced by Participant 147, whose parents "*automatically assumed I couldn't be trusted*" which may reflect a belief that people who have self-injured are perilous toward themselves and others.

The misconception that all self-injury is suicidal was also apparent, as evidence by Participant 30: "[people] *stating to my face that I 'should have tried a bit harder to kill myself', adding that I 'clearly didn't do a good enough job'*." Paradoxically, other participants described being minimized or dismissed due to their self-injury. Participant 85 described being called "*immature and told I needed to be more resilient*", and Participant 98 was told "*That I was just being stupid, and a child*." These examples may reflect a belief that NSSI is non-significant, contradicting the perception that NSSI is suicidal.

Aesthetics

Participants described experiences of aesthetic evaluation of their scars, often hearing that NSSI scars are "*disgusting*". Participant 89 was asked, "*Why would you ruin your arms like that?*", with an apparent assumption that self-injury scars irreversibly damage one's appearance. Additionally, Participant 133's description of being told, "[you] *don't look like someone that suffers a mental illness, and would resort to self-injury*" was coded to aesthetics, capturing expectations regarding the appearance of someone who self-injures.

Disruptiveness

Disruptiveness was evident in descriptions of responses to self-injury, such as Participant 147's experience: "*my parents responded negatively when they found out I self-harmed. It impacted my relationship with them a lot. They had preconceptions about me that led to a loss of trust*." Participant 149 relayed a similar experience, "*The few close family members that found out I self-harmed reacted quite poorly. I was patronised*", as did Participant 33, being told by their mother that "*it would be unfair for me to marry anyone*." Across these cases, the discovery of self-injury co-occurred with a disruption to the relationship.

Beyond the family, disruption was also evident in friendships. Participant 113 described, "*i feel like people talk to me or act towards me as if theyre walking on eggshells, i feel like they treat me differently when i tell them that i have self-injured*," and Participant 127 wrote, "*Once people found out I self-harmed, they acted differently around me and were almost scared to talk to me*." Misconceptions about self-injury may underlie disruption to relationships.

Uncoded Data

Of the 731 data units, 455 (62.2%) were not coded. To investigate whether patterns among the uncoded data indicated a need to modify the framework, a post-hoc exploration of these data was conducted. A large proportion (n = 212, 46.6%) of the units were directly related to emotion, which were organized according to the classifications outlined by Parrot (2001), leading to 72 indications of anger, 114 of sadness, 18 of fear, and 7 that were unclassified (e.g., awful, horrible; Table 3.5). "Angry" was the most reported emotion (n = 40), and participants sometimes provided an explanation regarding their anger. For example, Participant 22's response to overhearing someone say that self-injury is "stupid" was: "*Frustrated and angry at their uneducated opinion and lack of understanding*." Righteous anger has been described by Corrigan and Watson (2002) as an empowering emotion in the context of mental illness stigma. The same may be true for people faced with self-injury stigma and these responses speak to an avenue for further investigation.

While the emotions reported by participants provide insight into the impact of NSSI stigma, the NSSI Stigma Framework (Staniland et al., 2021) does not intend to account for stigma outcomes. Therefore, this data did not serve to extend the framework.

Table 3.5
Uncoded Data Patterns

Primary Emotion	n	Secondary Emotion	n	Tertiary Emotion	n
Anger	72	Irritation	8	Irritated	1
				Annoyed	7
		Exasperation	14	Frustrated	14
		Rage	48	Angry	40
				Mad	4
				Infuriated	3
				Resentful	1
		Disgust	2	Disgusted	2
Sadness	114	Suffering	8	Hurt	7
				Heartbroken	1
		Sadness	38	Sad	14
				Upset	23
				Depressed	1
		Disappointment	4	Disappointed	4
		Shame	15	Ashamed	13
				Guilty	2
		Neglect	49	Isolated	3
				Alienated/didn’t belong	2
				Unloved/unlovable	2
				Lost/alone	4
				Embarrassed	4
				Vulnerable/ Exposed	2
				Self-conscious/ Awkward	3
				Misunderstood	11
				Worthless/insignificant/like dirt	7
				Pathetic/weak/ small	3
				Invalidated/ dismissed	3
				Judged/offended/	3
				Confused/betrayed	2
Fear	18	Nervousness	18	Anxious	1
				Uncomfortable	10
				Attacked/defensive	7
Other	7	Emotional	1		
		Awful	3		
		Horrible	2		
		Screwed-up	1		
		Unbothered	1		
Total	212				

Note. Organization of data patterns was informed by Parrot’s (2001) classifications outlined in *Emotions in social psychology: Key readings in social psychology*. Psychology Press.

The remaining 243 data units were either irrelevant to self-injury stigma (e.g., "*someone playing off sexual assault victims*"), not specific to self-injury (e.g., "*people can control whether they are mentally ill or not*"), or ambiguous (e.g., "*someone saying they were cutting themselves because it was fun*") and were not coded into the framework.

Discussion

The aim of this study was to investigate the applicability of the NSSI Stigma Framework (Staniland et al., 2021) using a directed content analysis (Hsieh & Shannon, 2005) of text responses to open-ended questions related to mental illness and self-injury. Participants described experiences of stigma that aligned with the framework's proposed elements, suggesting that the framework has utility to guide the identification and prediction of NSSI stigma. Most components of the framework were present in the data set, largely pertaining to public or enacted stigma. With more direct questioning, it could be expected that responses would more closely map onto the framework.

Many data units that captured stigma experiences were classified as public rather than enacted stigma because the comments were not directed toward the participant (i.e., they were overheard) or because the person making the comments was not aware of the participant's NSSI history (i.e., not directed at the participant). Given that these comments still impacted participants, indirect stigma represents an area of interest. It is plausible that being exposed to indirect stigma may increase an individual's self or anticipated stigma. Research into HIV stigma proposes vicarious stigma as a channel through which public stigma is communicated to individuals living with HIV, contributing to anticipated stigma (Steward et al., 2008), and mental illness research suggests that vicarious stigma leads to self-stigma (Serchuk et al., 2021). A person with lived experience may experience stigmatizing effects after witnessing NSSI stigma as a form of vicarious stigma. Extending the framework to include vicarious stigma as a context may allow for a more nuanced understanding of how NSSI stigma is experienced.

Minimal evidence of self-stigma likely reflects the nature of the questions asked. While emotional responses such as shame, guilt, and embarrassment may reflect self-stigma, the extent to which these feelings reflected self-stigma for our participants could not be determined with certainty. Future research should explore experiences of self-stigma to accurately determine the applicability of the framework at this level. Interviews are a viable method to achieve this, with the ability to clarify and explore participant responses with the framework in mind.

Few examples of anticipated stigma also likely reflect the questions asked. Participants did, however, describe stigma management - behaviors enacted to avoid stigmatization (Elliott & Doane, 2015). Hiding scars, injuring concealable parts of the body, and avoiding disclosure are examples of stigma management, and reflect anticipated stigma (Hodgson, 2004; Lewis & Mehrabkhani, 2016; Piccirillo et al., 2020). In this way, enacted stigma (both direct and indirect) appears to give rise to anticipated stigma, with both experiences and observations of NSSI stigma informing subsequent choices to keep NSSI concealed.

Turning to the stigma domains, we found evidence for origin across the public and enacted levels, with stereotypes and misconceptions about self-injury present. Origin was minimally evidenced within the self and anticipated stigma levels, likely reflecting the questions asked rather than a lack of validity at these levels. Evidence was found for concealability, most frequently at the anticipated and enacted stigma levels. This makes sense given that direct stigmatization is more likely to occur in response to seeing self-injury. The course domain emerged in data related to being told to "just stop it," which is a common instruction that dismisses the complexity of cessation and recovery (Kelada et al., 2016; Lewis & Hasking, 2019; Lewis et al., 2019). Concealability interacted with course, in that the visible nature of NSSI scarring may lead to ongoing stigmatization, despite cessation. This finding corroborates the suggestion by Staniland et al. (2021) that stigma may persevere due to scarring.

Perceptions of being dangerous, untrustworthy, and unpredictable were captured in the peril domain, and reflect prominent misconceptions about mental illness (Corrigan & Watson, 2002). Conversely, perceptions that self-injury is insignificant and trivial were also evident, supporting the argument by Staniland et al. (2021) that there is a dichotomy within this domain. The least prevalent domain was aesthetics, and due to visibility giving rise to evaluations of appearance (Staniland et al., 2021), shared data with the concealability domain. As expected, the disruptiveness domain interacted with other domains, as disruption to relationships may be an outcome of stigmatization rather than a construct underlying it (Jones et al., 1984). NSSI stigma may be responsible for disruptiveness, rather than self-injury itself.

The overlap in coding categories at the domain level suggests there may be some redundancy in the framework. Greater parsimony may have been achieved through additional cross-coding; however, it is most likely that limited theoretical and empirical understandings of NSSI stigma contributed to coding uncertainty. The overlap was most prominent between conceptually related domains, suggesting that these domains may represent a single construct

and should be collapsed, or that the distinction between domains is unclear and requires more precision. This should be explored in future research, utilising more extensive cross-coding and data triangulation to inform the ongoing conceptualisation of the NSSI stigma domains.

Limitations

While the present research offers preliminary support for the utility of the NSSI Stigma Framework to account for experiences of NSSI stigma, the format and nature of the questions asked presents a limitation. As part of a larger project about self-injury and mental illness, the open-ended questions were developed to collect information about stigmatizing experiences and were not directly informed by the framework. Therefore, the data were relatively general, limiting our capacity to wholistically assess the validity of the framework. It is unclear whether gaps in the framework are due to inadequate data or inadequate framework fit. For example, the disparity in the amount of data coded at the public and enacted levels compared to the self and anticipated levels likely reflects the nature of the data, rather than a failing of the framework. However, without data collected for the purpose of testing the framework, the validity of the framework remains unclear.

Further research is required to assess the framework's applicability to experiences of self and anticipated NSSI stigma. Using a method similar to the one used in this study, researchers could pose open-ended questions such as, "Please tell us about a time when you were worried about how others might react if they found out about your history of self-injury" to capture anticipated stigma, and "When you consider your history of self-injury, how do you think and feel about yourself?" to capture self-stigma. Follow up questions asking participants to elaborate on why would provide further insight into self-injury stigma, offering more robust evidence for the framework and potential modifications.

Whilst most aspects of the NSSI Stigma Framework were represented by the data, some components of the framework (disruptiveness and self-stigma in particular) were difficult to code. While this may reflect limitations of the questions asked, coding difficulties may point to a need for greater definitional clarity within the framework. Based on Jones et al.'s (1984) original conceptualization, Staniland et al. (2021) identified potential complexities in the disruptiveness domain, arguing that self-injury may disrupt relationships because of the stigma of self-injury, rather than self-injury itself. This may explain the limited evidence of disruptiveness in participants' responses. At the self-stigma level, it was difficult to accurately discern whether a participants' reaction (e.g., shame) reflected an internalization of stigma, a response to stigma, or both. Shame is a salient emotion for people who have a history of self-injury (Long, 2018; Rosenrot & Lewis, 2018; Sheehy et al., 2019), and

research has demonstrated that shame plays an important role in the self-stigma of mental illness (Hasson-Ohayon et al., 2012), however, more research is needed to clarify the relationship between shame and stigma in this context.

While online formats of data collection may allow participants to feel more at ease sharing their experiences, the nature of text-based responses can limit the complexity and detail of the data. Without an opportunity to clarify ambiguous responses, we were often limited in the inferences that could be made about what a participant meant in their response. Only data units clearly representative of a framework component were coded, meaning ambiguous responses with potentially relevant detail were left uncoded. For example, in response to the question about hurtful things overheard, one participant wrote "*Someone saying they were cutting themselves because it was fun*" and that they felt "*angry… because I know how people reacted when they found out what id* [sic] *been through*". Without probing, it is difficult to determine whether this statement reflects stigma, and if so, from what perspective it originates. The participant could be reporting an example of public stigma or perhaps an example of in-group stigma. In depth, interview-based approaches to data collection are required to better understand the nature of self-injury stigma.

Implications and Future Directions

Overall, evidence was found in support of the public and enacted levels of the NSSI stigma framework. While this suggests the framework has utility in identifying stigma through these perspectives, more research will be needed to evaluate the framework's applicability to self and anticipated stigma. Furthermore, given the sample comprised mostly individuals with lived experience of self-injury, the perspective of those without a history of NSSI is not captured in this study. Conclusions about the public stigma level are therefore limited in scope. Future research will need to investigate public stigma from the perspectives of those without a history of NSSI to generate a more complete understanding of the content and form of public NSSI stigma.

The coding of several data units to multiple domains suggests there is overlap and interaction between domains, which should be considered in future work informed by or investigating the framework. For example, research on NSSI scarring requires consideration of concealability alongside aesthetics, but may also require consideration of course, given the potential for long-lasting scarring to give rise to stigma. Similarly, practitioners working with clients who have self-injured may need to consider the complexity of living in a scarred body and how mental health may be impacted by stigma even when NSSI is not an active experience.

The framework may hold utility for the development of multi-level self-injury stigma interventions. The need for multi-level stigma interventions has been highlighted (Smith et al., 2022) and the framework provides evidence that effective reduction of self-injury stigma requires a multi-level approach. Prior stigma reduction work has involved contact-based education, workshops, drama and performance, motivational interviewing, and social marketing to address stigma at the community level (Rao et al., 2019). Such approaches may prove useful in the context of self-injury stigma. The framework could be used in the development of such interventions by directing focus to specific aspects of self-injury stigma that may be amenable to change, such as beliefs about the functions of self-injury.

At the intrapersonal level, stigma-informed therapy may improve outcomes for clients who have a history of self-injury. Regardless of a client's motivation for seeking support, understanding and acknowledgement of the complexities of NSSI stigma is likely to benefit therapeutic engagement. Clinicians may find benefit in using the framework to further understand the impacts of NSSI stigma, such as shame and low self-esteem, and its implications for potential continued self-injury. Acknowledging and addressing NSSI stigma while providing clients with the safety to discuss their experiences may strengthen the therapeutic alliance and improve psychological outcomes. Indeed, interventions have shown promise in reducing self-stigma and related outcomes such as shame in the context of mental illness (Lucksted et al., 2011; Luoma et al., 2008).

Our findings also provide support for the framework's potential to inform stigma reduction through identification of how stigma develops and manifests, pointing to viable areas of intervention. Alongside this, assessment of NSSI stigma, its impacts, and effectiveness of interventions necessitate the development of an NSSI-specific stigma measure. The NSSI Stigma Framework may offer a basis for the development of such a tool.

Conclusion

In assessing the applicability of the NSSI Stigma Framework, we found it was able to account for experiences of NSSI stigma in a set of textual data. Public, self, anticipated, and enacted stigma were evidenced, with the presence of vicarious stigma apparent. Whilst further assessment of the framework is required, the present work offers encouraging support for its utility in research and practice as the field continues to develop a better understanding of NSSI stigma.

Chapter 4

News Media Framing of Self-Harm in Australia

In Chapter 2, I presented the NSSI Stigma Framework, which offers a theoretical conceptualisation of self-injury stigma that can be used as a basis for directing future research. In Chapter 3, I provided a preliminary validation of this framework. Researchers can use the NSSI Stigma Framework to inspire research questions that are directly relevant to self-injury stigma. This can be done at the stigma level (e.g., public), the stigma domain (e.g., origin), or at the intersection of any level/s and domain/s. Given current understanding of NSSI stigma is still limited, research questions with a wide scope are required. Therefore, for the study presented in Chapter 3, I posed a research question at the public level, encompassing all domains: How does the news media portray self-injury? In the following chapter, I present a media framing analysis of news articles published in Australia. Of note, the term “self-harm” is used throughout this chapter, rather than the term “self-injury”, which is used in the rest of this thesis. This is because the term “self-harm” is used predominantly in Australia.

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Attributions

Author	Contribution	Acknowledgement
Lexy Staniland	Development of research question and methodology, data collection, management, and analysis, interpretation of findings, and manuscript preparation	
Penelope Hasking Stephen Lewis Mark Boyes	Assisted with development of research question, interpretation of findings, and manuscript preparation	
Permission to include from the journal can be found in Appendix H.		

Abstract

As a conduit of knowledge for the general public, news media inform the development and maintenance of attitudes and beliefs about a range of topics, including mental health and related behaviors. News media portrayals of such topics can therefore contribute to stigma - the culmination of harmful stereotypes, prejudice, and discrimination. A topic of increasing media and research interest is self-harm, a behaviour that is still poorly understood and highly stigmatized. Despite the potential for news media to be a source of self-harm stigma, few investigations of such portrayals have been conducted. To understand how news media portrays self-harm, a qualitative media framing analysis was conducted on 545 news articles published in Australia during 2019. Six frames were identified: Inevitably Suicidal, A Tragic Outcome, Mentally Unwell, An Epidemic, Threatening and Dangerous, and A Manipulative Tactic, each drawing on a broader narrative of pathology, instability, and damage. Use of problematic language and a lack of definitional clarity reinforced these frames. While the analysed articles are limited to an Australian context, findings demonstrate continued misrepresentations of self-harm, which arguably contribute to ongoing self-harm stigma. Greater education and support for journalists reporting about self-harm is needed.

Introduction

Nonsuicidal self-injury (NSSI), the deliberate damage done to oneself without intent to die (ISSS, 2022), is relatively prevalent among adolescents (17.2%), young adults (13.4%), and adults (5.5%; Swannell et al., 2014), and is typically used to regulate unwanted emotions (Taylor et al., 2018). While explicitly a nonsuicidal act, NSSI is associated with increased risk of suicidality (Kiekens et al., 2018). With NSSI being a reliable predictor of later suicidality, understanding the lived experience of NSSI is an important component of suicide prevention. Whilst the aetiological and functional constructs of NSSI are well understood in the field, public and professional understanding of NSSI is still limited (Fu et al., 2020; Hamza et al., 2021; Newton & Bale, 2012) and despite increasing research and public interest in NSSI (Lewis & Plener, 2015), damaging myths about the behavior are pervasive. Such myths include that NSSI is manipulative, attention-seeking, isolated to teenagers, women, and girls, synonymous with mental illness, or invariably reflective of suicidality (Jeffery & Warm, 2009). These myths contribute to NSSI stigma (Staniland et al., 2021).

NSSI Stigma

According to a recently proposed framework (Staniland et al., 2021), NSSI stigma is a function of six constructs: origin, the reason underlying NSSI; concealability, the extent to which NSSI can be concealed; course, the way NSSI changes over time; peril, the lethality of NSSI; and disruptiveness, the extent to which NSSI impacts relationships (Jones et al., 1984). It is argued that NSSI incurs stigma above and beyond mental illness stigma due to its potential visibility, the responsibility attributed to the person who engages in it, and the misconceptions about why people self-injure (e.g., for attention; Staniland et al., 2020). NSSI stigma is evidenced across the research literature, with experiments (Burke et al., 2019; Lloyd et al., 2018; Nielson & Townsend, 2018), surveys (Fortune et al., 2008), and interviews (Mitten et al., 2015) demonstrating that NSSI stigma is endorsed and experienced.

Furthermore, research has illustrated detrimental impacts of NSSI stigma. Individuals seeking medical care report being disbelieved and having their concerns minimized (Mitten et al., 2015), with experiences of being misunderstood leading to fear, confusion, and reluctance to seek further support (Long et al., 2015). Negative attitudes toward self-injury also foster self-stigma and shame, further compounding fear and secrecy that may lead to worsening mental health (Long, 2018). Given the association between NSSI and increased distress and suicidality, appropriate support must be available to those who are self-injuring, however, NSSI stigma is a significant barrier to support seeking (Fortune et al., 2008; Mitten et al.,

2015). While there is a growing literature exploring what NSSI stigma is and how it is experienced, the question remains: how does NSSI stigma proliferate?

Stigma Communication

It has been argued that the primary function of stigma is to detect threat (Neuberg et al., 2000). Within this conceptualization, stereotypes operate as cognitive shortcuts that allow members of a group to quickly identify an individual who may pose a risk to the physical and social safety of the group, with the subsequent prejudicial thoughts and feelings informing discriminatory behaviours, such as withholding access to community resources. For stigma to operate effectively as a form of threat detection, members of the group must be aware of the stereotypes that identify those who may pose a risk (Smith, 2011). This awareness is developed via stigma communication, whereby messages that distinguish and categorize people based on some characteristic, condition, or behaviour (e.g., self-harm) teach that a stigmatized individual is dangerous to the physical and/or social safety of the group and that they are responsible for both the danger they pose and their subsequent stigmatization (Smith, 2007). Stigma messages are communicated socially, through networks such as news media (Smith, 2011).

Despite the contemporary media landscape offering a wide array of avenues to access and consume information, news media is still widely endorsed by the general public as a primary knowledge source (Newman et al., 2020). Specifically, news media is regularly used as a source of information about health-related matters (Van Slooten et al., 2013), including mental health (Oliver et al., 2020). Because news media are perceived as a reliable and accurate (Tsfati & Ariely, 2014) the presentation of information can profoundly impact public perceptions of mental health issues (Cohen & Kolla, 2019), meaning there is a unique power to provide balanced and compassionate perspectives of complex topics, including mental health. Unfortunately, many news media portrayals of mental health are negative (Ciydem et al., 2020) and promulgate stigma messages about mental health difficulties (Ma, 2017). News media often situate mental illness within a context of violence or danger (Ciydem et al., 2020; Corrigan, Watson, et al., 2005), which can inform and reinforce stereotypes about people living with mental illnesses, including that they are dangerous and unpredictable (Quintero Johnson & Riles, 2018). Exposure to such stereotypes can lead to prejudice and discrimination, compounding the already difficult symptoms of mental illness (Smith, 2007; Switaj et al., 2017). What is yet to be established is how the news media communicate about self-injury.

Of interest for the present research is the conflation between nonsuicidal and suicidal self-injury, both often discussed using the same referent: self-harm (Angelotta, 2015), which is a broad category of behaviors encompassing any deliberate damage caused to oneself regardless of intent (NICE, 2013). Therefore, self-harm captures both suicidal and nonsuicidal behaviors. While the term self-harm tends to bring NSSI to mind, a lack of distinction between suicidal and nonsuicidal behaviors may contribute to a misconception that all self-harm is suicidal in intent. Defining and categorizing self-injurious behavior is a topic of ongoing academic debate, with researchers in various locations across the globe opting to differentiate between NSSI and suicidal self-harm, while others use the undifferentiated term self-harm (Kapur et al., 2013). In Australia, this distinction is unclear in both academic and public spheres; however, given the general public tends to rely on informal sources, such as television, for information about mental health-related issues (Reavley et al., 2011), it is likely that understandings of self-harm are drawn from news media. Indeed, news media is cited as a primary source of information about self-harm (Newton & Bale, 2012). News media portrayals of self-harm may therefore have a significant impact on how consumers understand the behavior.

Media Representations of Self-Harm

Self-harm is represented across various media formats, including song (Baker & Brown, 2016; Whitlock et al., 2009), film (Bareiss, 2017), television (Whitlock et al., 2009), social media (Brown et al., 2018), and news media (Bareiss, 2014; Whitlock et al., 2009). Despite the important role news media plays in public information, few investigations of news media portrayals of self-harm have been conducted, and those that have find that self-harm is portrayed negatively (Bareiss, 2014; Whitlock et al., 2009). Recently published media guidelines (Westers et al., 2020) highlight the importance of responsible reporting about self-harm due to the potential for influence on public opinion. Six recommendations were made, including avoiding misinformation, avoiding sensational or stigmatizing language, and centering stories of recovery. These guidelines echo those published in Australia, which have been active in varying iterations since 2009 (Everymind, 2020). Given that Australian journalists have operated under this guidance for over a decade, Australian news media offers a unique site to examine framing of self-harm.

The Current Study

As a fundamental source of information, the news media is a primary conduit for stigma messages and is therefore an important site for investigating the types of self-harm related information consumers are exposed to. With limited understanding of how self-harm

stigma develops, research efforts are required to explore contexts that may communicate such stigma. Therefore, exploring how the news media portrays self-harm can provide insight into the role of news media in communicating self-harm stigma. The aim of the current study was to investigate news media framing of self-harm across digital and print news articles published in Australia during 2019. Doing so facilitates an understanding of how news media may perpetuate self-harm stigma through framing and provides potential insight into how this can be avoided.

Method

A qualitative media framing analysis was adopted, which allows a methodical examination of how news media portrays a phenomenon of interest (Entman, 1993). The six steps developed by Giles and Shaw (2009) for use in psychology research were followed. Step one involves identifying a story by categorizing articles into meaningful groups. Next, characters are identified by noting which individuals are most prominently featured within and across articles. The third step involves determining with whom the reader is invited to identify. From here, narrative structure and form are explored to determine how narrative conventions are employed by the writer. Step five involves analysis of linguistic constructions, exploring how the use of language informs a particular message or interpretation. In the final step, generalization of the frame/s to an ongoing phenomenon is attempted.

Procedure and Analysis

Search terms included: self-harm, self-injury, self-mutilation, self-abuse, self-cutting, and parasuicide, with alternative suffixes (-ed, -ing). The Factiva database and Google's search engine were used to find news articles published in Australia between January 1 and December 31, 2019. A total of 619 articles (205 print, 416 digital) were saved for screening (Table 4.1). All articles were catalogued into Microsoft Excel, where information regarding each article's title and publisher was stored. Media framing analysis was then conducted. During analysis, reactions, thoughts and ideas, and key decisions were documented by the lead author in a reflexive journal. Frequent discussions were also had within the research team to share insights and interpretations; these contributed to the formation of the findings. Screening and data familiarization occurred during thorough reads of each article. Duplicate ($n = 84$) and irrelevant ($n = 22$) articles were removed from the data set, as were articles not in news media format (e.g., radio transcript, book review; $n = 18$).

Table 4.1
Print and Digital Search Results

	Self-harm			Self-injury			Total		
Print	Found	Saved	Analysed	Found	Saved	Analysed	Found	Saved	Analysed
AAP	31	10	9	1	1	0	32	11	9
ABC	21	12	11	1	1	1	22	13	12
Daily Telegraph	39	14	12	2	2	0	41	16	12
Herald Sun	14	11	9	0	-	-	14	11	9
The Advertiser	10	8	7	0	-	-	19	8	7
The Age	18	11	10	0	-	-	18	11	10
The Australian	26	13	13	2	2	1	28	15	14
The Conversation	7	4	4	1	1	1	8	5	5
The Courier Mail	16	9	9	0	-	-	16	9	9
The Sydney Morning Herald	26	11	8	0	-	-	26	11	8
The West Australian	8	7	7	0	-	-	8	7	7
Other	188	88	71	1	0	-	189	88	71
Total Print	404	198	168	8	7	3	412	205	171
Digital									
news.com.au	78	69	65	1	0	-	79	69	65
abc.net.au	177	99	87	1	0	-	178	99	88
sbs.com.au	96	88	70	1	1	1	87	89	71
au.yahoo.com	0	-	-	0	0	-	-	-	-
theguardian.com/au	0	-	-	0	0	-	-	-	-
smh.com.au	176	156	149	1	0	-	177	157	150
huffingtonpost.com.au	1	0	-	35	0	-	36	0	0
thewest.com.au	1	1	1	0	-	-	1	1	1
Total Digital	529	413	371	39	3	3	568	416	374
Combined Totals	933	611	540	47	8	4	980	619	**545**

Note. No search results from terms “self-mutilation” (n = 2) or “self-abuse (n = 3) were saved for analysis

The final sample comprised 545 articles. Each article was re-read and categorized according to the dominant narrative focus (Table 4.2). Following categorization, steps two through five were completed by recording summaries, quotes, and interpretations in the catalogue. This was an iterative process; frames were formulated through a process of reading, identifying, describing, and reflecting (see Appendix I for journaling excerpts).

Table 4.2

Article Categories

Category	*n*	%
Aboriginal & Torres Strait Islander	24	4.43
Abuse/trauma	23	4.24
Crime	107	19.74
Entertainment/sport	30	5.53
General news/health	13	2.40
LGBTQI+	22	4.06
Mental health/illness	88	15.87
Nonsuicidal self-injury	4	0.74
Politics	29	5.35
Prison/detention	22	4.06
Refugee/asylum seeker	76	14.02
School	6	1.11
Suicide	33	6.09
Social media/internet	26	4.61
Teenagers	42	7.75
Total	$N = 545$	100%

Findings

Overall, self-harm was framed as an indication of pathology or damage. While six distinct frames emerged, each drew on a broader framing of self-harm as synonymous with mental illness, with self-harm leveraged to substantiate claims or bolster a narrative and was positioned as increasingly problematic.

Inevitably Suicidal

Many articles were related to suicide, and “self-harm” was used to reference suicidal behaviors; however, this was not universal, and definitions were typically ambiguous. “Self-harm” was used interchangeably to refer to both suicidal and nonsuicidal behaviors, as evidenced in article 163, wherein the journalist reported that two prisoners had died, “*one by suicide and one by self-harm.”* While accidental death following nonsuicidal self-injury can occur (Doshi et al., 2005), readers may be confused by the language in this article: why was the death by self-harm not referred to as suicide? Similarly, in article 33, “*the horrendous rates of suicide and attempts at self-harm involving a firearm*” were referred to as part of a discussion regarding firearm laws. Self-harm involving a firearm is likely suicidal in intent; therefore, the identification of the attempt as self-harm and not suicide creates confusion. Lack of distinction between suicidal and nonsuicidal self-harm, particularly when the method is likely suicidal, may lead readers to perceive all self-harm as suicidal.

Even in articles where there was an attempt to distinguish between suicidal and nonsuicidal self-harm, confusion arose. This was seen in article 191, wherein, despite stating that “*not everyone who self-harms is suicidal,”* the journalist presented behaviors typically viewed as suicidal, such as hanging and overdosing, as self-harm. Definitional ambiguity may lead to confusion regarding what people mean when they talk about self-harm. Indeed, it may influence the way a person reacts to someone who has engaged in nonsuicidal self-harm. If a person believes that all self-harm is suicidal, they may respond in an inappropriate or damaging way to an individual who has self-harmed, such as reacting with horror (Long, 2018) or forcing hospitalization (Lesniak, 2010).

A Tragic Outcome

Within 147 articles, self-harm was positioned as a tragic outcome of negative experiences such as sexual abuse, discrimination, detention, bullying, and social, school, and work pressures. Articles reporting on cases of sexual abuse referred to a survivor’s self-harm as indicative of how impactful the abuse was, as evidenced in article 99: a survivor “*developed an eating disorder and started self-harming.”* Such articles told of individuals significantly impacted by trauma, with self-harm framed as an outcome worse than the traumatic experience preceding it. Emblematic of pain and suffering, self-harm appeared to legitimize the impact of the survivor’s experience, as though self-harm was the indicator of impact, rather than the abuse itself warranting significant concern. Consistent linking of self-harm and trauma reinforces the misconception that sexual abuse causes self-harm (Klonsky & Moyer, 2008), which can inform an assumption that experiences of trauma are a prerequisite

for self-harm. In assuming that self-harm is preceded by trauma, the lived experience of many people may be dismissed. In absence of a 'legitimate' reason to self-harm, the behavior may be perceived as attention-seeking (Lloyd et al., 2018).

Drawing on self-harm to demonstrate impact was also employed in discourse related to LGBTQI+ discrimination. All 22 articles in this category referred to the comparatively high rates of self-harm among gender/sexuality diverse people to demonstrate the consequences of discrimination, as though in absence of self-harm, LGBTQI+ discrimination may be dismissed. For example, it was described in article 276 that "*Gay people who are the target of homophobic bullying are twice as likely to self-harm*" and in article 444 it was described that "*LGBTQI youth are 4 times more likely to attempt suicide, experience suicidal thoughts, and engage in self-harm* [than non-LGBTQI+ youth]." References to self-harm drew on a perception that self-harm is 'tragic' to encourage the reader to view LGBTQI+ discrimination as important, as though this detail was required to legitimize the impacts of LGBTQI+ discrimination. This 'tragic' perception was also drawn on when framing Australia's ongoing offshore detention of asylum seekers. Of these 77 articles, 48 inferred that self-harm stemmed from detention-related factors (e.g., isolation, hopelessness). In article 462, the journalist drew on the perspective of a psychologist to demonstrate this position, writing that "*She recalled witnessing the process of how adult asylum seekers and refugees gradually lost hope and even started to self-harm*." The use of "*even started*" suggests strategic use of self-harm to legitimize the narrative surrounding the impact of offshore detention.

The most prominent discourse in the context of asylum seeker detention pertained to the 2019 Australian federal election, in which the Liberal Party, a right-leaning political party that has campaigned against accepting refugees (Norman, 2019), was re-elected. The election result was portrayed as a catalyst for self-harm, with self-harm positioned as indicative of the damage caused by the re-election of a government with no intent to assist refugees. For example, it was written in article 148 that "T*he Morrison government has refused to address claims of an unprecedented self-harm crisis among refugees and asylum seekers… following the election*," and in article 522, a journalist "*echoed reports of a self-harm crisis… after the Morrison government's election victory*." Self-harm narratives were leveraged in these articles to depict a state of despair, with an underlying assumption that in absence of self-harm, the circumstances at hand were invalid. This may lead to a perception that only those experiencing extreme difficulties have legitimate reason to self-harm. This is problematic as the difficulties people face are highly individual and relative to prior experiences. Assuming self-harm occurs only in response to extreme difficulties ostensibly diminishes the

experiences of people whose self-harm has occurred in response to difficulties not perceived as 'sufficiently serious'.

Self-harm as an indication of severe circumstances was further exemplified in stories about people living with disabilities. Self-harm was positioned as an important component of the impact of disability, as seen in article 385: "*he requires 24-hour supervision to stop him self-harming*." References to self-harm as evidence of impact were seen in more complex reports, such as article 374, which focused on a person named Yoey: *"... he believed Yoey's life was an example of just how wrong things could go for someone with a disability... We heard Yoey smashing herself up in the toilet*." Through proximity and narrative flow, an implicit link may be drawn between self-harm and the idea that Yoey's life had gone "*wrong*". In the mind of a reader, self-harm may be interpreted to represent 'a life gone wrong'. Similarly, the following was included in article 385 outlining the experience of a boy named Alex:

> *He requires 24-hour supervision to stop him self-harming and hurting others... He was scratching his legs and his upper body, so there were just huge scratch marks that were bleeding all over him and we went 'what do we do?'*

In these articles, self-harm was framed as both an allegory for tragedy and an indication of desperation. Language such as "*smashing herself up*" and "*bleeding all over him*" may evoke emotional responses such as fear and horror, and in combination with the narrative context, may portray self-harm as violent, frightening, and uncontrollable. These portrayals may contribute to a perception that people who engage in self-harm are dangerous, a perception that has been associated with discrimination in mental illness research (Corrigan et al., 2003).

Self-harm as a tragic outcome was also framed across contexts such as workplace stress: "*high anxiety and extreme work conditions drove them to the brink of suicide and self-harm*" (173); school pressures: "*We're seeing self-harm in children as young as four, the push down of formalised education isn't working*" (370); childhood adversity: "*after fleeing a home full of verbal and physical violence... 'I got to the stage where I was self-harming'*" (398); bullying: "*The bullying and social isolation soon became so bad Imogen began self-harming*" (257); relational issues: "*family breakdown... can lead to teenage self-harming*" (645); and abuse: "*the psychological abuse she suffered led her to begin cutting herself*" (307). Across these contexts, self-harm was positioned to be caused by negative experiences, and framed as the tragic outcome of such experiences.

Mentally Unwell

Beyond being framed as an outcome of difficult experiences, self-harm was positioned as indicative of mental health difficulties. In article 554, the journalist reported on excessive waiting times at hospitals, with a doctor quoted as stating, "*often people presenting with mental health problems also need to be assessed… for self-harm injuries*." This may reinforce the idea that self-harm is always accompanied by "*mental health problems*". In some cases, self-harm was presented as a disorder in and of itself, as seen in article 155: "*We now know up to one-third of depression, anxiety and self-harm conditions experienced by Australian adults are related*." Described as a "*condition*", self-harm is positioned as an illness or disorder, which aligns with an incorrect assumption that self-harm is a mental illness (Vega et al., 2018).

Reports about particular mental illnesses, such as premenstrual dysphoric disorder (PMDD; 413), dissociative identity disorder (DID; 429, 451), and borderline personality disorder (BPD; 392, 486) were accompanied by references to self-harm. Historically, self-harm has been inaccurately attributed to BPD (Klonsky & Moyer, 2008); however, while self-harm is one diagnostic criterion for BPD, it is neither necessary nor sufficient to diagnose based on self-harm alone (APA, 2013). Despite this, self-harm was positioned as a salient experiential component of BPD, as seen in article 392, in which the featured individual, Claire "*had often presented to emergency departments distressed after self-harming*." Consistent representations of self-harm alongside mental illness may encourage the inaccurate inference that self-harm indicates mental illness.

References to self-harm were also used to indicate psychological instability. This was particularly prominent in reports about alleged and convicted criminals. In article 639, it was reported that a woman charged with attempting parricide "*has severe psychological problems, self-harming and has tried to commit suicide,"* and in article 447, the writer described that an inmate had "*many 'slash marks' (scars) from numerous attempts at self-harm*." References to self-harm in these articles tether the behavior to instability by implicating it as an important contextual fact about the individual. Rendered as salient detail, inclusion of alleged and convicted criminals' self-harm history may inform a spurious association between self-harm and criminality.

Psychological instability was also leveraged in articles about celebrities and public figures engaging in self-harm. Article 605 was an album-promoting piece for artist Iggy Pop, with his behavior described as "*Not so much intravenous cocaine and on-stage outrage and self-harm, more swims at the beach… and pre-gig meditation*." Here, drug use, outrage, and

self-harm are linked to portray a juxtaposition to the comparatively wholesome "*swims at the beach*" and "*meditation*." The reference to self-harm appears to strengthen the perception of Iggy Pop as unpredictable and unstable. Similarly, an entertainment piece about television program The Crown, referred to an advertisement calling for an actress to play the Princess of Wales, including the request for someone who could play a "*desperate and lonely self-harmer*" (298). The journalist subsequently reiterated: "*Desperate. Lonely. Self-harmer*," before writing, "*While it may be an accurate description of the doomed royal, this is bad news for Princes William and Harry*." Linguistic choices such as "*desperate*" and "*doomed royal*" portray a sense of mental instability, and the decision to identify the advertisement as an "*accurate description*" works to legitimize assumptions about self-harm being a behavior isolated to people perceived as mentally unstable.

In addition to instability, self-harm was also used to demonstrate vulnerability, particularly among criminal offenders who were "*at-risk*" and "*in need of protection*" (103). Choices to specifically mention when an offender was not at risk of self-harm illustrates a perception that this detail is important and/or interesting. This was seen in article 145, where a so-called "*notorious baby killer*" was "not regarded as being at imminent risk of self-harm". In addition to the possibility that the journalist assumed reader interest in this type of detail, reference to an absence of self-harm risk may act to indicate that despite having murdered a child, the offender is not so psychologically impacted to be at risk of self-harm.

References to self-harm were also apparent in mental health awareness and advocacy pieces, sourced from a range of perspectives, including mental health centers (166) and charities (236). Invariably, cessation of self-harm was central their mission. While cessation may be a goal for many people who self-harm, it is important to recognize the diversity and variability in people's recovery journeys (Lewis & Hasking, 2021). Emphasis on cessation may encourage a belief that self-harm is pathological and must be stopped at all costs, a belief that can lead to significant harm. Reliance on the opinions and correspondence of professionals (largely psychologists) to provide context and explanation for self-harm strengthened the portrayal of the behavior as pathological, a notion argued to contribute to NSSI stigma (Hasking et al., 2021).

In addition to pathologization, at times advocacy pieces featured language that invited judgement. Reporting on tattoo parlors offering discounted or free tattoos to cover self-harm scars, the journalist in article 11 wrote "*the cuts and bruises she inflicted on herself became a 'very nasty habit'*," and the writer of article 231 described that "*Underneath the images… lies something much darker. From the age of 12 until 19, Laila self-harmed*." Describing self-

harm as a "*nasty habit*" and framing it as something "*dark*" evokes judgment and fear. These narratives could have been framed as stories of recovery and hope; however, the chosen language framed self-harm as a regrettable behavior that should be hidden. Scar acceptance can be an important element of recovery (Kendall et al., 2021) and news media that portrays scars as shameful may negatively impact readers with lived experience of self-harm.

Further problematic phrasing was present in article 299, which reported on a prominent cardinal's visit to a prison. The journalist described offenders met by the cardinal, such as a woman who "*despite the best efforts of prison officers, was a repeat self-harmer*" and "*two other chronic self-harmers*". Labelling an individual by their behavior, as is seen by referring to someone as a "*self-harmer*", is dehumanizing and stigmatizing and should be avoided. Furthermore, referring to people who self-harm in an ongoing manner as "*chronic*" evokes pathology. By definition, chronic refers to persistent illness; identifying persistent self-injury as chronic medicalizes the behavior and removes autonomy, by implying that self-injury is an illness.

An Epidemic

Rates of self-harm were referenced across all article categories, but in 32 articles there was an implication that rates are increasing. For example, in article 405, it was described that "*The number of young women attempting suicide and self-harm is on the increase, causing concern for suicide prevention groups*" and in article 86 it was reported that "*Half of all state teachers and staff in Victoria say they know of students who have self-harmed.*" The sentiment that adolescents are increasingly engaging in self-harm was further evidenced in language such as that found in article 175, which described "*the brutal reality of teens in harm's way.*"

Articles also pointed to a downward trend in age at onset, implying that not only is self-harm increasing in prevalence, it is also being engaged in by younger and younger people. Indeed, article 174 reported, "The number of children aged under 13 treated at WA hospital emergency departments for self-harm has doubled in the past five years" and article 181, "*I have seen self-harming in children as young as prep* [pre-school], *grade one and two.*" While there is evidence to suggest that age of onset is decreasing (Griffin et al., 2018) and that rates are increasing (Hiscock et al., 2018; Morgan et al., 2017), there is limited distinction between suicidal and nonsuicidal self-harm when collecting and analyzing hospital data. Presenting self-harm as increasing in prevalence and decreasing in onset age may create unnecessary fear and panic amongst readers, particularly parents.

While articles did not categorically describe self-harm as an epidemic, the language used to describe rates of engagement positioned it as such. Statistics were described as "*shocking*", "*disturbing*", and "*terrible*", with emphasis placed on rising rates. These linguistic choices evoke fear and panic that may encourage a reader to perceive self-harm as epidemic; indeed, the development of self-harm as a moral panic has previously been identified (Gilman, 2013). The impact of self-harm rates was also positioned as a significant burden. In article 644 and 180, it was outlined that teachers and principals are "*struggling to respond", and in article 39 it was described that "self-harm is adding to the pressure on… stretched* [emergency] *departments*." While we do not dispute these accounts, there is an implication that self-harm is the problem, rather than underlying systemic issues (e.g., resource allocation). By framing self-harm as epidemic, news media establish it as a problem beyond control, a sentiment magnified by linguistic choices, such as "*disturbing*" and "*shocking*".

Self-harm as epidemic was linked to an implication that the behavior is 'spreading.' In articles 179 and 632, it was described that "*a contagion effect is driving an alarming trend* [self-harm increase]." This language implies that people who self-harm are contagious and can cause those around them to start self-harming as well. This perception may lead to discriminatory behaviors such as forced covering of scars and social isolation. While peers may influence self-harm engagement (Schwartz-Mette & Lawrence, 2019), disease-based language such as 'contagious/contagion' has been highlighted as problematic due to its stigmatizing potential. Furthermore, the representation of self-harm as driven by a "*contagion effect*" is reductionistic and does not provide the nuance required to understand how peer influence operates. News media have a responsibility to acknowledge and discuss the complexities of peer influence to ensure that damaging perceptions about self-harm are not perpetuated.

Threatening and Dangerous

Reports of police being called to attend situations involving an individual "*threatening self-harm*" were prominent - 37 articles had this focus. Such articles often criminalized the individual and conveyed a sense of danger, as seen in the description of a "*Christmas Eve siege*" where a "*knife-wielding man was threatening to self-harm*" (546). Likewise, articles 119 and 120 described a "*siege*" that was "*sparked when a man threatened self-harm.*" The word "*siege*" evokes war-like imagery, with the individual in need of support positioned as an enemy and danger to society. A similar narrative emerged in the case of a man who "*threatened to harm himself outside parliament house*" (62), with the situation described:

"*Dramatic scenes unfolded outside state parliament yesterday when heavily armed police swarmed a car that was loaded with fuel and removed a man who was threatening self-harm*" (64). Language such as "*dramatic scenes*" and "*swarmed*" evoke urgency and danger. While warranted in a life-threatening situation, these reactions may be inadvertently attached to self-harm rather than to the potential act of terrorism. Hence, self-harm may come to be understood as a dangerous and violent action.

Framing of self-harm as dangerous was also present in articles discussing the use of restraint and Tasers by police to prevent self-harm. In article 393 it was described that Patrina, a woman living with an intellectual disability "*was placed in handcuffs and put in the back seat of a wagon*" by police reportedly "*trying to protect Patrina who was self-harming at the time*." A similar narrative was present in article 185, which reported on police attendance to a teenage girl engaging in self-harm: "*two male officers arrived at the house where they restrained the girl and tried to force a self-harming implement from her hand*." Additionally, it was described in article 318 that, "*The officer said he finally fired the Taser when Mr Caristo stabbed himself in the leg, having formed the view that there was no other way to stop him harming himself more*." While it can be understood that these acts of intervention were attempts to help people who may pose a risk to themselves and others, self-harm is framed in these articles as a threat warranting police action. Linguistic choices, such as "*force a self-harming implement from her hand*" and "*finally fired the Taser*" position the actions of law enforcement as urgent, representing a justification of police intervention when an individual is self-harming. This may encourage a perception that when an individual engages in self-harm their autonomy is surrendered and restraint is acceptable. These articles also demonstrate the potential for confusion when self-harm is not defined. While restraining someone to prevent suicide may be appropriate, it may be less appropriate to restrain someone who intends to engage in nonsuicidal self-harm.

Perceptions of self-harm as threatening and dangerous were further evidenced in narratives pairing self-harm with acts of violence. It was described in article 521 that a man had "*stabbed his girlfriend and tried to set her alight, and he threatened self-harm*," and in article 365, it was described that after stabbing multiple people, a woman "*allegedly punched an officer and also attempted to self-harm*." More explicit links were evident in descriptions such as that found in article 396, wherein an offender was described as "a*n aggressive drunk who had been admitted to psychiatric units multiple times after self-harming*." Similarly, a man who attacked a police officer was described in article 218 as "*an alcoholic who, when intoxicated, makes contact threatening self-harm*." Narrative constructions that describe self-

harm and violence in proximity may lead to perceptions that people who self-harm are violent.

A Manipulative Tactic

Self-harm was frequently framed as manipulative, particularly within prison, abuse, and refugee narratives. Within the prison context, self-harm was portrayed as a tool used to modify circumstances, justify actions, or manipulate others. The self-harm of serial killer Ivan Milat was described with relative prominence and invariably as a method of escape: "*he was always scheming an escape, usually via hospital stay after self-harming*" (258). Likewise, serial killer Bradley Edwards reportedly injured himself to delay court proceedings: "*A cotton wool bud in his right ear was the only sign of the previous day's drama that led to the first day of his pretrial court hearing being adjourned*" (209). As in Milat's case, Edwards' self-harm was portrayed as a manipulation of circumstances. While prisoners may use self-harm in this way, a lack of alternative media representations may reinforce the myth that self-harm is typically used to manipulate people and circumstances. These portrayals also ignore the complexities of self-harm, which may be used as a means of expression or help-seeking when other options are not known or available (Edmondson et al., 2016). Failure to acknowledge these complexities reduces the behavior to a devious and manipulative tactic, a perception that can lead to poor treatment of people who have self-harmed (Karman et al., 2015) and help-seeking reluctance (Long, 2018).

Within the context of abuse, perpetrators were reported as using threats of self-harm to control their victim. This was evident in articles 335 and 620, where it was reported that "*the teacher threatened self-harm if the* [victim] *revealed what was going on*," and in article 584 where it was reported that "*the stepfather threatened self-harm after his partner confronted him with allegations* [of sexual abuse]." In these examples, it is evident that the motivation to self-harm was to influence others' behavior, and while an accurate portrayal of events, inclusion of detail regarding self-harm appears to leverage the stereotype that self-harm is manipulative. Activation of this stereotype may serve to bolster the characterization of perpetrators as manipulative, and also reinforce harmful stereotypes about people who have self-harmed.

Framing of self-harm as manipulative was also present in articles about asylum seekers. Eighteen of these 76 articles referred to a claim made by then Home Affairs Minister, Peter Dutton, that "*People have come to our country, people have self-harmed on advice from some of the refugee support groups or advocates, people have self-harmed in significant numbers*" (75). In articles 85, 465, 640, journalists reported that Home Affairs was "*concerned that self-*

harm is perceived as the most expedient means of accessing medical transfer [to Australia]." While counterclaims were included, this narrative fosters a perception that self-harm is enacted for the purpose of 'getting what you want'. It is important to consider the wider political context when interpreting articles covering asylum seeker issues. The current Australian government has led a strong deterrence campaign that has informed anti-refugee prejudice in Australia (Hartley et al., 2019). Therefore, claims made by politicians that the "*system was being exploited by asylum seekers who were being encouraged to self-harm*" (417) is likely to carry weight despite conflicting evidence. Regardless of the accuracy of the claims, the pairing of self-harm and manipulation is pervasive in these articles, and given public sentiment regarding asylum seekers, may be more readily accepted than claims of self-harm made in other contexts.

Discussion

Using media framing analysis, we investigated self-harm portrayals in Australian news media articles published in 2019. Our findings provide valuable insight into how the news media positions self-harm, and points to the news media as an important avenue through which people may develop stigmatizing views about the behavior. Six frames of self-harm were formed, each contributing to an overall perception that self-harm is dangerous and engaged in by people who are mentally unwell. While each frame captured distinct messaging, they were not mutually exclusive, and appeared to draw on a broader symbolism of pathology and damage.

While self-harm has long been tied to mental illness, first referenced in asylum records (Angelotta, 2015) before subsequent pathologization throughout the 1960's and 1970's (Millard, 2013), it is well established that not all people who self-harm have a mental illness (Kiekens et al., 2018). Despite this, self-harm was frequently synonymized with mental illness in the articles analysed, a sentiment strengthened by the prioritization of the voices of psychologists and medical professionals leveraged as experts. Contemporary news media continue to frame self-harm through a mental illness lens, which offers a limited perspective of what self-harm encompasses and how to best support people engaging in it. With news media a common information source about self-harm (Newton & Bale, 2021), it is important that journalists offer diverse and accurate perspectives of self-harm, including accurate definitions.

Ambiguity surrounding the distinction between suicidal and nonsuicidal self-harm was prominent and may lead to a conclusion that these concepts are one and the same. By continuing to amalgamate suicidal and nonsuicidal self-harm, news media inadvertently

contribute to the myth that all self-harm is suicidal. This amalgamation may also lead to a perception that self-harm without suicidal intent is non-serious or undeserving of support. In either case, reductionistic portrayals of self-harm impede understanding of the behavior, resulting in inaccurate and harmful beliefs that may inform inappropriate support. Delineating suicidal and nonsuicidal self-harm is necessary to improving portrayals of self-harm.

While references to self-harm were often fleeting or subtle, such references contribute to a reader's overall mental representation of self-harm. Mental representations include all relevant cognitive, emotive, and sensory experiences, both subtle (a line in a news article) and direct (a close friend with lived experience; Bartlett, 1932). Regardless of prominence, media frames of self-harm contribute to readers' mental representations of the behavior, which may inform subsequent attitudes and reactions toward to self-harm. For example, through exposure to news media about self-harm a person may develop a mental representation that concludes the behavior is inevitably suicidal in intent, which may lead to inappropriate support (e.g., forced hospitalization). By contributing to readers' mental representations of self-harm, the news media can impact how self-harm is appraised and how people who self-harm are treated. Furthermore, individuals with lived experience also absorb media framing of self-harm. When exposed to articles that imply people who self-harm are unstable, dangerous, or at fault for their difficulties, individuals may internalize such messages, which may result in feeling misunderstood, invalidated, and hurt. This may foment self-stigma (Staniland et al., 2021), which is associated with shame, isolation, and continued self-injury (Bachtelle & Pepper, 2015).

Our findings provide evidence that news media, at least that which is published in Australia, contributes to self-harm stigma. The extent to which this influences people's attitudes towards and beliefs about self-injury is unknown; however, mental illness research suggests that news media plays a role in the development and maintenance of stigma (Sieff, 2009). Despite operating under guidelines for responsible reporting on self-harm since 2009 (Everymind, 2020), Australian news media continue to use sensational and stigmatizing language. Research is needed to understand how reporting guidelines translate into practice, and whether more detailed advice, such as that found in the resource published by Westers et al. (2020), is required.

Furthermore, journalists must consider the impact of their language (see Hasking et al., 2021 for a data-informed commentary) and critically evaluate the need to include references to self-harm, particularly in reports about crime. While it is established in guidelines that reporting on self-harm methods is inappropriate, it should be considered whether the need to

report on self-harm is necessary at all. Many articles in our data set referred to self-harm in the context of a crime to establish a history or background for the offender. This detail was usually irrelevant to the story and connected self-harm with violence, instability, and danger. Asking "what purpose does this information serve?" may be an important reflection during the writing process. If self-harm detail is necessary to the story, then sensitive and considered inclusion of the information is warranted, but if the detail serves to explain the mental state of an offender or otherwise evoke emotion from a reader, the inclusion of the information is questionable.

Limitations, Implications, and Future Directions

While we drew on a large sample of news articles to analyze, our focus on Australian news media means that we were only able to capture a small section of a much larger mass media agglomerate. The role of social media in information sourcing is growing, and consumers source their information from a range of outlets, published both nationally and internationally (Newman et al., 2020). Therefore, the frames outlined here may not be representative of mass media at large. While our conclusions may be transferrable to news media from other English-speaking countries, it will be important to investigate the framing of self-harm across countries and across platforms (e.g., social media) in order to develop a more holistic understanding of the self-harm frames readers are exposed to.

While we have endeavoured to be transparent in our methodology and conclusions, media frames are never obvious or explicit, meaning that our analysis, like other approaches, relied on human interpretation. We acknowledge that the positioning of each member of the research team inevitably permeates these interpretations. In line with qualitative reporting standards (Levitt et al., 2018), we adopted structured methods of reflexivity including regular team meetings, reflexive journaling, and bracketing. In our bracketing efforts, we acknowledged and reflected on our relevant stigma foci to minimize the risk of transposing frames that we expected, rather than finding frames that were there. Furthermore, while our interpretations are described and explained with examples, we cannot account for journalistic intention. Understanding framing of self-harm would benefit from collaboration with journalists.

Reducing the stigma of self-harm requires interdisciplinary efforts. In absence of a commitment from journalists and media organizations to address the harmful impacts of negative self-harm frames, efforts made by advocates and researchers will be impeded. While challenges such as editorial pressures, fulfilling public interest, and funding competition contribute to writing choices, and should be considered (Holland, 2018), there are freely

accessible guidelines that direct responsible and appropriate reporting on self-harm (Westers et al., 2020). Like the behaviour itself, portrayals of self-harm must be nuanced, with meaningful efforts made to center lived experiences and stories of hope without sensationalizing the behaviour (as seen in article 11 with the description of self-harm as a "nasty habit").

In addition to researching the framing of self-harm in other types of media, future work should investigate what aspects of framing are attended to and retained. This could be achieved experimentally, by exposing participants to various representations of self-harm and administering pre- and post-observation measures of relevant knowledge, attitudes, and beliefs. The findings of such research may point to potential impacts of media framing on readers' understanding and perception of self-harm. Furthermore, investigating reader responses to self-harm related media can provide insight into how people think and feel about self-harm. Many people access news media through social media platforms that allow public commenting, therefore, there is potential to investigate reader framing of self-harm in comments sections. This could be achieved by extracting comments made on self-harm-related news articles and completing a framing analysis on the comments.

Finally, as the field continues to investigate self-harm stigma and work to reduce it, consideration must be made to macro-level influences. As Scambler (2018) articulates, stigma is a product not just of evolutionary processes (i.e., fundamental aversion to difference) but also a tool through which to maintain the status quo. A shift in news media portrayals, while necessary, may not be sufficient to disrupt the pervasive nature of stigma (Scambler, 2018). Change in news media portrayals is one small component of a larger movement needed to destigmatize mental health difficulties and requires collaborative advocacy efforts. The inclusion of lived-experience narratives and recovery-oriented foci is vital, but it must also be acknowledged that self-harm stigma, like other stigmas, are intersectional and complex, and require intersectional and complex solutions.

Conclusion

Self-harm continues to be misunderstood and misrepresented, in part due to ambiguity regarding what constitutes self-harm and why people engage in the behavior. While research focused on self-harm stigma is emerging, there is still limited understanding of how self-harm stigma propagates and perpetuates. We know that news media provides the public with health information, and in doing so sets an agenda for what is perceived as important and true (Kennedy & Prat, 2019). As such, the way news media frame an issue has an impact on how the public perceive it. With news media being a dominant source of information about self-

harm (Newton & Bale, 2012), stigma messages communicated by news media have significant implications for public understanding about the behavior and people who engage in it. The present work provides valuable insight into the types of stigma messages conveyed about self-harm in news media and highlights an important site through which self-harm stigma may manifest. By drawing attention to the subtle ways stigma is communicated, we hope this work encourages the widespread use of Westers and colleagues' (2020) reporting guidelines and critical consideration of how self-harm narratives are constructed and construed.

Chapter 5

Development and Validation of the Self-Injury Stigma Questionnaire

The preceding chapters have contributed to a foundational understanding of self-injury stigma. By developing the NSSI Stigma Framework, I proposed a conceptualisation of self-injury stigma that offers a way to consider, identify, and explain NSSI stigma. In Chapter 3 I demonstrated the applicability of the Framework to individuals' lived experiences of self-injury stigma and in Chapter 4 I demonstrated the utility of the Framework to direct the development of research questions. An additional limitation of the field is the lack of a measure of stigma specific to NSSI. In the following chapter, I present the development and validation of the Self-Injury Stigma Questionnaire.

Staniland, L., Hasking, P., Boyes, M., & Lewis, S. (under review). The development and validation of the Self-Injury Stigma Questionnaire (SIS-Q).

Attributions

Author	Contribution	Acknowledgement
Lexy Staniland	Development of research question and methodology, data management and analysis, interpretation of results, and manuscript preparation	
Penelope Hasking Stephen Lewis Mark Boyes	Assisted with development of research question, interpretation of results, and manuscript preparation	

Abstract

Nonsuicidal self-injury is a highly stigmatised behaviour. Individuals who have self-injured report stigma to be a significant contributor to ongoing distress and a barrier to support-seeking and recovery. Despite these potential impacts, limited research has investigated self-injury stigma. Without a valid and reliable tool through which to assess self-injury stigma, our understanding of it remains limited. In study one, we drew on a conceptual framework of self-injury stigma to develop item pools representing five types of stigma (Public, Personal, Self, Anticipated, Enacted). The item pools were piloted with a sample of 316 MTurk participants before being reduced through correlation and factor analyses. In study two, the reduced item pools were administered alongside validation measures to a sample of 722 participants recruited via social media, our university, and MTurk. Confirmatory factor analyses revealed four factors (Origin, Concealability, Peril, Disruption) which were consistent across the five scales. Internal consistency was sound, and both convergent and divergent validity were demonstrated through correlations with measures of mental illness stigma, social exposure to self-injury, social reactions to self-injury, self-esteem, and shame. Psychometric equivalence across samples with and without a history of self-injury was demonstrated. The Self-Injury Stigma Questionnaire (SIS-Q) was theoretically informed and represents a reliable and valid measure of self-injury stigma. The SIS-Q offers a comprehensive tool that may allow researchers to investigate how self-injury stigma develops and persists, and the impact it has on the wellbeing of individuals with lived experience of self-injury.

Introduction

Nonsuicidal self-injury (NSSI) is a highly stigmatized behavior (Staniland et al., 2021) that involves damaging one's own body without intent to die (ISSS, 2022). It typically involves cutting, burning, or hitting oneself and is usually enacted as an emotion regulation strategy (Taylor et al., 2018). Relatively common, lifetime prevalence rates of NSSI are estimated at approximately 17% for adolescents, 13% for young adults, and 5% for adults (Swannell et al., 2014). People with lived experience of self-injury tend to experience greater psychological distress (Buelens et al., 2019), shame (Sheehy et al., 2019), and interpersonal difficulties (Turner et al., 2017) than people with no such experience, and a history of NSSI confers increased risk for suicidality (Ribeiro et al., 2016). Emerging evidence suggests that rates of NSSI are increasing, particularly among adolescents (Hiscock et al., 2018), although changes in how hospitals record self-inflicted injuries, as well as definitional ambiguity regarding the distinction between suicidal and non-suicidal self-injury may inflate such estimates. Regardless, associated challenges and risks position NSSI as a behavior warranting research attention.

While substantial research has investigated the etiological and functional processes of NSSI (Cipriano et al., 2017), only recently has there been a shift to exploring the lived experience of NSSI (Lindgren et al., 2021). Part of this shift has involved directing attention to the experiences involved in the well-being of individuals with lived experience of self-injury (e.g., Lewis et al., 2019). One aspect of this new focus is a consideration of NSSI stigma.

NSSI Stigma

Stigma is a social construct and represents the culmination of stereotype, prejudice, and discrimination directed toward and individual or groups of individuals who engage in a behavior that is socially derided (Link & Phelan, 2001). Whilst incipient, the extant literature demonstrates that NSSI stigma is a salient experience for people who have self-injured, who describe being stereotyped as "attention-seeking" (Rowe et al., 2014), "goth" or "emo" (Long, 2018), or perceived as "crazy" or "damaged" (Klineberg et al., 2013; Mitten et al., 2015). Prejudice has been exemplified in reactions of hostility, anger, and judgement (Long, 2018; Rosenrot & Lewis, 2018) and assumptions that NSSI is inevitably suicidal (Brown & Kimball, 2012). Discrimination has been described in the form of delayed or inappropriate treatment, invalidation, and belittlement (Klineberg et al., 2013; Long et al., 2015; Mitten et al., 2015; Williams et al., 2020). These stigma experiences impede help-seeking (Fortune et al., 2008;

Long, 2018; Rowe et al., 2014), effective prevention and intervention efforts in schools (Parker, 2018), and foment shame (Brown & Kimball, 2012; Long, 2018; Rosenrot & Lewis, 2018).

While the extent to which people experience NSSI stigma has been minimally explored, researchers suggest that healthcare workers often hold stigmatizing views toward people who self-injure (Cleaver, 2014; Karman et al., 2014) and some parents of children who self-injure endorse NSSI stereotypes (Fu et al., 2020). Interviews (Newton & Bale, 2012) and experimental studies using descriptive vignettes of characters who have self-injured have also demonstrated that people hold largely negative perceptions of NSSI (Law et al., 2009; Lloyd et al., 2018; Burke et al. 2019). Given that stigma is associated with adverse outcomes such as diminished self-esteem (Corrigan & Rao, 2012) and increased shame (Livingston & Boyd, 2010), and prevents support-seeking for people who have self-injured (Long, 2018), NSSI stigma requires urgent research attention. Despite increasing evidence that stigma is relevant to well-being, help seeking, and recovery (Staniland et al., 2021), a comprehensive and theoretically informed measure of NSSI stigma has yet to be developed. Without a valid and reliable measure of NSSI stigma, efforts to advance our understanding of NSSI stigma may be limited.

Measuring NSSI Stigma

While prior research has adapted measures of mental illness stigma to assess NSSI stigma (e.g., Hamza et al., 2021), facets of self-injury, such as its potential visibility and voluntary nature, distinguish it both conceptually and experientially from mental illness (Staniland et al., 2021). Adaptations are unlikely to capture the full scope of NSSI stigma; thus, the utility of adapted measures is likely limited. Recently, it was theorized that NSSI stigma arises as a function of six underlying domains: origin, the reason for NSSI; concealability, the visibility of NSSI; course, the modifiability of NSSI; peril, the dangerousness of NSSI; and disruptiveness, the degree to which NSSI impacts relationships (Staniland et al., 2021). Further, it was proposed that these domains emerge as five types of stigma: public, the attitudes and beliefs of the general population; personal, the attitudes and beliefs held by an individual about others; self, the internalization of public and/or personal attitudes and beliefs; anticipated, the expectation of stigma; and enacted, the direct or indirect experience of stereotype, prejudice, and/or discrimination. Staniland et al.'s (2021) framework thus offers an empirically informed rubric that may have relevance in the development a comprehensive measure of NSSI stigma.

Measuring NSSI stigma is vital to advancing our understanding of how and why it emerges and the impact it has on people with lived experience. An NSSI stigma scale would enable researchers, clinicians, and advocates to measure levels of NSSI stigma, understand how it correlates with other constructs, and evaluate the effectiveness of stigma reduction interventions and initiatives. In this paper, we outline the development and evaluation of the Self-Injury Stigma Questionnaire (SIS-Q) across two studies. In the first study, we developed a large pool of items intended to capture each element of the NSSI stigma framework (Staniland et al., 2021), which were pilot tested and assessed for construct validity. The item pool was then reduced based on inter-item correlations and factor loadings. In the second study, we administered the reduced item pool to a new sample and assessed the psychometric properties of the SIS-Q.

Study One

The aims of Study One were twofold. The first was item generation, a deductive process informed by the NSSI stigma framework (Staniland et al., 2021). Items were generated within each domain of the NSSI stigma framework (origin, concealability, course, peril, aesthetics, and disruptiveness) and mapped across each type of NSSI stigma (public, personal, self, anticipated, and enacted). Each type of stigma was designed to operate as an independent scale, with each domain expected to operate as a factor. Therefore, we proposed five scales, each comprising six factors. The second aim was item reduction, a statistically and theoretically driven process.

Method

Measures

Alongside standard demographic information, the following were measured.

Self-Injury Stigma

Items were developed by the research team in consultation with the literature (e.g., Corrigan et al., 2012), qualitative data collected by the authors, and a special-interest research group comprising researchers, clinicians, advocates, individuals with lived experiences, and students interested in the study of self-injury. Using the NSSI Stigma Framework as a basis, we brainstormed attitudes, beliefs, and common stereotypes about self-injury (e.g., weak, resilient, drain on the healthcare system) which we phrased into items (e.g., people who self-injure are weak, people who self-injure are resilient). A total of 150 items were generated, 30 of these being positively worded. The item stems were modified to map onto each of the scales:

- Public stigma scale stem: “I think the public believe that…”

- Personal stigma scale stem: "I personally believe that…"
- Self-stigma scale stem: "Because of my self-injury, I…"
- Anticipated stigma scale stem: "If people find out about my self-injury, they…"
- Enacted stigma scale stem: "Because of my self-injury, people have…"

Both the public and personal scales comprised 150 items, 34 of which were positively worded. The self-stigma scale comprised 130 items, 34 of which were positively worded. Twenty of the items did not translate from the public/personal scales to the self-stigma scale due to some items (e.g., people who self-injured did it because their friends did) not representing self-stigma. Similarly, two items from the public/personal scales did not map onto the anticipated and enacted scales, which each comprised 148 items, 34 of which were positively worded. The final item pool comprised 726 items (see Appendix J). The latter three scales are completed only by people with a history of self-injury. Each item is responded to on a 7-point Likert scale from 1 (*strongly disagree*/*extremely unlikely*/*never*) to 7 (*strongly agree*/*extremely likely*/*always*), with higher scores indicating greater stigma.

Nonsuicidal Self-Injury

The Inventory of Statements about Self-Injury (ISAS; Klonsky & Olino, 2008) was used to collect data about self-injury. Participants were asked whether they have self-injured during their lifetime and if so, at what age they first self-injured, how many times they had done so during the past 12 months, and what their primary method was/is. The ISAS has established test-retest reliability (Glenn & Klonsky, 2011) and is a widely used (Taylor et al., 2018).

Procedure

Upon receiving ethical approval (Appendix K), the survey was built via Qualtrics and advertised to participants on Amazon's Mechanical Turk (MTurk, 2019), an online recruitment platform that allows researchers access to a large sample of people who complete surveys in exchange for monetary compensation. Participants were paid according to the anticipated completion time, which was one hour for people with a history of NSSI (USD $5.00) and 15 minutes for those without a history of NSSI (USD $2.00). Interested participants were routed from MTurk to Qualtrics where they were presented with an information sheet. Consent was obtained using a check box that allowed participants to proceed to the survey.

Participants

Based on the recommendations of Goretzko et al. (2019), a minimum sample size of 400 participants was required, with sampling adequacy to be evaluated once communalities and item-to-factor ratios were determined. We aimed to recruit approximately equal numbers of participants with and without a history of NSSI. A total of 472 responses were recorded. After removing incomplete (*n* = 85), duplicate (*n* = 55), and nonsense (e.g., free text entry in wrong format; *n* = 16) responses, the sample comprised 316 individuals aged between 20 and 67 years (*M* = 32.1, *SD* = 7.7). Most participants reported as male (*n* = 215, 68.0%) and heterosexual (*n* = 171, 54.1%). Fifty-five (17.4%) participants reported a mental illness diagnosis and 189 (40.0%) reported a history of NSSI. Most participants were employed full-time (*n* = 291, 92.1%), with 18 (5.7%) part-time/casual, six (1.9%) unemployed, and one unreported. Participants were mostly from Asia (*n* = 161, 50.9%) and the Americas (North = 64, 20.3%; South = 36, 11.4%), with the remainder from Europe (*n* = 15, 4.7%), another region (*n* = 7, 2.2%), or unreported (*n* = 33, 10.4%).

Data Analysis

Responses were first evaluated for normality, with univariate skewness $< \pm 2$ and kurtosis $< \pm 7$ demonstrating normal distribution (West et al., 1995). Data were then disaggregated by NSSI history and assessed by scale and factor. Item reduction occurred iteratively through examination of inter-item correlations and exploratory factor analyses using SPSS Version 27.

Results

Preliminary Results

Data provided by participants with no history of NSSI were missing completely at random $\chi^2(79.961) = 15728$, $p = 1.000$, as were data provided by participants with a history of NSSI, $\chi^2(.000) = 103612$, $p = 1.000$ (Little, 1988). Expectation Maximization was used to impute missing values (EM; Scheffer, 2002). Of the 189 participants reporting a history of NSSI, 171 had self-injured within the past 12 months, most having done so once (*n* = 89, 52.1%) or twice (*n* = 45, 26.3%). Reported age of onset ranged from 2[4] to 47 years (*M* = 22.2, *SD* = 7.7).

[4] "Documented age of onset tends to range between 12 and 16 years (Gholamrezaei et al., 2015), however, self-injury has been recorded among children as young as 3 years (Luby et al., 2019). It is possible that a response of 2 may have been in error (i.e., meant to be 12), however, this cannot be known for sure. Therefore, participants' responses are reported as they were entered into the survey."

Participants reported up to five physical scars, most reporting one (n = 91, 28.8%) or two (n = 68, 21.5%), with cutting the most reported main form of self-injury (n = 95, 50.3%).

Item Reduction

Item reduction occurred in two stages: first via inter-item correlations, and second via factor loadings. Because items were developed within the six domains proposed by the NSSI stigma framework (origin, concealability, course, peril, aesthetics, and disruptiveness; Staniland et al., 2021), it was expected that each of these domains would represent a factor within each scale (public, personal, self, anticipated, and enacted). For example, the item "people who self-injure are weak" was developed to capture origin, so it was expected that this item, along with other items developed within the origin domain, would load onto an "origin" factor. Additionally, each item was represented across each scale of the questionnaire, rephrased to fit the type of stigma. For example, the item "people who self-injure are weak" represents the public and personal scales, whereas on the self-stigma scale, this item was phrased as "I am weak". An overview of the reduction process can be seen in Table 5.1

Inter-Item Correlations

As per Ferketich's (1991) guidance, items correlating ≥ 0.70 or ≤ 0.40 were considered for removal. Items with high correlations were compared for face-validity; the item with the preferred wording was retained. Items with low correlations were compared across scales and retained only if inter-item correlations were ≥ 0.70 on two or more scales. Several iterations were performed until all inter-item correlations fell within the desired range, resulting in 53 items for the public, personal, anticipated, and enacted NSSI stigma scales (origin = 14, concealability = 7, course = 7, peril = 8, aesthetics = 6, disruption = 11) and 42 for the NSSI self-stigma scale (origin = 10, concealability = 7, course = 6, peril = 6, aesthetics = 6, disruption = 9).

Exploratory Factor Analyses

Exploratory factor analyses (EFA) were used to assess each item's performance as an indicator of its theorized factor (see Table 5.2). The minimum acceptable factor loading was set at 0.32, with any item loading ≥ 0.32 across two or more factors consider to be cross-loading and therefore a candidate for removal (Tabachnick & Fidell's, 2001). The minimum acceptable item communality was set at 0.40, with a preference for communalities to be ≥ 0.70 (Velicer & Fava, 1998). Because the SIS-Q comprises five scales, each with six proposed factors, items were clustered into their theorized factors and then assessed using EFA with oblique Promax rotation

and principal axis extraction, forcing a one factor solution. Each item's factor loading was compared across scales to identify those that did not load onto their respective factor consistently across scales. In the first round of EFAs, all items produced strong factor loadings of ≥ 0.50 (Costello & Osborne, 2005). Given the item pool was still large, items loading < 0.70 were considered for removal. Several iterations were performed until all factor loadings exceeded 0.70, resulting in 33 items for the public, personal, anticipated, and enacted NSSI stigma scales (origin = 7, concealability = 5, course = 5, peril = 5, aesthetics = 4, disruption = 7) and 28 for the NSSI self-stigma scale (origin = 5, concealability = 5, course = 5, peril = 3, aesthetics = 3, disruption = 7).

Table 5.1
Item Reduction Process

	Public Stigma			Personal Stigma			Self-Stigma			Anticipated Stigma			Enacted Stigma		
	I think the public believes…			I believe that…			My experience of self-injury means that…			…how likely do you think the following would occur?			…how often the following have happened?		
	Number of items at each step														
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Origin	36	14	7	36	14	7	32	10	5	37	14	7	37	14	7
Concealability	22	7	5	22	7	5	18	7	5	19	7	5	19	7	5
Course	18	7	5	18	7	5	16	6	5	18	7	5	18	7	5
Peril	23	8	5	23	8	5	19	6	3	23	8	5	23	8	5
Aesthetics	13	6	4	13	6	4	11	5	3	13	6	4	13	6	4
Disruptiveness	38	11	7	38	11	7	35	9	7	38	11	7	38	11	7
Total	150	53	33	150	53	33	130	42	28	148	53	33	148	53	33

Note. Step 1 = initial pool of items, step 2 = after reduction based on bivariate correlations, step 3 = after reduction based on exploratory factor analysis.

Table 5.2
Factor Loadings

	NSSI-N (n = 127)						NSSI-Y (n = 189)															
	Public			Personal			Public			Personal			Self			Anticipated			Enacted		
	Factor Loadings at each Iteration																				
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Origin																					
… are/am manipulative	.85	.79	-	.79	.84	-	.80	.84	-	.87	.84	-	.80	.79	-	.77	.81	-	.82	.81	-
… are/am crazy	.78	.83	-	.84	.78	-	.81	.82	-	.83	.84	-	.82	.80	-	.76	.74	-	.76	.75	-
… copied it from social media/internet	.76	.84	-	.81	.74	-	.72	.78	-	.79	.83	-	-	-	-	.69	.74	-	.75	.76	-
… are/am attention seeking	.77	.72	-	.71	.75	-	.69	.70	-	.81	.83	-	.81	.81	-	.77	.79	-	.81	.81	-
… are/am to blame for their/my problems	.76	.73	-	.78	.77	-	.78	.78	-	.84	.85	-	.74	.76	-	.81	.80	-	.83	.82	-
… are/am weak	.77	.78	-	.76	.81	-	.77	.78	-	.85	.87	-	.80	.79	-	.70	.69	-	.77	.78	-
… did it because their/my friends did	.76	.76	-	.76	.77	-	.73	.74	-	.79	.81	-	-	-	-	.73	.76	-	.83	.85	-
… are/am masochistic	.76	-	-	.72	-	-	.74	-	-	.74	-	-	-	-	-	.71	-	-	.79	-	-
… are/am childish	.75	-	-	.72	-	-	.72	-	-	.73	-	-	-.77	-	-	-.66	-	-	.76	-	-
… are/am dysfunctional	.74	-	-	.69	-	-	.79	-	-	.72	-	-	.76		-	.75	-	-	.74	-	-
… are/am “emo” or “goth”	.68	-	-	.76	-	-	.76	-	-	.84	-	-	-	-	-	-.66	-	-	.81	-	-
… have a mental illness	.67	-	-	.68	-	-	.77	-	-	.65	-	-	.75	-	-	.71	-	-	.75	-	-
… don’t really have anything to complain about	.66	-	-	.81	-	-	.73	-	-	.83	-	-	.80	-	-	.71	-	-	.75	-	-
… are/am emotionally unstable	.54	-	-	.65	-	-	.78	-	-	.67	-	-	.77	-	-	.76	-	-	.79	-	-

Concealability																					
… should not let others know about it	.84	.85	.81	.82	.81	.82	.83	.83	.82	.79	.81	.83	.77	.76	.74	.72	.73	.72	.83	.84	.84
… should avoid talking about self-injury	.75	.76	.76	.76	.75	.76	.82	.83	.83	.83	.83	.84	.78	.80	.81	.78	.78	.76	.84	.83	.83
… should cover up their/my self-injury	.75	.75	.75	.73	.75	.76	.74	.77	.77	.78	.77	.78	.80	.81	.86	.75	.76	.79	.86	.87	.88
… don't need to talk about it	.74	.75	-	.54	.52	-	.66	-	-	.73	.75	-	.67	.67	-	.78	.76	-	.84	.83	-
… should not post about self-injury online	.71	.71	.82	.81	.82	.73	.79	.79	.79	.79	.80	.79	.74	.75	.72	.70	.71	.73	.82	.83	.83
… should toughen up	.66	.64	.80	.80	.79	.65	.70	.67	.78	.81	.79	.65	.76	.74	.72	.77	.78	.75	.75	.75	.75
…should show evidence of their self-injury when asked	.64	-	-	.83	-	-	.59	-	-	.70	-	-	.58	-	-	.72	-	-	.83	-	-
Course																					
… will never be able to manage their/my emotions	.78	.79	-	.77	.77	-	.72	.71	-	.77	.77	-	.77	.80	-	.68	.69	-	.80	.80	-
… will never be able to cope	.74	.71	-	.73	.74	-	.78	.77	-	.77	.74	-	.78	.82	-	.75	.72	-	.80	.77	-
… just going through a phase	.73	.74	-	.79	.74	-	.81	.79	-	.74	.76	-	.66	.58	-	.71	.66	-	.78	.75	-
… should be forced to stop	.67	.71	-	.70	.72	-	.76	.79	-	.76	.75	-	.78	.78	-	.68	.72	-	.73	.77	-
… don't have the guts to kill themselves	.63	-	-	.75	-	-	.69	-	-	.75	-	-	-	-	-	.71	-	-	.79	-	-
… should be able to easily recover	.58	-	-	.68	-	-	.77	-	-	.78	-	-	.67	-	-	.65	-	-	.77	-	-
… should be checked for signs of self-injury	.58	.58	-	.52	.545	-	.74		-	.72	-	-	.80	.79	-	.76	.78	-	.77	.79	-
Peril																					
… belong in a mental institution	.77	.77	.78	.82	.83	.84	.78	.79	.78	.81	.80	.80	.86	.91	.93	.82	.82	.81	.80	.81	.80
… are/am dangerous	.74	.73	.74	.77	.75	.75	.76	.76	.75	.84	.86	.86	.78	.79	.79	.79	.82	.82	.87	.87	.87

… share pictures of their self-injury online	.74	.74	.72	.70	.69	.69	.77	.75	.77	.77	.76	.75	-	-	-	.72	.74	.75	.78	.79	.80
… copied the behaviour from someone else	.70	.67	.66	.78	.79	.76	.75	.74	.75	.82	.83	.83	-	-	-	.71	.74	.75	.81	.82	.83
… always be at risk of suicide	.69	.69	.71	.74	.74	.75	.79	.81	.80	.78	.79	.79	.79	.81	.79	.75	.72	.70	.84	.83	.81
… are/am impulsive	.69	.69	-	.70	.70	-	.80	.79	-	.67	.64	-	.71	.61	-	.72	.69	-	.84	.83	-
… are/am reckless	.64	-	-	.65	-	-	.70	-	-	.79	-	-	.81	-	-	.75	-	-	.75	-	-
… self-injury is not important	.63	-	-	.66	-	-	.65	-	-	.72	-	-	.76	-	-	.70	-	-	.82	-	-
Disruptiveness																					
… don’t care if they upset their friends and family	.77	.76	.75	.77	.75	.71	.81	.78	.76	.71	.67	.61	.87	.87	.87	.74	.74	.72	.78	.79	.79
… should not have children	.76	.77	.78	.74	.73	.75	.74	.75	.76	.78	.82	.84	.84	.86	.86	.82	.81	.82	.80	.80	.80
… do not care about others	.80	.90	.80	.72	.76	.78	.78	.79	.82	.76	.77	.80	.84	.83	.83	.84	.83	.84	.79	.79	.80
… should avoid talking about it with others	.77	.80	.78	.70	.71	.74	.77	.77	.78	.80	.81	.82	.72	.70	.70	.75	.75	.74	.77	.76	.75
… should stay away from me/people who self-injure	.77	.75	.76	.72	.70	.71	.81	.81	.81	.76	.75	.78	.89	.89	.89	.82	.82	.83	.85	.86	.86
… waste their/my friends’ time	.77	.80	.79	.70	.72	.69	.77	.77	.77	.67	.65	.58	.81	.80	.81	.76	.78	.77	.80	.79	.79
… deserve poor treatment	.61	.63	.64	.60	.63	.63	.68	.71	.70	.72	.76	.77	.85	.86	.86	.78	.78	.80	.82	.83	.84
… are selfish	.77	-	-	.65	-	-	.78	-	-	.65	-	-	.70	-	-	.67	-	-	.81	-	-
… refuse to accept help	.76	.77	-	.64	.607	-	.81	.80	-	.61	.58	-	-	-	-	.74	.74	-	.80	.80	-
… need to be controlled	.71	-	-	.63	-	-	.66	-	-	.72	-	-	.67	-	-	.78	-	-	.79	-	-
… need to be treated delicately	.40	-	-	.43	-	-	.67	-	-	.61	-	-		-	-	.77	-	-	.77	-	-

Study Two

The aim of Study Two was to assess the psychometric properties of the SIS-Q. Confirmatory factor analyses were used to examine the factor structure of the scales and measurement invariance between participants with and without a history of NSSI on the public and personal scale. Further item reduction occurred as appropriate. Construct validity was assessed through examination of correlations between the SIS-Q and measures of mental illness stigma, social exposure to NSSI, and indicators of stigma impact including shame and self-esteem. Internal consistency was assessed using Cronbach's alpha and McDonald's omega.

Method

Measures

Alongside standard demographic information, the following constructs were measured.

Nonsuicidal Self-Injury

As described in Study One, NSSI was assessed using the ISAS (Klonsky & Olino, 2008).

Self-Injury Stigma Questionnaire

The final set of items from Study One was used.

Mental Illness Stigma

The Self-Stigma of Mental Illness Scale (SSMIS; Corrigan et al., 2006) was included as a validation measure for the SIS-Q. The SSMIS comprises four subscales, each with 10 items: awareness ("I think the public believes most people with a mental illness cannot be trusted); agreement ("I think most people with a mental illness cannot be trusted"); application ("Because I have a mental illness, I cannot be trusted); and harm ("I currently respect myself less because I cannot be trusted"). The harm subscale was not used, as it indicates an outcome of stigma, rather than the construct itself. Participants reporting a mental illness diagnosis were presented with the SSMIS and asked to rate each item on a 9-point Likert scale, ranging from 1 (*strongly disagree*) to 9 (*strongly agree*), with higher scores indicating greater stigma. Each subscale has acceptable internal consistency (awareness, $\alpha = 0.91$; agreement, $\alpha = .0.72$; application, $\alpha = .81$) and test-retest reliability (awareness, $r = 0.73$; agreement, $r = .0.68$; application, $r = .82$; Corrigan et al., 2006). In the present sample, Cronbach's alphas were 0.94 for awareness, 0.92 for agreement, and 0.89 for application. Positive correlations were expected between awareness and public NSSI stigma, agreement and personal NSSI stigma, and between application and self-stigma.

NSSI Social Exposure

The 10-item[5] Social Exposure to NSSI Scale (SENS; Zelkowitz et al., 2017) measures the degree of exposure participants have had to NSSI-related media (e.g., “I have seen references to different forms of NSSI in movies”) and in interpersonal relationships (e.g., “I have friends who engage in NSSI”). Each item has a 4-point Likert response scale from 1 (*never*) to 4 (*frequently*), with responses on each subscale summed to provide a media exposure score and an interpersonal exposure score, with higher scores indicating more social exposure to NSSI. Both subscales demonstrate acceptable internal consistency (interpersonal, α = 0.85; media, α = 0.79; Zelkowitz et al., 2017), including in the present sample (interpersonal, α = 0.89; media; α = 0.84). Positive correlations were expected between media exposure and the SIS-Q. Small negative correlations were expected between interpersonal exposure and the SIS-Q.

Social Reactions to NSSI

The 39-item Social Reactions to Self-Injury Disclosure scale (SRSD; Ammerman & McCloskey, 2020) measures three types of possible reactions experienced in response to disclosing NSSI: negative reactions (e.g., “pulled away from you”), tangible aid (e.g., “distracted you with other things”), and emotional support (e.g., “spent time with you”), each scored on a 5-point Likert scale from 0 (*never*) to 4 (*always*). Each subscale has acceptable internal consistency (negative reactions, α = 0.96 - 0.97; tangible aid, α = 0.69 - 0.71; emotional support, α = 0.91 - 0.92; Ammerman & McCloskey, 2020), including in the present study (negative reactions, α = 0.97; tangible aid, α = 0.72; emotional support, α = 0.93). Positive correlations were expected between negative reactions and the self-, anticipated, and enacted NSSI stigma scales. Negative correlations were expected between tangible aid and emotional support, and the self-, anticipated, and enacted NSSI stigma scales.

Self-Esteem

The 10-item Rosenberg Self-Esteem scale (RSE; Rosenberg, 1965) was used to assess self-esteem (e.g., “On the whole I am satisfied with myself”). Each item is scored on a 4-point Likert scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*), with higher scores indicating higher self-esteem. The RSE has sound internal consistency (α = 0.84 - 0.95; Sinclair et al.,

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[5] Zelkowitz et al. excluded items 2 and item 8 due to poor factor loadings. In the present sample both items meaningfully loaded onto the media factor as expected and were thus included (output presented in Appendix L).

2010), including in the present sample (α = 0.94). Negative correlations were expected between the RSE and the self-, anticipated, and enacted NSSI stigma scales.

Shame

The 25-item Experiences of Shame Scale (ESS; Andrews et al., 2002) comprises three subscales: characterological shame (e.g., "have you felt ashamed of any of your personal habits?"), behavioral shame (e.g., "do you feel ashamed when you do something wrong?"), and bodily shame (e.g., "have you felt ashamed of your body or any part of it?"). Each item is scored on a 4-point Likert scale from 1 (*not at all*) to 4 (*very much*), with higher scores indicating stronger feelings of shame. The ESS has demonstrated internal consistency (α = 0.92; Andrews et al., 2002), including in the present sample (α = 0.96). Positive correlations were expected between the ESS and the self-, anticipated, and enacted NSSI stigma scales.

Instructional Attention Check

An instructional attention check is a response-format matched item embedded within a scale that provides participants with a specific instruction, such as “Please select *strongly agree* for this question” (Huang et al., 2015). To identify careless responses, which can contaminate data and challenge validity, an instructional attention check was included for each of the Self-Injury Stigma Questionnaire. Participants without lived experience were exposed to two attention checks, one in the public stigma scale and one in the personal stigma scale, with incorrect responses to both resulting in the participant’s data being excluded from analysis. Participants with lived experience were exposed to five attention checks, one each on the public, personal, self, anticipated, and enacted stigma scales, with incorrect responses to two or more resulting in the participant's data being excluded from analysis.

Procedure

Upon receiving ethical approval, the study was advertised on MTurk, social media platforms, and our university’s research participant pool. Details about the study were provided in the advertisements and interested participants could click a link to take them to an information sheet. Informed consent was obtained via clickable checkbox, which took participants to a set of three multi-choice questions (e.g., what is the study about?) that assessed comprehension of the information sheet. Correct responses indicated that participants understood the detail given in the information sheet and were therefore able to provide informed consent. Incorrect responses suggested comprehension of the information sheet was insufficient to provide informed consent.

Participants who responded incorrectly were unable to proceed and were shown a thank you message, participants who responded correctly proceeded to the survey, where they completed the battery of measures. Participants recruited via MTurk were reimbursed as per Study One, those recruited via social media were not reimbursed, and those recruited through our university's research participation pool were awarded course credit for their contribution.

Participants

A minimum sample size of 322 (161 participants with a history of NSSI and 161 participants without) was required given an anticipated effect size of 0.3, desired power of 0.8, 33 observed variables (items per scale), six latent variables (representing the six domains), and probability set at .05 (Soper, 2022; Westland, 2010). Simulations suggest accurate parameter estimates are obtained with 500 participants given fewer than 240 items (Jiang et al., 2016). Therefore, we aimed to recruit 1000 participants (500 participants with a history of NSSI and 500 without).

A total of 1112 participants responded to the survey. After removing incomplete responses (n = 314), duplicate cases (n = 22), and those who failed the attention checks (n = 54), the final sample comprised 722 participants aged between 14 and 75 years (M = 29.2, SD = 12.7). Participants were recruited via social media platforms (n = 271, 37.5%), our university research participant pool (n = 262, 36.3%), and MTurk (n = 188, 26.0%). Of the sample, 402 (55.7%) reported a lifetime history of NSSI. Of these participants, 269 (66.9%) had self-injured within the past year, most having done so five or more times (n = 145). Reported age of onset ranged between 4[6] and 44 years (M = 14.6, SD = 4.89), with cutting the most common main form of self-injury (n = 217, 54.9%). Sample demographics are displayed in Table 5.3.

Data Analysis

Due to the theoretically informed structure of the proposed measurement model, confirmatory factors analysis (CFA) was deemed most appropriate (Brown & Moore, 2012). Evaluation of univariate skewness and kurtosis revealed several positively skewed (>2) and leptokurtic (>7) items (West et al., 1995; see Tables 5.4 – 5.8). Consequently, maximum likelihood mean adjusted (MLM) estimation with robust standard errors was used, scaled with

[6] Documented age of onset tends to range between 12 and 16 years (Gholamrezaei et al., 2015). It is possible that a response of 4 may have been in error (i.e., meant to be 14), however, this cannot be known for sure. Therefore, participants' responses are reported as they were entered into the survey.

the Satorra-Bentler (SB) correction factor (scf; Satorra & Bentler, 1994). Model fit was assessed iteratively as per conventions outlined by Brown (2015), with Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI) values of 0.95 or above, Root Mean Square Error of Approximation (RMSEA) and Standardized Root Mean Square (SRMR) values below 0.08, and non-significant chi-square values representing good fit.

Table 5.3
Sample Demographics Disaggregated by NSSI history for Study Two

	NSSI History		No NSSI History		Total Sample	
	n	%	*n*	%	*n*	%
Gender						
Woman	261	65.1	201	62.8	462	64.1
Man	85	21.2	112	35.0	197	27.3
Transgender	15	3.7	3	0.9	18	2.5
Nonbinary	37	9.2	3	0.9	40	5.5
Other*	3	0.6	1	0.3	4	0.9
Sexual Orientation						
Gay/Lesbian	37	9.2	13	4.1	50	7.0
Bisexual	119	29.7	31	9.8	150	20.9
Asexual	22	5.5	5	1.6	27	3.8
Heterosexual	206	51.4	264	83.3	470	65.5
Queer	9	2.2	1	0.3	10	1.4
Other*	8	1.9	4	0.9	12	1.5
MI Diagnosis						
Yes	275	68.8	94	29.4	369	51.2
No	125	31.3	226	70.6	351	48.8

Note. *Other included genderfluid (n = 1), unsure (n = 1), and prefer not to say (n = 2). MI = mental illness.

The psychometric equivalence of the public and personal scales across participants with and without a history of NSSI was assessed using multigroup CFA, again with MLM estimation and SB correction. Configural, metric, scalar, and strict invariance were evaluated as per conventions outlined by Chen (2007), whereby invariance is demonstrated through non-significant chi-square changes and changes in CFI, RMSEA, and SRMR less than 0.01, 0.015, and 0.015 respectively. Being the first assessment of the SIS-Q's psychometric properties, evaluation of factor structure and measurement invariance occurred in tandem, such that measurement invariance results informed the final model. This enabled appropriate representation of the construct informed by successive modification indices. All CFA analyses were conducted using the *lavaan* package for R (version 0.6-8; Rosseel et al., 2021).

Internal consistency was evaluated using Cronbach's alpha and McDonald's omega, both computed in JASP (JASP Team, 2020), with values ≥ 0.70 considered acceptable (Lance et al., 2006). Using SPSS Version 27, a one-way analysis of variance was conducted to examine differences between participants with and without a history of NSSI on the public and personal scales, and bivariate correlations were used to investigate convergent and discriminant validity.

Results

Preliminary Results

Data were missing completely at random for all scales except negative reactions, $\chi^2(483) = 547.14$, $p = .023$, and shame, $\chi^2(561) = 693.94$, $p < .001$. Given no more than 5% of data were missing, EM was used to impute missing values (Scheffer, 2002).

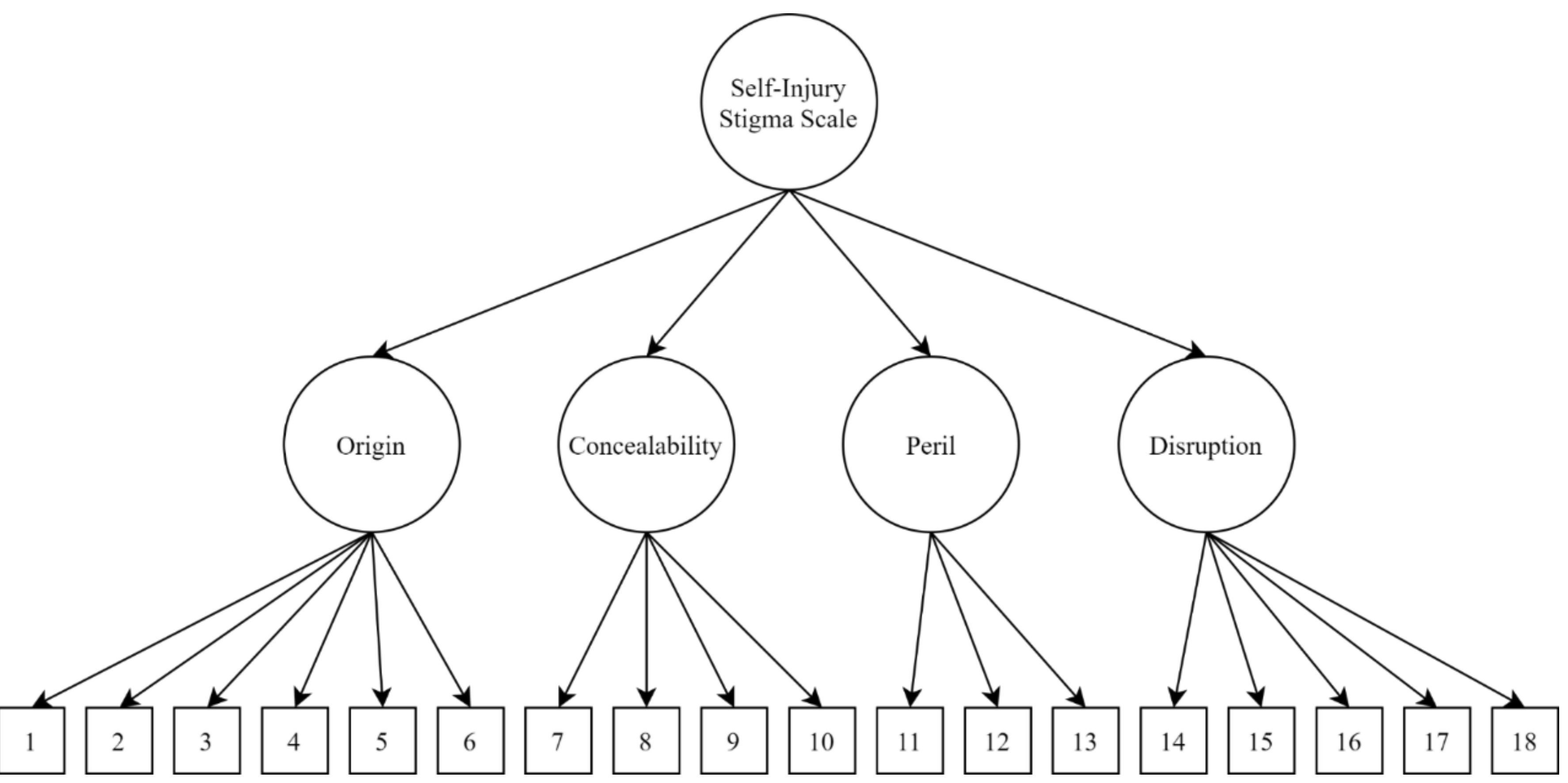
Scale Evaluation

Model Identification and Factor Structure

The theorized model was first evaluated per scale (public, personal, self, anticipated, and enacted stigma) and then iteratively re-specified. Model fit statistics can be found in Table 5.4 for the public and personal scales, completed by the whole sample, and in Table 5.5 for the self, anticipated, and enacted scales, completed only by participants with lived experience of NSSI. A conceptual diagram of the SIS-Q can be seen in Figure 5.1.

Figure 5.1

Visual Conceptualization of Factors and Indicators of the Self-Injury Stigma Questionnaire



Note. This conceptualization is applicable to each of the five scales: Public, Personal, Self, Anticipated, and Enacted.

Public and Personal NSSI Stigma Scales. Initial model fit was poor for the public scale and reasonable for the personal scale (Table 5.4). Due to a non-positive-definite sample covariance matrix for the public scale, model re-specification began with the personal scale. Three low-loading (< .40) items ("self-injury scars represent strength", "self-injury scares are no different to other types of scars", and "people who have self-injured should be forced to stop") were removed and factors five (aesthetics) and six (disruption) were collapsed due to high covariance (> .90) and conceptual overlap of items. Subsequent re-specifications were informed by theoretically valid modification indices, whereby items were iteratively moved, removed, or covaried. Prior to analysis of measurement invariance, this intermediate model comprised five factors: Origin, represented by five items; Concealability, represented by four items; Course, represented by three items, Peril, represented by three items; and Disruption, represented by five items. This model demonstrated acceptable fit to the public scale.

Measurement invariance of the public and personal scales was then assessed. Configural invariance was demonstrated for the public scale but not the personal scale. Examination of modification indices indicated Chi-square improvement if factors one (origin) and three (course) were collapsed. Due to theoretical and conceptual overlap between the indicators of these constructs, we proceeded with the modified four-factor model, and configural invariance was met for both the public and personal scales. Factor loadings were then fixed across both groups to assess metric invariance, which was demonstrated for the public scale but not the personal scale. Modification indices identified two items ("I think people who have self-injured should be forced to stop" and "I think people who have self-injured will never be able to manage their emotions") as variant. These were removed and metric invariance was subsequently met.

Intercepts were then fixed to assess scalar invariance, which was partially met for the public scale by allowing two items to intercept freely, and for the personal scale by allowing five items to intercept freely. Finally, residuals were fixed to assess strict invariance, which was partially met for the public scale by freeing five residuals and for the personal scale holding prior specifications. Despite achieving only partial strict invariance, examination of latent mean score differences demonstrated that accounting for such invariance did not substantially alter the latent mean scores for each sample on each scale. The final model demonstrated acceptable fit (Chen, 2007) and comprised four factors: Origin, represented by six items; Concealability, represented by four items; Peril, represented by three items; and Disruption, represented by five items.

Table 5.4

Model Fit Statistics for Confirmatory Factor Analyses of the Public and Personal NSSI Stigma Scale

	$_{SB}\chi^2$ (df)	*scf*	$\Delta\chi^2$(df)	*p*	CFI	ΔCFI	TLI	ΔTLI	RMSEA	ΔRMSEA	SRMR	ΔSRMR
Public Scale												
Initial Model	2601.39 (480)[a]	1.29	-	< .001	0.853	-	0.838	-	0.089	-	0.061	-
Intermediate Model	432.82 (141)	1.32	-	< .001	0.964	-	0.956	-	0.061	-	0.039	-
Configural Model	479.47 (248)	-	-	-	0.967	-	0.960	-	0.058	-	0.041	-
Metric Model	493.24 (262)	-	13.77 (14)	0.467	0.968	0.001	0.962	-0.002	0.056	-0.002	0.047	-0.006
Partial Scalar Model	508.24 (274)	-	15.00 (12)	0.241	0.968	0.000	0.964	0.002	0.055	-0.001	0.047	0.000
Partial Strict Model	509.21 (286)	-	0.97 (12)	1.000	0.969	0.001	0.967	0.003	0.052	-0.003	0.048	0.001
Final Model	355.67 (124)	1.29	-	< .001	0.969	-	0.962	-	0.058	-	0.038	-
Personal Scale												
Initial Model	2452.86 (480)	1.57	-	< .001	0.765	-	0.740	-	0.094	-	0.078	-
Intermediate Model	421.55 (160)	1.73	-	< .001	0.942	-	0.931	-	0.062	-	0.051	-
Configural Model	415.44 (250)	-	-	-	0.958	-	0.948	-	0.056	-	0.048	-
Metric Model	427.08 (264)	-	10.64 (14)	0.714	0.958	0.000	0.952	0.004	0.054	-0.002	0.057	0.009
Partial Scalar Model	443.35 (273)	-	16.27 (9)	0.061	0.957	-0.001	0.952	0.000	0.054	0.000	0.058	0.001
Partial Strict Model	460.47 (291)	-	17.12 (18)	0.515	0.956	-0.001	0.954	0.002	0.053	-0.001	0.060	0.002
Final Model	322.37 (125)	1.69	-	< .001	0.952	-	0.941	-	0.061	-	0.047	-

Note. [a]Initial fit for the public scale produced a non-positive-definite sample covariance matrix. All $_{SB}\chi^2$ values significant at $p < .001$.

Self, Anticipated, and Enacted NSSI Stigma Scales. Initial model fit, using the hypothesised factor structure, was unacceptable for each of the self, anticipated, and enacted scales (Table 5.5). Model re-specification began with the self scale. To maintain item consistency across scales, decisions were guided by those made for the personal/public model where possible. We first collapsed factors five (aesthetics) and six (disruption) and removed low-loading (< .40) items ("I should be forced to stop", "I must be going through a phase", "I deserve to have my body searched for signs of self-injury", "my self-injury represents strength", "I don't care if I upset my friends and family", and "I do not care about others". Modification indices suggested one item from the course factor ("I should just toughen up") belonged to the origin factor; given that the origin and course factors were collapsed in the personal/public models, we proceeded to do the same for the self scale. For parsimony, item 19 ("I am unattractive") was removed. Two items ("I am just going through a phase" and "I do not care about others") did not load meaningfully within the self scale, and were removed, leaving two items ("I should just toughen up" and "People should stay away from me") in their place. The final model demonstrated acceptable fit (Chen, 2007; Table 5.5) and comprised four factors: Origin, represented by six items; Concealability, represented by four items; Peril, represented by three items; and Disruption, represented by five items. This model was then fit to the anticipated and enacted scales, each demonstrating acceptable fit (Chen, 2007).

Table 5.5

Model Fit Statistics for Confirmatory Factor Analyses of Self, Anticipated, and Enacted NSSI Stigma Scales

	Initial Fit						Final Fit					
	$_{SB}\chi^2$ (df)	*scf*	CFI	TLI	RMSEA	SRMR	$_{SB}\chi^2$ (df)	*scf*	CFI	TLI	RMSEA	SRMR
Self	954.69 (309)	1.25	0.835	0.813	0.089	0.084	243.37 (126)	1.21	0.957	0.948	0.058	0.052
Anticipated	1602.11 (480)	1.25	0.814	0.795	0.095	0.082	225.45 (125)	1.30	0.968	0.961	0.056	0.039
Enacted	1242.38 (480)	1.64	0.846	0.831	0.091	0.061	166.95 (124)	1.64	0.983	0.979	0.043	0.034

Note. All $_{SB}\chi^2$ values significant at $p < .001$.

Validity Analyses

The convergent and divergent validity of each factor was assessed by NSSI Stigma scale, disaggregated by NSSI history for the public and personal scales. Correlation tables are presented in the supplementary materials.

Public Stigma Scale. Within the full sample, all factors of the public NSSI stigma scale positively correlated with public mental illness stigma, demonstrating convergent validity. Origin and concealability were negatively correlated, and peril and disruption were uncorrelated with personal mental illness stigma, demonstrating divergent validity. All factors were positively correlated with interpersonal exposure to NSSI. Origin and peril were positively correlated, and concealability and disruption were uncorrelated with media exposure. Within the sample with lived experience, all factors were positively correlated with public mental illness stigma. Origin was negatively correlated and the other factors uncorrelated with personal mental illness stigma. All factors were positively correlated with interpersonal exposure. Peril was positively correlated and the other factors uncorrelated with media exposure. Within the sample without lived experience, all factors positively correlated with public mental illness stigma. Disruption was positively correlated and the other factors uncorrelated with personal mental illness stigma. No factors were correlated with media exposure. Origin was positively correlated, and the other factors were uncorrelated with interpersonal exposure.

Personal Stigma Scale. Within the full sample, all factors of the personal stigma scale were positively correlated with personal mental illness stigma, demonstrating convergent validity. All factors were uncorrelated with public mental illness stigma, demonstrating divergent validity. All factors except peril were negatively correlated with media exposure. All factors were negatively correlated with interpersonal exposure. Within the sample with lived experience, all factors were positively correlated with personal mental illness stigma and were uncorrelated with public mental illness stigma. All factors except peril were negatively correlated with both media and interpersonal exposure. Within the sample without lived experience, all factors were positively correlated with personal mental illness stigma and were uncorrelated with public mental illness stigma. Origin and peril were negatively correlated, and concealability and disruption were uncorrelated with media exposure. All factors were negatively correlated with interpersonal exposure.

Table 5.6
Bivariate Correlations Between Factors of Public and Personal NSSI Stigma and Validation Variables for the Full Sample

Variable	1	2	3	4	5	6	7	8	9	10	12	13
1. PUB Origin	-											
2. PUB Conceal	.73***	-										
3. PUB Peril	.68***	.62***	-									
4. PUB Disrupt	.67***	.65***	.72***	-								
5. PER Origin	.01	-.06	.01	.02	-							
6. PER Conceal	.07	.16***	.08*	.11**	.46***	-						
7. PER Peril	-.08*	-.07*	.18***	.01	.56***	.35***	-					
8. PER Disrupt	-.09*	-.04	.02	.12**	.66***	.46***	.59***	-				
9. Public MI stigma	.52***	.44***	.47***	.50***	-.07	.03	.88	-.03	-			
10. Personal MI stigma	-.08*	-.09*	.03	.03	.60***	.42***	.47***	.58***	.13**	-		
12. NSSI Media Exposure	.10**	.06	.11*	.06	-.12**	-.13**	-.06	-.11**	.12**	-.04	-	
13. NSSI Interpersonal Exposure	.20***	.16***	.16***	.12**	-.17***	-.16***	-.11**	-.15***	.14***	-.13***	.61***	-

Note. $N = 722$. PUB = Public, PER = Personal, MI = Mental illness.
*$p < .05$. **$p < .01$. ***$p < .001$

Table 5.7

Bivariate Correlations Between Factors of Public and Personal NSSI Stigma and Validation Variables Disaggregated by NSSI History

Variable	1	2	3	4	5	6	7	8	9	10	12	13
1. PUB Origin	-	.70***	.64***	.61***	.14***	.09	-.03	-.05	.49***	-.01	.08	.15*
2. PUB Conceal	.72***	-	.58***	.58***	.05	.19**	-.02	.002	.40***	-.04	.01	.07
3. PUB Peril	.69***	.64***	-	.64***	.11*	.12*	.29***	.08	.44***	.08	.05	.08
4. PUB Disrupt	.68***	.68***	.75***	-	.18**	.17**	.09	.25***	.43***	.15**	.01	.04
5. PER Origin	-.03	-.10	-.02	-.50	-	.57***	.60***	.69***	.01	.61***	-.12*	-.18**
6. PER Conceal	.01	.10	.04	.03	.44***	-	.48***	.55***	-.002	.50***	-.10	-.14*
7. PER Peril	-.02	-.02	.16**	.03	.48***	.43***	-	.64***	.005	.57***	-.11*	-.18**
8. PER Disrupt	-.06	-.02	.01	.07	.60***	.45***	.51***	-	-.04	.62***	-.10	-.13*
9. Public MI stigma	.50***	.41***	.46***	.51***	-.09	.01	.08	.03	-	.22***	.15**	.11
10. Personal MI stigma	-.10*	-.08	.03	-.01	.58***	.41***	.55***	.53***	.06	-	-.003	-.14*
12. NSSI Media Exposure	.09	.08	.14**	.07	-.10*	-.16**	.01	-.11*	.08	-.06	-	.58***
13. NSSI Interpersonal Exposure	.17***	.15**	.17**	.11*	-.12*	-.20***	-.003	-.14**	.11*	-.10*	.62***	-

Note. PUB = Public, PER = Personal, MI = Mental illness.
Lower left correlations = sample with an NSSI history (n = 402), upper right correlations = sample with no NSSI history (n = 320).
*p < .05. **p < .01. ***p < .001

Self-Stigma Scale. All factors of the self-stigma scale positively correlated with mental illness self-stigma, demonstrating convergent validity. All factors were positively correlated with the corresponding factors on the personal NSSI stigma scale, with weak to moderate correlations demonstrating divergent validity. All factors except origin positively correlated with negative social reactions. Origin was positively correlated and the other factors uncorrelated with tangible aid. Disruption was negatively correlated and the other factors uncorrelated with social support. Peril was positively correlated and the other factors uncorrelated with both interpersonal and media exposure. All factors were negatively correlated with self-esteem and positively correlated with shame.

Anticipated Stigma Scale. All factors of the anticipated stigma scale were positively correlated with their corresponding factors on the enacted stigma scale. Weak to moderate correlations demonstrated divergent validity. No factors were correlated with personal mental illness stigma, further demonstrating divergent validity. All factors were positively correlated with public mental illness stigma and negative reactions, demonstrating convergent validity. Peril and disruption were positively correlated, and origin and concealability uncorrelated with tangible aid. All factors except peril were negatively correlated with emotional support. No factors correlated with media or interpersonal exposure.

Enacted Stigma Scale. All factors of the enacted stigma scale were positively correlated with their corresponding factors on the anticipated stigma scale. Weak to moderate correlations demonstrated divergent validity. No factors were correlated with personal mental illness stigma, further demonstrating divergent validity. All factors were positively correlated with public mental illness stigma, negative reactions, and tangible aid demonstrating convergent validity. All factors except peril were negatively correlated with emotional support and positively correlated with both interpersonal and media exposure.

Table 5.8

Bivariate Correlations Between Factors of NSSI Self-Stigma and Validation Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. SELF Origin	-															
2. SELF Conceal	.50***	-														
3. SELF Peril	.50***	.26***	-													
4. SELF Disrupt	.65***	.47***	.60***	-												
5. PER Origin	.24***	.12*	.09	.09	-											
6. PER Conceal	.06	.31***	.04	.09	.44***	-										
7. PER Peril	.15**	.13*	.40***	.12*	.48***	.32***	-									
8. PER Disrupt	.16**	.13*	.16**	.23***	.60***	.45***	.51***	-								
9. MI self-stigma	.43***	.23***	.42***	.48***	.26***	.06	.28***	.18**	-							
10. Negative Reactions	.11	.13*	.18**	.20**	-.06	.01	.11*	.006	.15*	-						
11. Tangible Aid	.13*	.03	.01	.11	-.04	-.01	.03	-.001	.01	.13	-					
12. Emotional Support	-.001	-.08	-.09	-.13*	-.05	-.08	-.08	-.08	-.17*	-.52***	.41***	-				
13. IP Exposure	.01	-.09	.15**	.03	-.12*	-.20***	-.004	-.14**	.04	.20***	.20***	.06	-			
14. Media Exposure	.04	-.06	.12*	.02	-.10*	-.16**	.01	-.11*	.02	.21***	.07	.08	.62***	-		
15. Self-esteem	-.50***	-.35***	-.49***	-.65***	.07	.04	-.14**	-.02	-.49***	-.25***	-.13*	.14*	-.19***	-.16**	-	
16. Shame	.46***	.37***	.34***	.51***	-.09	-.09	.04	-.06	.41***	.32***	.25***	-.08	.19***	.21***	-.68***	-

Note. PER = Personal, MI = Mental illness, IP = Interpersonal.
*p < .05. **p < .01. ***p < .001

Table 5.9

Bivariate Correlations Between Factors of Anticipated and Enacted NSSI Stigma and Validation Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. ANT Origin	-														
2. ANT Conceal	.69***	-													
3. ANT Peril	.68***	.56***	-												
4. ANT Disrupt	.74***	.58***	.73***	-											
5. ENA Origin	.43***	.27***	.35***	.37***	-										
6. ENA Conceal	.34***	.37***	.34***	.37***	.73***	-									
7. ENA Peril	.42***	.30***	.49***	.39***	.75***	.64***	-								
8. ENA Disrupt	.39***	.28***	.36***	.47***	.77***	.67***	.75***	-							
9. Public MI stigma	.35***	.30***	.35***	.43***	.30***	.30***	.28***	.28***	-						
10. Personal MI stigma	.05	-.05	.05	.09	.05	.05	.28	.10	.09	-					
11. Negative Reactions	.41***	.30***	.38***	.44***	.72***	.64***	.66***	.65***	.35***	.04	-				
12. Tangible Aid	.11	.09	.21**	.13*	.13*	.22***	.25***	.13*	.07	-.04	.13*	-			
13. Emotional Support	-.20**	-.141*	-.08	-.20**	-.35***	-.22***	-.27***	-.35***	-.22***	-.10	-.52***	.41***	-		
14. Interpersonal Exposure	.004	.03	.06	.01	.17**	.19**	.28***	.22***	.11*	-.10*	.20***	.20***	.06	-	
15. Media Exposure	.06	.05	.08	.06	.13*	.18**	.13*	.15**	.08	-.06	.21***	.07	.08	.62***	-

Note. ANT = Anticipated, ENA = Enacted, MI = Mental illness.
*p < .05. **p < .01. ***p < .001

Group Means Comparison

The sample with a history of NSSI reported significantly greater agreement (see Tables 4-8) with statements on all subscales of public NSSI stigma: Origin, F_{Welch} (1, 652.20) = 60.78, $p <$ .001; Concealability, F_{Welch} (1, 655.37) = 68.48, $p < .001$; Peril, F_{Welch} (1, 716.10) = 23.43, $p <$ .001; and Disruption, F_{Welch} (1, 713.09) = 52.10, $p < .001$. For personal NSSI stigma, the sample without a history of NSSI reported significantly higher agreement with Origin, F_{Welch} (1, 611.21) = 13.37, $p < .001$, Peril, F_{Welch} (1, 618.76) = 25.95, $p = < .001$, and Disruption, F_{Welch} (1, 580.38) = 10.08, $p = .002$, and significantly lower levels of agreement with Concealability, F_{Welch} (1, 720.00) = 9.10, $p = .003$, than the sample with a history of self-injury.

Discussion

The aim of this research was to develop and validate a theoretically informed and comprehensive measure of NSSI stigma. Following a phase of item generation, an item pool was selected (Study One). Further item reduction and scale validation were then conducted (Study Two), culminating in the final Self-Injury Stigma Questionnaire (SIS-Q). While we expected a six-factor solution based on Staniland et al.'s (2021) theoretical model of NSSI stigma, a four-factor model was the best fit to the data. Each factor comprised thematically relevant items, each representing a theorized NSSI stigma domain: Origin, Concealability, Peril, and Disruption. The structure held across the five stigma scales: Public, Personal, Self, Anticipated, and Enacted.

The construct validity of the SIS-Q was supported through significant correlations with related constructs and psychometric equivalence between samples with and without a history of NSSI was demonstrated. While only partial measurement invariance was supported, comparison of latent means accounting for the variant items suggested the public and personal stigma scales operate equally for people who do and do not have a history of self-injury. As expected, individuals with lived experience of self-injury reported more public NSSI stigma and less personal NSSI stigma than individuals with no lived experience. This finding suggests that individuals who have self-injured are more cognizant of public NSSI stigma than individuals who have never self-injured, and that having lived experience of self-injury likely corresponds with less personal NSSI stigma.

The pattern of group differences observed at the scale level was largely sustained at the factor level; however, concealability-related personal stigma was rated more highly for individuals with a history of NSSI compared to those without. That individuals who had self-

injured reported more personal endorsement of covering NSSI and avoiding discussion of it points to the salience of scarring (Lewis & Mehrabkhani, 2016) and disclosure (Simone & Hamza, 2020) in people's lived experiences, and suggests that capturing domain-specific stigma is important for understanding the complexities of NSSI stigma. What it means for people with lived experience to believe that others with lived experience should cover their NSSI and avoid talking about it requires further investigation.

Capturing four distinct facets across five types of stigma, the SIS-Q may offer utility to researchers, clinicians, and advocates. Researchers may use the scales to understand how stigma develops and persists. The scales point to areas where NSSI stigma may manifest and can be used to direct future research. Clinicians may use the scales to inform therapeutic practice; an understanding and appreciation of NSSI stigma may have relevance in clinical contexts (e.g., recovery, perceptions of scarring, self-acceptance). Lastly, advocates may use the scales to both inform and evaluate anti-stigma initiatives.

Limitations and Future Directions

While our development and validation processes were robust and theoretically informed, the SIS-Q is currently limited in generality. Participants were recruited through several sources, including MTurk, social media, and a university student participant pool, however, an important next step will be investigating the psychometric properties in more diverse samples. Given the potential that conceptualizations of both self-injury (Gholamrezaei et al., 2015) and stigma (Yang et al., 2014) may differ cross-culturally, further validation will be required.

Relatedly, the present work was unable to account for intersectionality. Stigma is known to be intersectional and cumulative, meaning that when an individual holds more than one stigmatized identity (e.g., living with HIV and visible scarring) the impacts of stigma are additive. When investigating stigma, consideration of intersecting stigmatized identities is required so that the breadth of risk and vulnerability can be understood (Turan et al., 2019). While this is not thought to be crucial to the initial development and validation of the SIS-Q, critical engagement with intersectional stigma is necessary for the advancement of our understanding of NSSI stigma, particularly given the potential for both mental illness stigma and NSSI stigma to occur simultaneously (Staniland et al., 2021). Finally, it is intended that the SIS-Q be used for multiple purposes, including in research, clinical practice, and in program

development and evaluation. Future work will be needed to examine the validity of the SIS-Q in clinical samples and examine its test-retest reliability to assess temporal stability.

Conclusion

Despite being an emerging research area within the NSSI scholarship, stigma is often a salient and significant experience for people who have self-injured. A concentrated and sustained effort is required, not just from researchers, but clinicians and advocates alike, to better understanding, reduce, and prevent NSSI stigma. The SIS-Q offers a psychometrically valid way to begin addressing this priority.

Table 5.10

Descriptive Statistics Disaggregated by NSSI History, Factor Loadings, Standard Errors, and Internal Consistency Statistics for the Public NSSI Stigma Scale

"I think the public believes that people who have self-injured…"	NSSI-Y (n = 402)				NSSI-N (n = 320)							
	M	SD	α_3	α_4	M	SD	α_3	α_4	Loadings	Errors	α	Ω
Origin	5.63	1.20	-1.52	2.78	4.89	1.32	-1.08	0.98			0.91	0.91
… are to blame for their problems	5.41	1.45	-1.20	1.25	4.68	1.57	-0.81	0.03	0.758	0.059		
… are weak	5.62	1.36	-1.28	1.64	4.94	1.51	-1.01	0.55	0.810	0.062		
… are crazy	5.74	1.44	-1.38	1.59	4.87	1.56	-1.00	-0.41	0.883	0.056		
… are manipulative	5.30	1.57	-0.86	0.08	4.60	1.56	-0.52	-0.34	0.765	0.055		
… are attention seeking	6.04	1.33	-1.85	3.48	5.38	1.54	-1.16	1.05	0.833	0.062		
… are just going through a phase	1.93	1.26	1.47	1.65	4.83	1.66	-0.78	-0.08	0.751	0.061		
Concealability	5.39	1.40	-1.05	0.76	4.47	1.53	-0.59	-0.39			0.89	0.90
… should not let others know about it	4.81	1.77	-0.51	-0.64	3.95	1.75	-0.14	-0.94	0.707	0.060		
… should cover up their self-injury	5.56	1.62	-1.21	0.74	4.52	1.75	-0.60	-0.69	0.831	0.057		
People should avoid talking about self-injury	5.33	1.68	-0.92	-0.02	4.35	1.83	-0.36	-0.92	0.920	0.046		
People should not post about self-injury online	5.85	1.48	-1.50	1.77	5.08	1.76	-0.93	-0.11	0.779	0.063		
Peril	5.10	1.47	-0.79	0.25	4.60	1.26	-0.54	0.12			0.83	0.84
… will always be at risk of suicide	5.41	1.54	-1.03	0.60	5.11	1.47	-0.93	-0.56	0.711	0.061		
… are dangerous	4.81	1.71	-0.59	-0.43	4.25	1.49	-0.31	-0.42	0.791	0.051		

… belong in a mental institution	5.06	1.73	-0.83	-0.10	4.45	1.61	-0.35	-0.51	0.862	0.048		
Disruption	4.19	1.56	-0.21	1.81	3.40	1.37	0.07	-0.68			0.91	0.91
… injured do not deserve intimacy with others	3.58	1.76	0.25	-0.82	3.03	1.46	-0.35	-0.65	0.808	0.050		
… are a waste of time	4.15	1.87	-0.18	-1.08	3.29	1.66	0.37	-0.85	0.850	0.043		
… deserve to be treated poorly	3.82	1.81	0.18	-0.97	2.94	1.44	0.50	-0.39	0.798	0.050		
… should not have children	4.63	1.88	-0.48	-0.80	1.95	1.41	1.57	1.78	0.789	0.050		
… do not care about others	4.75	1.84	-0.52	-0.80	3.95	1.75	-0.18	-0.99	0.837	0.048		

Note. α_3 = skewness, α_4 = kurtosis, α = Cronbach's alpha, Ω = McDonald's omega. Loadings and errors are standardized.

Table 5.11

Descriptive Statistics Disaggregated by NSSI History, Factor Loadings, Standard Errors, and Internal Consistency Statistics for the Personal NSSI Stigma Scale

	NSSI-Y (n = 402)				NSSI-N (n = 320)							
"I personally believe people who have self-injured…"	*M*	*SD*	α_3	α_4	*M*	*SD*	α_3	α_4	Loadings	Errors	α	Ω
Origin	2.04	0.96	1.21	1.81	2.34	1.18	0.93	0.50			0.88	0.88
… are to blame for their problems	2.01	1.22	1.61	2.73	2.19	1.29	1.30	1.47	0.687	0.058		
… are weak	2.06	1.37	1.52	1.83	2.26	1.48	1.29	0.92	0.773	0.055		
… are crazy	1.90	1.23	1.50	1.65	2.00	1.31	1.55	1.90	0.788	0.054		
… are manipulative	2.03	1.23	1.27	1.18	2.50	1.48	0.97	0.28	0.746	0.054		
… are attention seeking	2.33	1.38	0.89	-0.08	2.86	1.63	0.59	-0.61	0.654	0.057		
… are just going through a phase	1.93	1.26	1.47	1.65	2.24	1.42	1.11	0.58	0.641	0.054		
Concealability	2.68	1.43	0.86	0.19	2.39	1.14	0.97	1.27			0.81	0.81
… should not let others know about it	2.23	1.57	1.32	1.00	1.85	1.23	1.95	4.30	0.781	0.064		
… should cover up their self-injury	2.87	1.79	0.68	-0.58	2.39	1.45	1.03	0.50	0.787	0.056		
People should avoid talking about self-injury	2.13	1.50	1.49	1.53	1.88	1.31	1.95	3.93	0.840	0.066		
People should not post about self-injury online	3.49	2.04	0.25	-1.25	3.45	1.93	0.23	-1.17	0.543	0.066		
Peril	2.02	0.98	1.01	0.58	2.44	1.18	0.76	0.18			0.72	0.73
… will always be at risk of suicide	2.66	1.59	0.68	-0.63	3.17	1.72	0.33	-0.97	0.598	0.055		
… are dangerous	1.66	1.05	1.96	3.86	2.06	1.27	1.32	1.40	0.796	0.055		

… belong in a mental institution	1.75	1.08	1.54	1.78	2.09	1.34	1.30	1.05	0.711	0.053		
Disruption	1.43	0.70	2.55	7.82	1.62	0.93	2.15	5.26			0.84	0.84
… do not deserve intimacy with others	1.41	0.88	2.88	9.04	1.48	0.97	2.75	9.09	0.799	0.063		
… are a waste of time	1.33	0.78	3.17	11.73	1.46	0.96	2.61	7.62	0.793	0.058		
… deserve to be treated poorly	1.24	0.68	3.89	16.97	1.38	0.89	3.05	10.57	0.781	0.063		
… should not have children	1.70	1.23	2.10	4.30	1.95	1.41	1.57	1.78	0.703	0.060		
… do not care about others	1.45	0.95	2.97	10.07	1.86	1.24	1.71	2.67	0.771	0.062		

Note. α_3 = skewness, α_4 = kurtosis, α = Cronbach's alpha, Ω = McDonald's omega. Loadings and errors are standardized.

Table 5.12

Descriptive Statistics, Factor Loadings, Standard Errors, and Internal Consistency Statistics for the NSSI Self-Stigma Scale

"Because I have self-injured…"	*M*	*SD*	α_3	α_4	Loadings	Errors	α	Ω
Origin	3.27	1.38	0.20	-0.63			0.82	0.83
… I am to blame for my problems	3.86	1.95	-0.09	-1.32	0.631	0.101		
… I am weak	4.06	2.11	-0.12	-1.43	0.812	0.077		
… I am crazy	3.22	1.94	0.42	-1.17	0.717	0.086		
… I am manipulative	2.21	1.59	1.28	0.59	0.421	0.097		
… I am an attention-seeker	2.38	1.75	1.10	-0.05	0.420	0.104		
… I should just toughen up	3.91	2.08	-0.03	-1.31	0.711	0.088		
Concealability	4.75	1.68	-0.51	-0.59			0.86	0.86
… I should not let others know about my self-injury	4.48	2.06	-0.36	-1.23	0.846	0.075		
… I should cover up my self-injury	4.88	1.95	-0.75	-0.61	0.818	0.086		
… I should avoid talking about my self-injury	4.59	1.96	-0.45	-1.02	0.874	0.073		
… I should avoid posting about my experiences of self-injury online	5.03	2.11	-0.64	-1.05	0.562	0.112		
Peril	2.21	1.29	1.21	1.19			0.73	0.73
… I will always be at risk of suicide	2.99	1.99	0.57	-1.03	0.757	0.093		
… I am dangerous	1.63	1.25	2.38	5.32	0.575	0.106		
… I belong in a mental institution	2.01	1.53	1.48	1.16	0.722	0.105		
Disruption	2.80	1.80	0.78	-0.53			0.91	0.91

… I do not deserve intimacy with others	2.69	2.02	0.92	-0.54	0.861	0.085
… I am a waste of time	3.52	2.36	0.25	-1.57	0.857	0.062
… I deserve to be treated poorly	2.41	1.95	1.15	-0.13	0.822	0.096
… I should not have children	2.88	2.24	0.74	-1.05	0.733	0.099
… people should stay away from me	2.50	1.88	1.07	-0.11	0.818	0.089

Note. α_3 = skewness, α_4 = kurtosis, α = Cronbach's alpha, Ω = McDonald's omega. Loadings and errors are standardized.

Table 5.13

Descriptive Statistics, Factor Loadings, Standard Errors, and Internal Consistency Statistics for the Anticipated NSSI Stigma Scale

"If people find out about my self-injury, they…"	*M*	*SD*	α_3	α_4	Loadings	Errors	α	Ω
Origin	5.10	1.43	-0.99	0.40			0.90	0.90
… will blame me for my problems	4.91	1.66	-0.83	-0.07	0.712	0.091		
… will think I am weak	5.20	1.70	-0.92	-0.02	0.795	0.082		
… will think I am crazy	5.22	1.80	-0.92	-0.21	0.825	0.083		
… will think I am manipulative	4.56	1.85	-0.52	-0.82	0.701	0.085		
… will think I am attention seeking	5.46	1.75	-1.21	0.51	0.822	0.089		
… will think I should toughen up	5.24	1.71	-0.90	-0.10	0.756	0.087		
Concealability	5.21	1.44	-0.90	0.42			0.86	0.87
… will think that I should not let others know about my self-injury	4.77	1.72	-0.59	-0.60	0.722	0.085		
… will think I should cover up my self-injury	5.35	1.70	-1.06	0.24	0.829	0.086		
… will think I shouldn't talk about my self-injury	5.10	1.75	-0.81	-0.26	0.828	0.085		
… will think I shouldn't post about my experiences of self-injury online	5.62	1.67	-1.37	1.07	0.679	0.108		
Peril	4.64	1.62	-0.50	-0.45			0.82	0.83
… will think I am at risk of suicide	5.52	1.66	-1.36	1.13	0.693	0.103		
… will think I am dangerous	3.92	2.00	-0.04	-1.25	0.768	0.077		
… will think I belong in a mental institution	4.46	1.20	-0.21	-1.21	0.871	0.069		
Disruption	4.13	1.65	-0.17	-0.85			0.90	0.90

… won't want to be intimate with me	4.19	1.98	-0.21	-1.21	0.705	0.084
… will think I am a waste of time	4.10	1.99	-0.10	-1.22	0.804	0.068
… will treat me poorly	4.19	1.87	-0.15	-1.12	0.835	0.065
… will think I should not have children	3.62	2.07	0.17	-1.29	0.746	0.077
… will stay away from me	4.53	1.82	-0.49	-0.85	0.863	0.070

Note. α_3 = skewness, α_4 = kurtosis, α = Cronbach's alpha, Ω = McDonald's omega. Loadings and errors are standardized.

Table 5.14

Descriptive Statistics, Factor Loadings, Standard Errors, and Internal Consistency Statistics for the Enacted NSSI Stigma Scale

"Because of my self-injury, people have…	*M*	*SD*	α_3	α_4	Loadings	Errors	α	Ω
Origin	2.52	1.50	0.69	-0.60			0.92	0.92
… said that I brought this upon myself	2.34	1.63	0.94	-0.21	0.737	0.079		
… said that I am weak	2.28	1.62	1.00	-0.22	0.803	0.070		
… said that I am crazy	2.57	1.82	0.81	-0.63	0.851	0.072		
… said that I am manipulative	2.26	1.62	1.07	0.08	0.771	0.087		
… said that I am attention seeking	2.84	1.91	0.57	-1.00	0.819	0.073		
… said that I should toughen up	2.83	1.98	0.64	-0.97	0.839	0.071		
Concealability	2.54	1.67	0.95	-0.09			0.90	0.91
… told me I should not let others know about my self-injury	2.52	1.80	0.90	-0.39	0.835	0.088		
… told me to cover up my self-injury	2.81	1.96	0.63	-0.97	0.877	0.074		
… told me not to talk about my self-injury	2.67	1.92	0.82	-0.63	0.886	0.077		
… told me not to post about my experiences of self-injury online	2.14	1.92	1.50	0.83	0.708	0.113		
Peril	2.44	1.50	1.00	0.32			0.83	0.82
… said I am at risk of suicide	3.22	2.02	0.35	-1.15	0.736	0.082		
… said they think I am dangerous	1.86	1.48	1.82	2.48	0.801	0.099		
… said that I belong in a mental institution	2.24	1.73	1.28	0.54	0.815	0.092		
Disruption	2.03	1.22	1.23	0.75			0.87	0.88

… not wanted to be intimate with me	1.71	1.33	1.95	3.11	0.626	0.083
… said I am a waste of time	1.77	1.39	1.83	2.52	0.805	0.089
… treated me poorly	2.69	1.84	0.68	-0.88	0.838	0.073
… said that I should not have children	1.57	1.23	2.38	5.14	0.748	0.097
… stayed away from me	2.38	1.66	0.83	-0.63	0.804	0.072

Note. α_3 = skewness, α_4 = kurtosis, α = Cronbach's alpha, Ω = McDonald's omega. Loadings and errors are standardized.

Chapter 6
General Discussion

Introduction

In the following chapter, I discuss the thesis findings, beginning with a summary of the overarching aim and explanation of how that aim was met. I then provide an overview of the key findings of the thesis before discussing implications and future directions. Finally, I address the limitations of the thesis and provide a conclusion.

Overarching Aim

Despite many years of NSSI-related research, the stigmatization of self-injury has yet to be explored in depth, which is surprising, given the negative impacts of stigma more broadly (Sickel et al., 2014). Understanding NSSI stigma with the view to drive future research and inform stigma reduction is crucial to improving the lives of individuals with lived experience of self-injury. Therefore, the overarching aim of this PhD was to develop a better understanding of NSSI stigma. This was achieved through four objectives: One, collate existing knowledge to propose a theoretical framework of NSSI stigma; Two, explore the utility and validity of the NSSI Stigma Framework; Three, explore the news media as a potential mechanism for the development of NSSI stigma; and Four, develop and validate a measure of self-injury stigma.

Key Findings

Because self-injury is used primarily as a method of emotion regulation (Taylor et al., 2018), is related to mental health difficulties, and confers increased likelihood of suicidality (Kiekens et al., 2018), the behavior is often considered through a mental illness lens. Current considerations of self-injury stigma follow this approach, applying models derived from mental illness theory to inform NSSI stigma research. For example, the experimental research conducted by Burke et al. (2019), Law et al. (2009), Lloyd et al. (2018), and Piccirillo et al. (2020) draws on Corrigan et al.'s (2003) attribution model of mental illness stigma and adapts Corrigan et al.'s (2001) Attribution Questionnaire to assess attitudes toward self-injury. Methodologically, these choices are sound in the context of the research questions posed; however, in the broader context of understanding self-injury stigma, existing models and questionnaires adapted for use in self-injury research may not be sufficient, due to their potentially limited ability to capture key aspects of self-injury.

As a self-directed behavior that often leaves marks in the form of wounds and scars (Ho et al., 2018), the volitional and visible nature of NSSI needs to be considered when exploring and examining self-injury stigma. An absence of self-injury-specific conceptualizations of

stigma led to the development of the NSSI Stigma Framework presented in Chapter 2, which represents the culmination of existing research relating to the experience of NSSI stigma situated within established models of stigma. Specifically, and drawing on work by Jones et al. (1984), Corrigan and Watson (2002), and Quinn and Chaudoir (2009), the Framework outlines the levels at which stigma may manifest and the domains underpinning why self-injury stigma may arise. Through this intersection of models, the NSSI Stigma Framework offers a comprehensive conceptualization of how, why, and where NSSI stigma may manifest.

While the development of the NSSI Stigma Framework was grounded in prior research and theory, it was critical to assess its utility and determine its applicability to people's lived experiences of NSSI stigma. This was achieved in Chapter 3, where I used the Framework as a coding rubric in a directed content analysis of qualitative responses provided by participants about their experiences of stigma. To this end, the Framework was useful in identifying and explaining people's experiences of stigma and demonstrated utility as a guiding structure to conceptualize self-injury stigma moving forward. However, uncertainty remains regarding its structure. The findings of Chapter 3 and Chapter 5 suggest a more parsimonious model. While this preliminary validation of the NSSI Stigma Framework offered support for its utility to direct NSSI stigma research and generate relevant research questions, the overlap in coding categories found in Chapter 3 in combination with the four-factor measurement model found in Chapter 5 suggests that the Framework may benefit from revision. In consideration of these findings, a revised version of the Framework is proposed in Table 6.1. This version captures four domains by collapsing aesthetics and disruption, and origin and course, in line with overlap discovered in Chapter 3 and factor structure discovered in Chapter 5. Additionally, vicarious stigma has been added as a level, to account for the emergence of this possibility in Chapter 3. This validity of this version requires exploration and is flexible to further modifications in light of subsequent research.

The nature of the NSSI Stigma Framework means research questions can be posed at the stigma level (e.g., public), stigma domain (e.g., origin), or at any level-domain intersection (e.g., public stigma related to origin). For example, a researcher seeking to better understand how NSSI stigma develops may look to the public level of the framework and pose the research question: "How is public NSSI stigma perpetuated in the media?"; or the researcher may look to the origin domain of the framework and pose the research question: "What is the role of origin in NSSI stereotypes?" Intersecting the two, a researcher may ask: "How does the media portray the origin of NSSI?" In this way, the framework both serves

and is served by researchers; the Framework directs relevant research and is subsequently improved by the findings of such research. Chapter 4 demonstrates how the NSSI Stigma Framework can support the development of research questions. Driven by the public stigma level and spanning the domains, I asked: how is self-injury portrayed by the news media?

The media are a known conduit for stigmatizing messages (Ma, 2017; Smith, 2012) and people have reported the news media as a primary source of information about self-injury (Newton & Bale, 2012). Therefore, an investigation of news media messaging related to self-injury is a relevant point of inquiry to inform our understanding of self-injury stigma at the public level. Using a media framing analysis of 545 Australian news articles, I found that news media representations of self-injury are overwhelmingly negative in valence and portrayals appear underpinned by assumptions and misconceptions related to the domains proposed by the NSSI Stigma Framework. For example, the frames *A Manipulative Tactic* and *Mentally Unwell* relate to the origin domain; beliefs that self-injury is motivated by manipulation or enacted only by individuals living with mental illness represent common misconceptions about why an individual self-injures (origin). These misconceptions inform NSSI stigma, demonstrating one way in which public self-injury stigma may manifest.

Chapter 4 contributes to our understanding of how NSSI stigma manifests at the public stigma level and stimulates additional research questions. For example, it will be important to understand how exposure to such messaging informs the development of NSSI stigma at an individual level (personal stigma and self-stigma) and how such messaging may impact people with lived experience of self-injury (e.g., self-esteem, shame). To effectively pursue such enquiry, a measure of NSSI stigma is needed. To fulfil this need, I developed the Self-Injury Stigma Questionnaire (SIS-Q) in Chapter 5.

Given the theoretical and empirical underpinnings of the NSSI Stigma Framework and the subsequent evidence pointing to its utility, it served as a robust foundation from which to develop a measure. Through a rigorous process of item generation, reduction, evaluation, and validation, five 18-item scales were developed to assess NSSI stigma at each of the public, personal, self, anticipated, and enacted stigma levels proposed by the NSSI Stigma Framework. Each scale comprises four subscales, informed by the domains of the Framework. While six domains are proposed in the Framework, through empirical testing, the course and peril domains were collapsed into a single factor, as were the concealability and aesthetics domains. The overlap between these domains is conceptually supported by the findings in Chapter 3, whereby data coded to aesthetics was often coded to concealability and

data coded to course was frequently coded to peril. Furthermore, in proposing the original domains, Jones et al. (1984) explained that they are not mutually exclusive.

The Self-Injury Stigma Questionnaire serves as a comprehensive measurement tool rooted in a theoretical framework derived from and tested with people's lived experiences of NSSI stigma. In this way, it accounts for the unique components of NSSI stigma that mental illness stigma scales (e.g., the Self-Stigma of Mental Illness Scale; Corrigan et al., 2006) are not able to because they do not capture the domains that underpin self-injury stigma. While the SIS-Q requires further validation and testing, it presents an opportunity for researchers to investigate NSSI stigma with more clarity and focus.

Theoretical Implications and Future Directions

The importance of stigma in the experiences and wellbeing of individuals who have self-injured has been emphasized (Aggarwal et al., 2021; Hasking & Boyes, 2018). As this priority area gains traction, theoretically grounded approaches to investigating self-injury stigma are required. The NSSI Stigma Framework provides such an approach, offering a heuristic to guide how we think and pose questions about self-injury stigma. Informed by the Framework, the Self-Injury Stigma Questionnaire offers a measure that allows nuanced and holistic assessment of self-injury stigma. In conjunction, the Framework and the SIS-Q demonstrate that self-injury stigma is fundamentally different from other types of stigma.

While support for the NSSI Stigma Framework is evident, further validation and examination of its proposed structure is required. Uncertainty remains regarding its structure, with the findings from Chapter 3 and Chapter 5 suggesting a more parsimonious model. The Framework was developed upon the basis of lived experience accounts mined from published research and data collected within the broader research team; however, interviews driven by the Framework are recommended as part of the testing process. Interview questions that tap into the elements proposed by the Framework will allow researchers to better understand how experiences at each level and within each domain manifest. The in-depth nature of interviews will also enable exploration of missingness or redundancy, informing a more precise and targeted theory. Indeed, the potential for a sixth stigma level (vicarious stigma) illuminated in Chapter 3 points to the need to conduct more in-depth exploration of the Framework.

Vicarious stigma captures the complex experience of public stigma for individuals with lived experience of self-injury. In addition to exposure to stigma in the public sphere (e.g., through media), individuals may also experience stigma indirectly, via others who vocalize stigma without knowing that their words are directly relevant to the individual. For example, one participant described how their friends, unaware of their NSSI history, discussed another

individual's self-injury, "*talking about how she only did it for attention and had nothing to truly be sad about*." Experiences such as this create a form of inadvertent enacted stigma that may impact individuals in ways different than enacted or public stigma. Indeed, it is likely that experiences of vicarious stigma have a direct impact on the development of self-stigma, anticipated stigma, and care-seeking reluctance. For example, if an individual who has self-injured reads a comment online blaming long wait times in an emergency department on individuals presenting for medical treatment of self-injury, that individual may avoid seeking necessary medical care for self-injury in the future, even if they need it. Additionally, the source of vicarious stigma may be important to consider. Vicarious stigma communicated by a romantic partner or close friend may differ in its impact compared to vicarious stigma communicated by a work colleague or teacher. Exploration of how the levels inform one another, in addition to consideration of relational complexities within each level, is required.

The overlapping nature of the stigma domains is also a point for further investigation. Evidence was found for each domain in Chapter 3 (albeit in varying frequencies across levels); however, coding patterns in the directed content analysis together with the factor structure of the Self-Injury Stigma Questionnaire suggest the relationship between the domains is complex. It is possible that the salience of each domain differs across stigma levels. For example, the potentially visible nature of self-injury may mean that concealability is particularly important at the anticipated stigma level, while origin may be most important at the public and personal levels due to self-injury stereotypes centering on reasons for self-injury. However, this is speculative, and more research will be needed to further our understanding of the domains and how they interact.

Furthermore, the substantial overlap in coding categories found in Chapter 3 in combination with the four-factor measurement model found in Chapter 5 suggests that the Framework needs revision. In consideration of these findings, a revised version of the Framework is proposed in Table 6.1. This version captures four domains by collapsing aesthetics and disruption, and origin and course, in line with overlap discovered in Chapter 3 and factor structure discovered in Chapter 5. Additionally, vicarious stigma has been added as a level, to account for the emergence of this possibility in Chapter 3. This validity of this version requires exploration and is flexible to further modifications in light of subsequent research.

Table 6.1

The Revised NSSI Stigma Framework

	Public Stigma	Personal Stigma	Self-Stigma	Enacted Stigma	Vicarious Stigma	Anticipated Stigma
	Attitudes and beliefs held by the general public about self-injury or people who have self-injured.	Attitudes and beliefs held by an individual about self-injury or people who have self-injured.	Attitudes and beliefs held by an individual who has self-injured about themselves.	An individual's direct experiences of stigma that relate to their own experience of self-injury.	An individual's indirect experiences of stigma that do not relate to their own experience of self-injury.	Expectations of enacted or vicarious stigma.
Origin	People who self-injure are just attention seeking and weak.	People who self-injure are just attention seeking and weak.	I feel weak for needing to self-injure.	People have told me I am weak and an attention-seeker.	I have overheard people talk about how weak those who self-injure are.	I am worried people will think I am attention-seeking.
Concealability	People should not have their self-injury on display.	People should not have their self-injury on display.	I must hide my self-injury from others.	People have told me I should cover my self-injury.	I have seen someone be told to cover their self-injury scars in public.	I cover my self-injury so others won't comment on it.
Peril	Self-injury is definitely suicidal, even if the person doesn't realise it.	Self-injury is definitely suicidal, even if the person doesn't realise it.	I don't want to end my life, so why am I self-injuring?	I don't believe you when you say you aren't suicidal, so we are sectioning you.	I have witnessed someone be hospitalised as suicidal after presenting to ED with self-injury.	If I talk about my self-injury, people will assume I am suicidal.
Disruption	People who self-injure are wasting hospital resources.	People who self-injure are wasting hospital resources.	I don't deserve medical help for this injury.	I have lost friends because they found out I have self-injured.	I know of people who have been ostracised because of their self-injury.	I am worried that people will reject me if they find out I self-injure.

Note. From "Stigma and Nonsuicidal Self-Injury: Application of a Conceptual Framework" by Staniland et al., 2020.

While the contributions of the NSSI Stigma Framework and the Self-Injury Stigma Questionnaire are valuable from a theoretical and measurement standpoint, neither intend to capture or assess the impact of self-injury stigma. We know from research thus far that self-injury stigma foments shame and reduces help-seeking (Long et al., 2018; Rosenrot & Lewis, 2018; Williams et al., 2020); however, a greater understanding of the impacts of self-injury stigma, and the components that may be most salient in particular contexts, is a key priority for future work. Documenting these impacts will help illuminate the importance of self-injury stigma research and hopefully encourage efforts to reduce self-injury stigma.

An additional consideration for future research will be the role of constructs such as responsibility. If perceptions of personal responsibility (i.e., self-blame) are high, this may strengthen, for example, an association between public stigma and anticipated stigma, and anticipated stigma and disclosure. This is only one of many possible predictions that may be tested and, in turn, point to subsequent areas of focus for future research. Examining how multiple constructs work together, using the NSSI Stigma Framework as a starting point and the Self-Injury Stigma Questionnaire as a measurement tool, can further our understanding of self-injury stigma. With greater understanding, we can turn our attention to stigma reduction.

Practical Implications and Future Directions

Stigma reduction is a priority outcome for many researchers (Casados, 2017). The motivation of the present work is no different, and a major implication of the NSSI Stigma Framework and Self-Injury Stigma Questionnaire is their potential to inform stigma reduction efforts by pointing to areas of priority and enabling evaluation of the effectiveness of such efforts. Given the limited research focussed on self-injury stigma, we do not know the extent of self-injury stigma endorsement, which limits our ability to effectively reduce NSSI stigma. Measuring the extent of NSSI stigma among different health professionals, the general public, individuals with lived experience, and friends and family of individuals who have self-injured is a critical first step in stigma reduction. A baseline from which to draw later comparisons is required to demonstrate the effectiveness of stigma reduction efforts. This can be achieved using the Self-Injury Stigma Questionnaire, which allows NSSI stigma to be assessed across various levels, providing insight into which domains of NSSI stigma may be most important to target.

When considering how to approach NSSI stigma reduction, we can turn to other fields for inspiration. In the mental illness field, stigma reduction frequently takes the form of awareness building or education, often delivered through public health campaigns and institutions (e.g., school and work settings; Morgan et al., 2018). Such efforts have

demonstrated variable effectiveness. Short-term effects are often promising, but few interventions extend beyond the pilot phase, limiting evaluation of long-term effects (Morgan et al., 2018). A recent review of stigma reduction initiatives in Australia found face-to-face programs were effective in reducing stigma, although few programs were sufficiently evaluated to demonstrate long-term impacts (Morgan et al., 2021). The ongoing nature of mental illness stigma suggests that education and awareness building alone are insufficient to make meaningful and sustained change (Smith et al., 2022). Efforts to diminish self-injury stigma will undoubtedly face the same challenges, and it is critical that our efforts consider stigma reduction in a holistic manner, going beyond the individual level to tackle stigma at multiple social-cultural levels.

A holistic approach to self-injury stigma reduction can be informed by the NSSI Stigma Framework, which was designed to encourage consideration of the social-cultural and bidirectional nature of stigma development. The stigma levels proposed within the Framework are encompassed by macrosystemic forces that, intentionally or otherwise, work to reinforce stigma. Structures and mechanism ingrained into cultural, social, and political institutions operate as the conduits of stigma (Link et al., 2014) but are exceedingly difficult to change (Pescosolido, 2013). However, given the bidirectional nature of stigma development, individuals, as part of groups, committees, and organisations, can generate changes at the macrosystemic level.

The NSSI Stigma Framework can provide insight into where change can begin. For example, the public stigma level demonstrates the importance of stereotypes in the development and perpetuation of NSSI stigma. As evidenced in Chapter 3, self-injury stigma is often underpinned by misconceptions spanning stigma domains, including that self-injury is “just a phase”, that “people who hurt themselves are weak”, and assumptions that “every self-injury is an attempt to comit [sic] suicide”. These misconceptions represent stereotypes that may be amenable to change through education and awareness; however, in addition to disseminating information to contradict NSSI stereotypes, social contexts must also be targeted (Yzerbyt & Carnaghi, 2008).

Self-injury stigma manifests in various social contexts, including families, friendships and relationships, workplaces, schools, and healthcare settings. Affecting change across these settings requires advocacy from individuals within these settings. While individuals comprise the settings in which stigma reduction must occur, these settings are ultimately impacted by systemic issues, such as resource allocation, and governed by overarching or external bodies that impose policies to guide practice. For example, hospital emergency departments are a

salient source of stigma for individuals who have attended for self-injury wound care (MacDonald et al., 2020), and are therefore a key target for stigma reduction. However, beyond education and training (which has shown success in improving attitudes; Gibson et al., 2019), interventions must tackle systemic issues. Insufficient funding and resourcing contribute to pressures that may inform NSSI stigma, such as the perception that self-injury is "low priority" (Masuku, 2019).

Furthermore, policies overarching practice can inform NSSI stigma. Such policies are often designed to protect vulnerable individuals from harm. For example, mental health ward admission policies often stipulate that self-injury wounds and scars must be concealed at all times (e.g., Perth Clinic, 2022). Of course, self-injury wounds should be dressed like any other medical injury, however, the requirement to cover scars may be harmful. While the intention of such a policy is to avoid triggering other patients, an unintentional consequence may be the conveyance of messaging that self-injury scars are "bad", "dangerous", and "shameful" (Lewis & Mehrabkhani, 2016; Stirling & Chandler, 2020). In this example, the policy to conceal self-injury scars may contribute to the development and perpetuation of self-injury stigma.

Using the NSSI Stigma Framework, we can see how such a policy is informed by the concealability and peril domains, and how the policy could manifest as stigma across all levels. In this way, the NSSI Stigma Framework may be useful to informing the development and modification of NSSI-related policies. For example, if one was to incorporate the Framework into their evaluation of a policy stipulating scar concealment, they would be able to see how that policy could perpetuate self-injury stigma. Such knowledge could be incorporated into their determination of any policy modification.

Underpinning the above is the need to understand self-injury stigma within the context of broader social-cultural phenomenon, such as sexism and homophobia. While gender and sexuality are factors currently considered within NSSI research, the focus steers toward how NSSI differs across gender and sexuality identities (Angoff et al., 2021; Speer et al., 2022). In the context of stigma reduction, however, the intersection of identities requires further investigation. For example, boys and men may be subject to greater NSSI stigma than girls and women, due to the misconception that self-injury is more common among girls and women compared to boys and men (Klonsky et al., 2014). For individuals who identify as lesbian, gay, bisexual, transgender, queer, intersex, or another diverse gender or sexuality (LGBTQI+), self-injury stigma is compounded by stigma associated with LGBTQI+ identification (Jackman et al., 2018).

Future self-injury stigma work could be informed by intersectionality theory, which critically considers the complex interaction among identities such as race, culture, gender, sexuality, religion, and class (Turan et al., 2019). Understanding such interactions is key to understanding self-injury stigma and its impact. For example, a preponderance of NSSI stigma research has been conducted with participants sampled from the United States, the United Kingdom, Canada, Australia, and Ireland. The intersection of NSSI stigma and culture is therefore unclear but requires consideration. For example, in research by Williams et al. (2020), a participant shared that self-injury "*isn't understood in this country*", suggesting that in some cultures, NSSI may be stigmatised more harshly than others. Understanding this complexity is critical to meaningful and effective NSSI stigma reduction.

The NSSI Stigma Framework and Self-Injury Stigma Questionnaire offer direction for the development and evaluation of anti-stigma efforts; however, it is critical that such efforts are created in partnership with individuals who have lived experience of self-injury stigma (Lewis & Hasking, 2019) and should draw on existing, effective efforts whilst incorporating the unique facets of self-injury stigma.

While it is clear that self-injury stigma reduction is a key priority, it would be remiss to ignore what may be a real expectation and belief that stigma can serve as a means of NSSI prevention. That is, some researchers and professionals may believe a consequence of reducing self-injury stigma is an increase in rates of self-injury. For example, one anonymous reviewer's feedback on the paper presented in Chapter 3 was: "*Further, as an active clinician, I worry about the goals of the project. If we aim to reduce the stigma surrounding NSSI, I wonder if there a risk that normalization will increase the prevalence of these acts*". There appears to be an underlying assumption that reduction or cessation of self-injury is primarily driven by stigma, or that stigma is a key barrier to engaging in self-injury. While the benefits and barriers model of NSSI engagement (Hooley & Franklin, 2017) suggests social norms are a key barrier to self-injuring, NSSI stigma thwarts help-seeking, impedes recovery and wellbeing (Claréus et al., 2021; Rosenrot & Lewis, 2018; Simone & Hamza, 2020, and can perpetuate self-injury engagement (MacDonald et al., 2020). Self-injury stigma reduction is not a case of condoning or encouraging NSSI. It is a critical component to supporting and respecting individuals who have self-injured.

Limitations

Despite the significant contribution of this body of work to the field of NSSI research, it is not without limitations. Firstly, while the NSSI Stigma Framework and Self-Injury Stigma Questionnaire are both theoretically informed and supported by existing literature, the

overlap in dimensions of self-injury stigma does raise the question of how distinct they are from one another. Jones et al. (1984) made explicit that the boundary between domains is permeable; however, our ability to accurately assess, predict, and modify self-injury stigma relies on a clear conceptualisation. It may be that demarcation between the domains is not possible, due to the nature of stigma comprising interweaving elements. However, it is also possible that the NSSI Stigma Framework requires modification. It is likely that, as defined by the Self-Injury Stigma Questionnaire, the pertinent domains underlying NSSI stigma are *origin*, *concealability*, *peril*, and *disruption*. Future research focused on self-injury stigma is needed to further our understanding of the domains, how they do (and do not) overlap, and what modifications to the Framework are required.

Secondly, this thesis provides a robust theoretical explanation for why self-injury is stigmatised and how that stigma may manifest but it does not capture the impact of self-injury stigma. The findings in Chapter 3 do offer insight, particularly with the uncoded data; however, exploring the impact of self-injury stigma was not the focus of that study. Without capturing the impact of self-injury stigma, our understanding of it remains incomplete.

Thirdly, while this program of research is cohesive and combines multiple forms of data to address the overarching aim, interviews and experiments would further contribute to an understanding of self-injury stigma. Interviews allow a rich examination of a phenomenon, and an absence of interviews means there is scope to delve further into the experience of self-injury stigma. Experiments allow testing of hypotheses within controlled environments and enable inferences that can be stronger than those generated from self-report data. A lack of experimental research means my theoretical propositions are yet to be fully tested.

Finally, the representativeness and temporal stability of the Self-Injury Stigma Questionnaire has yet to be established. The SIS-Q was developed with samples that are not broadly generalisable, meaning further work is required to examine its representativeness of the Scales and make necessary adjustments. As discussed above, intersectionality is critical to understanding stigma and further assessment of the Self-Injury Stigma Questionnaire requires efforts to recruit diverse samples. Further, assessment of the temporal stability of the Self-Injury Stigma Questionnaire is required. Alongside continued investigation of the psychometric properties of the SIS-Q, test-retest reliability needs to be established.

Conclusion

Limitations notwithstanding, the work presented in this thesis makes a significant contribution to the field of NSSI research by offering a theoretical framework that conceptualises self-injury stigma and a comprehensive tool to measure self-injury stigma and

inform the development and evaluation of stigma reduction efforts. Together, the NSSI Stigma Framework and Self-Injury Stigma Questionnaire offer innovative tools to support the advancement of NSSI stigma research. It is my hope that the work presented here contributes meaningfully and productively to the reduction of NSSI stigma and the ongoing prioritisation of the wellbeing of individuals who have lived experience of self-injury.

Chapter 7

Reflexivity Statement

As an individual with lived experience of self-injury, I was aware from the outset of my PhD that these experiences would inevitably shape the way that I engaged with my research. At first, I was concerned that my role as an insider would delegitimise my work; that I would be perceived as doing "me-search" and therefore unable to be objective (Gardner et al., 2017). Despite rejecting the notion of objectivity, I felt pressure to be completely impartial. A theory-oriented approach was therefore appealing to me. I was able to ground my research in established ideas, thus creating some distance between my own and others' experiences. However, as I became more comfortable, I learned that my role as an insider was a strength. I was able to connect with participants and data in a curious, compassionate, and non-judgmental way, noticing patterns and trends that individuals without lived experience might not. My personal experience of self-injury and NSSI stigma was an asset to my research, rather than something to be compartmentalised and set aside. Still, it was critical for me to constantly engage in reflection and supervision to notice and manage moments when I might have been leaning toward a conclusion that supported my assumptions rather than reflecting the data. For example, it was easy for me to see stigma in ambiguous cases in Chapter 3 and Chapter 4. I was mindful that my *personal* reactions to a given statement or opinion did not necessarily constitute a representative reaction. I was careful not to impose my meanings and interpretations onto others and to be open to stories that were unexpected.

While my thesis appears informed by positivism, my epistemological view is that no phenomenon can be understood through a single lens and that methodological and philosophical approaches should be chosen based on the research question at hand (Maxcy, 2003). Through a pragmatist lens, I was able to pose and answer several distinct research questions requiring different methodologies and philosophical assumptions. I engaged in many research activities not presented in this thesis that contributed to my overall conclusions. For example, I conducted 23 interviews with individuals about their experiences of NSSI stigma; while I was unable to include this study due to time constraints, the experiences shared by participants informed my interpretations and conclusions across thesis.

Given my lived experience, my PhD journey was a constellation of curiosity, compassion, and rage. My appreciation of reflexivity and self-care grew and I learned the value of my insider position. My lived experience fuelled my passion when I felt defeated and equipped me with the resilience and compassion to conduct this research in a way that honoured the lived experiences of myself, my participants, colleagues, and loved ones.

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Portions	All content on pages 312-323.
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Appendix B

Chapter 3 Journal Permission Request

From: Flude, Annabel
To: Lexy Staniland
Cc: Flude, Annabel
Subject: RE: udbh20:Crazy, Weak, and Incompetent: A Directed Content Analysis of Self-Injury Stigma Experiences
Date: 04 May 2022 17:49:12
Attachments: image001.png
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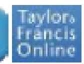

Appendix C
Chapter 3 Ethical Approval

Office of Research and Development

GPO Box U1987
Perth Western Australia 6845

Telephone +61 8 9266 7863
Facsimile +61 8 9266 3793
Web research.curtin.edu.au

18-Sep-2018

Name: Penelope Hasking
Department/School: School of Psychology
Email: Penelope.Hasking@curtin.edu.au

Dear Penelope Hasking

RE: Ethics approval
Approval number: HRE2018-0615

Thank you for submitting your application to the Human Research Ethics Office for the project **The experience of self-injury**.

Your application was reviewed by the Curtin University Human Research Ethics Committee at their meeting on **04-Sep-2018**.

The review outcome is: **Approved**.

Your proposal meets the requirements described in National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*.

Approval is granted for a period of one year from **18-Sep-2018** to **18-Sep-2019**. Continuation of approval will be granted on an annual basis following submission of an annual report.

Personnel authorised to work on this project:

Name	Role
Hasking, Penelope	CI
Boyes, Mark	Co-Inv
Lewis, Stephen	Co-Inv

Standard conditions of approval

1. Research must be conducted according to the approved proposal
2. Report in a timely manner anything that might warrant review of ethical approval of the project including:
   - proposed changes to the approved proposal or conduct of the study
   - unanticipated problems that might affect continued ethical acceptability of the project
   - major deviations from the approved proposal and/or regulatory guidelines
   - serious adverse events

Appendix D

Chapter 3 Participant Information Sheet

The Experience of Self-Injury
Professor Penelope Hasking & Dr Mark Boyes (Curtin University)
A/Prof Stephen Lewis (University of Guelph)

What is this study about?
Non-suicidal self-injury is a behaviour that is confusing to many people. Usually used to help manage overwhelming emotions, self-injury can seem counter-intuitive to the tendency to avoid pain and injury. While a significant amount of work has been done to better understand why people self-injure, less work has focused on the experience of self-injury, as voiced by people with experience of self-injury. In this project we are particularly interested in your experiences of stigma associated with self-injury, your experiences of disclosing your self-injury to someone else (or reasons you have not disclosed your history of self-injury), and the effect of any self-injury-related scars on various aspects of your life.

What will you be asked to do?
In completing this survey you will be asked a number of questions about your experiences of self-injury, including the nature and extent of your history of the behaviour. The survey should take approximately 30 minutes of your time. You will also be asked to comment on what you think the general public think about both mental illness in general, and self-injury specifically. We will ask you about any experiences you have had that might reflect any stigma associated with self-injury. Finally we will ask you about whether you have ever told anyone about your self-injury, and your experiences to do with disclosing self-injury to someone else.

Are there any risks or benefits?
We appreciate that reflecting on your history of self-injury could be confronting, or could bring back some unpleasant memories. Remember that you can take a break at any time, or stop doing the survey by simply closing your browser. You can come back to finish the survey anytime within a 2-week period (after 2 weeks you would need to start from the beginning). If you wish to talk to anyone about any of the topics raised in this survey we suggest one of these Useful resources. You can download this list to refer to later.

Students recruited through SONA (the School of Psychology online sign up system for research participation) will receive 2 SONA points for completing the survey. Participants recruited through other means will not be reimbursed for their time. However, people have also told us that they value the opportunity to express their views, and to help others who might be self-injuring. As such, your participation will benefit others. However, the choice to participate or not is completely up to you.

Is my data secure?
All responses you provide are anonymous. Students recruited through SONA will be directed to a separate site to add their name and student ID for the purpose of awarding SONA points - at no time will your name be linked to the responses you provide. We will ask you at the end of the survey if you are interested in being interviewed about your experiences of self-injury. If you are interested in an interview you will also be directed to an external site to enter your contact details.

Data will be stored in an electronic file, on a secure server, accessible only via a password protected computer. Only the Chief Investigators will have access to the raw data. In accordance with the WA University Sector Disposal Authority, data will be kept for up to 8 years after publication and then destroyed.

Aggregate data will be used in peer-reviewed journal articles, conferences, and other publications (e.g., books), but at no point will anyone be able to identify your individual responses. We may also use direct quotes from open ended responses in publications, but will use a pseudonym so you can never be identified.

At the end of the survey we will ask if you are interested in participating in an interview about self-injury. If you are, you will be directed to a separate site to add your contact details. This means we cannot link your contact details to your survey responses.

What if I have questions?
If you have any questions about the project feel free to contact either:

Penelope Hasking: Penelope.Hasking@curtin.edu.au
Mark Boyes: Mark.Boyes@curtin.edu.au

Can I see the results?
If you are interested in seeing the aggregate research findings, please contact us in December 2019.

Thank you for taking the time to consider participating in our research.

Penny Hasking, Mark Boyes, & Stephen Lewis

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2018-0615). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Appendix E

Chapter 3 Consent

I have read the information above and agree to participate in this anonymous survey about my experience of self-injury.

- ○ Yes, I would like to complete the survey
- ○ No, I am not interested

Appendix F

Chapter 3 Study Advertisements

SONA Advert

Study name: The experience of self-injury

Description: Non-suicidal self-injury is a behaviour that is perplexing to many people. Usually used to help manage overwhelming emotions, self-injury appears to counter the human instinct to avoid pain and injury. While a significant amount of work has been done to better understand why people self-injure, less work has focused on the experience of self-injury, as voiced by people with experience of self-injury. In this project we are particularly interested in your experiences of stigma associated with self-injury, your experiences of disclosing your self-injury to someone else (or reasons you have not disclosed your history of self-injury), and the effect of any self-injury-related scars on various aspects of your life.

If you choose to participate in the study you will be asked to complete an anonymous questionnaire about your experience of self-injury, stigma, and disclosure of self-injury

Eligibility: Any student with lived experience of self-injury

Duration: 30 minutes

Points: 2 points

Preparation: None

Researchers: A/Prof Hasking, Dr Mark Boyes, A/Prof Stephen Lewis (U of Guelph), Lexy Staniland
HREC Approval Number: HRE2018-0615

Example Social Media Advert

Non-suicidal self-injury is a behaviour that is perplexing to many people. Usually used to help manage overwhelming emotions, self-injury appears to counter the human instinct to avoid pain and injury. While a significant amount of work has been done to better understand why people self-injure, less work has focused on the experience of self-injury, as voiced by people with experience of self-injury. In this project we are particularly interested in people's experiences of stigma associated with self-injury, and the impact of any self-injury-related scars. If you have ever engaged in self-injury we want to hear your story. To read more about the study and participate in the anonymous online survey click here.

This study has been approved by the Curtin University Human Research Ethics Committee (HRE2018-0615). If you are experiencing any distress and wish to talk to someone about these feelings remember you can always call: Lifeline: 13 11 14 or BeyondBlue: 1300 22 4636.

Appendix G

Chapter 3 Questionnaire

Demographics

Before we get started we just need some background information about you.

What is your gender?

- ◯ Male
- ◯ Female
- ◯ Another gender

How old are you?

What is your postcode?

What country were you born in?

Do you identify as Aboriginal or Torres Strait Islander?

- ◯ Yes
- ◯ No

Are you a university student?

- ◯ Yes
- ◯ No

Which university are you enrolled in?

Are you a Curtin undergraduate psychology student participating for SONA points?

- ◯ Yes
- ◯ No

Are you an undergraduate or postgraduate student?

- ◯ Undergraduate (including Honours)
- ◯ Postgraduate

What year of your degree are you in?

Are you studying full time or part time?

- ◯ Full time
- ◯ Part time

Where are you living?

- ○ At home with parents/family
- ○ In university accommodation
- ○ With flatmates
- ○ On your own
- ○ With a partner
- ○ Other (please specify)

Have you ever been diagnosed with a mental illness? (if yes, please specify)

- ○ Yes
- ○ No

At what age were you first diagnosed with a mental illness?

What was the mental illness?

How old were you when first diagnosed?

How old were you when you last experienced this mental illness?

NSSI

Now we are going to ask questions about your experiences of self-injury, and any history of suicidal thoughts and behaviours. Remember you can take a break or stop doing the questionnaire at any time. If you wish to talk to someone about feelings that may come about through doing this questionnaire remember you can call:

Lifeline: 13 11 14
BeyondBlue: 1300 22 4636

Nonsuicidal Self-Injury
Nonsuicidal self-injury is defined as the deliberate damage to one's body that is not associated with conscious suicidal intent. This does not include socially acceptable forms of tissue damage such as tattooing and body piercing.

Have you ever thought about engaging in self-injury?

- ○ Yes
- ○ No

Have you ever engaged in nonsuicidal self-injury?

- ○ Yes
- ○ No

How many times have you self-injured in the last year?

None	Once	Twice	Three times	Four times	5 or more times
○	○	○	○	○	○

Please only select a behaviour if you have done it intentionally (i.e., on purpose) and without suicidal intent (i.e., not for suicidal reasons).

Please estimate the number of times in your life you have intentionally (i.e., on purpose) performed each types of nonsuicidal self-injury (please write a number)

	Click to write
Cutting	
Biting	
Burning	
Carving	
Pinching	
Pulling hair	

Severe scratching	
Banging or hitting yourself	
Interfering with wound healing	
Rubbing skin against rough surface	
Sticking yourself with needles	
Swallowing dangerous substances	
Other	

If you feel that you have/had a *main* form of self-injury, please indicate from the list below the behaviour you consider to be your main form of self-injury

- ◯ Cutting
- ◯ Biting
- ◯ Burning
- ◯ Carving
- ◯ Pinching
- ◯ Pulling hair
- ◯ Severe scratching
- ◯ Banging or hitting yourself
- ◯ Interfering with wound healing
- ◯ Rubbing skin against rough surface
- ◯ Sticking yourself with needles
- ◯ Swallowing dangerous substances
- ◯ Other

At what age did you (please write a number):

	Click to write
First injure yourself?	
Most recently injure yourself?	

Do/did you experience physical pain during self-injury?

- ◯ Yes
- ◯ Sometimes
- ◯ No

When you self-injure are/were you alone?

- ◯ Yes
- ◯ Sometimes
- ◯ No

Typically, how much time elapses(d) from the time you have the urge to self-injure until you act on the urge?

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

Do/did you want to stop self-injuring?

- ◯ Yes
- ◯ No

This inventory was written to help us better understand the experience of nonsuicidal self-injury. Below is a list of statements that may or may not be relevant to your experience of self-injury.
Please indicate how relevant each statement is to your experience of self-injury.

When I self-injure I am/was...

	Not relevant	Somewhat relevant	Very relevant
calming myself down	○	○	○
creating a boundary between myself and others	○	○	○
punishing myself	○	○	○
giving myself a way to care for myself (by attending to the wound)	○	○	○
causing pain so I will stop feeling numb	○	○	○
avoiding the impulse to attempt suicide	○	○	○
doing something to generate excitement or exhilaration	○	○	○
bonding with peers	○	○	○
letting others know the extent of my emotional pain	○	○	○
seeing if I can stand the pain	○	○	○
creating a physical sign that I feel awful	○	○	○
getting back at someone	○	○	○
ensuring I am self-sufficient	○	○	○
releasing emotional pressure that has built up inside of me	○	○	○
demonstrating that I am separate from other people	○	○	○
expressing anger towards myself for being worthless or stupid	○	○	○
creating a physical injury is easier to care for than my emotional distress	○	○	○
trying to feel something (as opposed to nothing) even if it is physical pain	○	○	○
responding to suicidal thoughts without actually attempting suicide	○	○	○
entertaining myself or others by doing something extreme	○	○	○

	Not relevant	Somewhat relevant	Very relevant
fitting in with others	○	○	○
seeking care or help from others	○	○	○
demonstrating I am tough or strong	○	○	○
proving to myself that emotional pain is real	○	○	○
getting revenge against others	○	○	○
demonstrating that I do not need to rely on others for help	○	○	○
reducing anxiety, frustration, anger, or other overwhelming emotions	○	○	○
establishing a barrier between myself and others	○	○	○
reacting to feeling unhappy with myself or disgusted with myself	○	○	○
allowing myself to focus on treating the injury, which can be gratifying or satisfying	○	○	○
making sure I am alive when I don't feel real	○	○	○
putting a stop to suicidal thoughts	○	○	○
pushing my limits in a manner akin to skydiving or other extreme activities	○	○	○
creating a sign of friendship or kinship with friends or loved ones	○	○	○
keeping a loved one from leaving or abandoning me	○	○	○
proving I can take the physical pain	○	○	○
signifying the emotional distress I'm experiencing	○	○	○
trying to hurt someone close to me	○	○	○
establishing that I am autonomous/independent	○	○	○

Have you ever experienced stigma as a result of mental illness?

◯ Yes

◯ No

If you would like to, please tell us about your experience with stigma

Have you ever experienced stigma as a result of your self-injury?

◯ Yes

◯ No

If you would like to, please tell us a little bit about your experiences of stigma.

Have you ever heard anyone talking about self-injury in a way that made you feel uncomfortable, angry, or upset?

◯ Yes

◯ No

Think of the time you were most uncomfortable/angry/upset by something you overheard.
Can you recall what they said that made you feel that way? Please write below.

Could you please expand on how this made you feel?

What was your response to this situation?

Has anyone ever said anything directly to you, regarding self-injury, that made you feel uncomfortable, angry, or upsetting?

◯ Yes

◯ No

Think of the time you were most uncomfortable/angry/upset by something someone said to you.
Can you recall what they said that made you feel that way? Please write below.

Could you please expand on how this made you feel?

What was your response to this situation?

Finally, please enjoy this brief clip from Finding Nemo which people say they find amusing (feel free to skip this and go straight to the end of the survey).

FN from Emotion Research on Vimeo.

Please watch the short video clip and then click the "NEXT" button

FN

from Emotion Research

Self injury fact sheet
Shedding light on self-injury
Self-injury and recovery resources
Self-injury outreach and support
Stress management

Would you be interested in participating in an interview about your experiences of self-injury? If you are, please leave your contact details here. These details will only ever be used to contact you if we are conducting an interview study and will be stored on a password protected computer, completely separate from your survey responses.

Email address

Phone number

Appendix H

Chapter 4 Journal Permission

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Appendix I

Chapter 4 Reflexive Journaling Excerpts

26/3/21

Everything is everything.

I'm talking about self-harm threats, "dramatic scenes unfolded as a man threatened self harm outside parliament house", then there's the restraint and tasering of people who have threatened or engaged in self-harm, and the self-harm legitimises the practice, like a person dying from a taser is better than them ending their own life or harming themselves, then there's the danger aspect of arresting someone who is threatening self-harm.

24/8/20

The sense I am having about the way self-harm is often portrayed - particularly when identified as an outcome or consequence, is that it is non-voluntary, as thought people have no control or agency over their behaviour - it is a very simplistic and un-nuanced view/approach/take/expression. And that in prison/detention/refugee contexts, "self-harm" is an indication of trouble and problems. Perhaps the "context" for prison/detention/refugee/state care could be referred to as "facilities"?

The couple suing the school over fees really irritates me, because self-harm is used to heighten the severity of the situation, as though self-harm is this worst outcome ever things, I dunno how to articulate this... Like, the focus is on her academic performance, but the self-harm sort of flavours the article with a sense that the school did real harm. Maybe my anger is misplaced here, perhaps I am looking for ways in which the media has failed - that's certainly accurate, I need to be looking at this more objectively. How does the media frame NSSI? How is self-injury portrayed? Is it my own bias that is construing the articles to have this flavour of invoking self-injury imagery to further a particular vantage point? What am I even saying here?

21/8/20

I think one of the issues about how self-harm is handled by the media, is that it is spoken about in varying terms and with varying connotations. In contexts where it is used to demonstrate the seriousness of a particular issues, for example, in article 09-284, the authors include the following, "The inquiry said Veterans Affairs should deal separately with veterans submitting mental health claims because problems some found when dealing with the department may lead to negative reactions or "in the worst possible case, self-harm"". The attempt appears to be to highlight the importance of dealing sensitively with mental health difficulties faced by veterans, and that is legitimate. However, because self-

harm in this context likely refers to suicide or suicide attempts, and not to self-injury, it is difficult to see how readers assimilate this information. We need to know more about how people differentiate these things and whether the inconsistent terminology has any impact of stigma, treatment, service-delivery etc.

18/2/20

The other thing I am wondering is whether my time frame is ambitious... I have decided to continue with the time frame we used in the content analysis, however, this is returning a lot of results, which may leave me with a data set that is unsuitable for a media framing analysis. Perhaps I will need to block the articles into time points, like 2007-2012 and then 2013-2019, as a comparison in line with the DSM-V release... I'll continue collating and then decide this once I can see what my data set it like. This particular aspect may also change my research question, because if I am comparing these time point, my research question is actually "How does media framing of NSSI change over time?" Or something like that...

17/2/20

Day one of article collation. Some issues that I seem to be running into include some confusion around what articles can answer my research question, and whether my research question is enough. My question is: "How does the news media represent people who have a history of nonsuicidal self-injury?" This question is specific and discrete, the population is clearly articulated, and the types of stories that will be relevant is clear. I guess, as I am going through the list of articles and reviewing their content, other questions come to mind. The question "How does the news media represent nonsuicidal self-injury?" captures more information about the behaviour, whereas I want to know about how the people who engage in self-injury are framed. My research question is informed by a desire to understand how NSSI stereotypes develop, which necessitates an investigation of how people who self-injure are portrayed. But, these other questions that are coming to mind as I screen the articles are important, too. How the media discusses the rates of NSSI is also very interesting, because it likely informs people's understanding of the so-called NSSI "epidemic". But I need to maintain focus on the people.

Appendix J

Chapter 5 Initial Item Pool

Table J.1

Initial Item Pool

Public Stigma Scale	Personal Stigma Scale	Self-Stigma Scale	Anticipated Stigma Scale	Enacted Stigma Scale
People who have self-injured are to blame for their problems (1)	People who have self-injured are to blame for their problems (1)	I am to blame for my problems (1)	People will blame me for my problems (1)	People have said that I brought this upon myself (1)
People who have self-injured do not deserve sympathy (2)	People who have self-injured do not deserve sympathy (2)	I do not deserve sympathy for my problems (2)	People will tell me I don't deserve sympathy (2)	People have said that I do not deserve sympathy (2)
People who self-injured are dysfunctional (3)	People who self injured are dysfunctional (3)	I am dysfunctional (3)	People will think I am dysfunctional (3)	People have said that I am dysfunctional (3)
People who have self-injured should just get over it (4)	People who have self-injured should just get over it (4)	I should just get over my problems (4)	People will tell me to just get over it (4)	People have said that I should just get over it (4)
People who have self-injured are pathetic (5)	People who have self-injured are pathetic (5)	I am pathetic (5)	People will think I am pathetic (5)	People have said that I am pathetic (5)
People who have self-injured are weak (6)	People who have self-injured are weak (6)	I am weak (6)	People will think I am weak (6)	People have said that I am weak (6)
People who have self-injured are crazy (7)	People who have self-injured are crazy (7)	I am crazy (7)	People will think I am crazy (7)	People have said that I am crazy (7)
People who have self-injured are emotionally unstable (8)	People who have self-injured are emotionally unstable (8)	I am emotionally unstable (8)	People will think I am emotionally unstable (8)	People have said that I am emotionally unstable (8)
People who have self-injured are manipulative (9)	People who have self-injured are manipulative (9)	I am manipulative (9)	People will think I am manipulative (9)	People have said that I am manipulative (9)
People who have self-injured can’t help it (10)	People who have self-injured can’t help it (10)	I can't help it (10)	People will think I can't help it (10)	People have said that I can't help it (10)
People who have self-injured can't cope with life (11)	People who have self-injured can't cope with life (11)	I can't cope with life (11)	People will think I can't cope with life (11)	People have said I can't cope with life (11)
People who have self-injured are emotionally damaged (12)	People who have self-injured are emotionally damaged (12)	I am emotionally damaged (12)	People will think I am emotionally damaged (12)	People have said that I am emotionally damaged (12)
People who have self-injured are failures (13)	People who have self-injured are failures (13)	I am a failure (13)	People will think I am a failure (13)	People have said I am a failure (13)
People who have self-injured are attention seeking (14)	People who have self-injured are attention seeking (14)	I'm an attention-seeker (14)	People will think I am attention-seeking (14)	People have said I am attention-seeking (14)
People who have self-injured deserve the pain (15)	People who have self-injured deserve the pain (15)	I deserve pain (15)	People will think that I deserve pain (15)	People have said that I deserve pain (15)
People who have self-injured have a mental illness (16)	People who have self-injured have a mental illness (16)	I have a mental illness (16)	People will think I have a mental illness (16)	People have said I have a mental illness, despite not knowing whether that was true (16)
People who have self-injured have no self-control (17)	People who have self-injured have no self-control (17)	I have no self-control (17)	People will think I have no self control (17)	People have said I have no self-control (17)
People who have self-injured did it because their friends did (18)	People who have self-injured did it because their friends did (18)	I am not normal (18)	People will think I have done it to fit in (18)	People have said I have done it just to fit in (18)
People who have self-injured copied it from social media/internet (19)	People who have self-injured copied it from social media/internet (19)	I don't really have anything to complain about (19)	People will think I just copied it from social media/internet (19)	People have said I just copied it from social media/internet (19)

People who have self-injured copied it from TV/Movies (20)	People who have self-injured copied it from TV/Movies (20)	I am stupid (20)	People will think I copied it from TV/movies (1)	People have said I copied it from TV/movies (1)
People who have self-injured are not normal (21)	People who have self-injured are not normal (21)	*I am resilient (21)*	People will think I am not normal (2)	People have said I am not normal (2)
People who have self-injured don’t really have anything to complain about (1)	People who have self-injured don’t really have anything to complain about (22)	*I am capable (22)*	People will think I don't really have anything to complain about (3)	People have said I don't really have anything to complain about (3)
Self-injury is a stupid thing to do (2)	Self-injury is a stupid thing to do (1)	*I can fight through adversity (23)*	People will think my self-injury is a stupid thing to do (4)	People have said that my self-injury is a stupid thing to do (4)
People who have self-injured are resilient (3)	*People who have self-injured are resilient (2)*	*I can overcome challenges (24)*	*People will think I am resilient (5)*	*People have said that I am resilient (5)*
People who have self-injured are capable (4)	*People who have self-injured are capable (3)*	*I am coping as best I can (25)*	*People will think I am capable (6)*	*People have said that I am capable (6)*
People who have self-injured can fight through adversity (5)	*People who have self-injured can fight through adversity (4)*	*I am strong (26)*	*People will think I can fight through adversity (7)*	*People have said I an fight through adversity (7)*
People who have self-injured can overcome challenges (6)	*People who have self-injured can overcome challenges (5)*	*I can manage my emotions (27)*	*People will think I can overcome challenges (8)*	*People have said I can overcome challenges (8)*
People who have self-injured are coping as best they can (7)	*People who have self-injured are coping as best they can (6)*	*I am only human (28)*	*People will think I am coping as best I can (9)*	*People have said I am coping as best I can (9)*
People who have self-injured are strong (8)	*People who have self-injured are strong (7)*	*I can get through things (29)*	*People with think I am strong (10)*	*People have said I am strong (10)*
People who have self-injured can manage their emotions (9)	*People who have self-injured can manage their emotions (8)*	I am childish (30)	*People will think I can manage my emotions (11)*	*People have said that I can manage my emotions (11)*
People who have self-injured are only human (10)	*People who have self-injured are only human (9)*	I should keep my self-injury hidden (1)	*People will think I am only human (12)*	*People have said I am only human (12)*
People who have self-injured can get through things (11)	*People who have self-injured can get through things (10)*	I should not let others know about my self-injury (2)	*People will think I can get through things (13)*	*People have said I can get through things (13)*
People who have self-injured are just trying to be different/special (12)	People who have self-injured are just trying to be different/special (11)	I should not let others see my self-injury (3)	People will think I am just trying to be different/special (14)	People have said that I am just trying to be different/special (14)
People who have self-injured are childish (13)	People who have self-injured are childish (12)	I should cover up my self-injury (4)	People will think I am childish (15)	People have said that I am childish (15)
People who have self-injured are masochistic (14)	People who have self-injured are masochistic (13)	My problems are not "real" problems (5)	People will think I am masochistic (16)	People have said I am masochistic (16)
People who have self-injured are "emo" or "goth" (15)	People who have self-injured are "emo" or "goth" (14)	I avoid talking about my self-injury (6)	People will call me names like "cutter" (17)	People have called me names like “cutter” (17)
People who have self-injured should keep their self-injury hidden (16)	People who have self-injured should keep their self-injury hidden (1)	*I talk about my self-injury (7)*	People will think I am "emo" or "goth" (18)	People have called me an “emo” or a “goth” (18)
People who have self-injured should not let others know about it (17)	People who have self-injured should not let others know about it (2)	I avoid discussing my experiences of self-injury online (8)	People will think I should keep my self-injury hidden (1)	
People who have self-injured should not let others see their self-injury (18)	People who have self-injured should not let others see their self-injury (3)	I avoid posting about my experiences of self-injury online (9)	People will think that I should not let others know about my self-injury (2)	People have told me I should not let others know about my self-injury (2)
People who have self-injured should cover up their self-injury (19)	People who have self-injured should cover up their self-injury (4)	I feel that I have to prove that I have self-injured when asked (10)	People will think I should not let others see my self-injury (3)	People have told me I should not let others see my self-injury (3)
People who have self-injured don’t have any “real” problems (20)	People who have self-injured don’t have any “real” problems (5)	I do not make an effort to hide my self-injury (11)	People will think I should cover up my self-injury (4)	People have told me to cover my self-injury (1)
People should avoid talking about self-injury (21)	People should avoid talking about self-injury (6)	I have to show my self-injury to prove I have done it (12)	People will think I don't have any real problems (5)	People have dismissed me as not having any real problems (5)
People who have self-injured should be allowed to talk about it (22)	*People who have self-injured should be allowed to talk about it (7)*	*I am able to talk about my experiences of self-injury (13)*	People will think I shouldn't talk about my self-injury (6)	People have told me not to talk about my self-injury (6)

People should not discuss self-injury online (23)	People should not discuss self-injury online (8)	I shouldn't need to talk about my self-injury (14)	*People will think it's okay to talk about my self-injury (7)*	*People have told me it's okay to talk about my self-injury (7)*
People should not post about self-injury online (24)	People should not post about self-injury online (9)	*I share my experiences of self-injury with other people (15)*	People will think I shouldn't discuss my experiences of self-injury online (8)	People have told me not to discuss my experiences of self-injury online (8)
People who have self-injured should show evidence of their self-injury when asked (1)	People who have self-injured should show evidence of their self-injury when asked (10)	*I am open about my experiences of self-injury (16)*	People will think I shouldn't post about my experiences of self-injury online (9)	People have told me not to post about my experiences of self-injury online (9)
People who have self-injured should not need to hide it (2)	*People who have self-injured shouldn't need to hide it (11)*	*I do not hide my self-injury (17)*	People will pressure me to show them my self-injury (10)	People have pressured me to show them my self-injury (10)
People who have self-injured should be forced to prove it (3)	People who have self-injured should be forced to prove it (12)	I should just toughen up (18)	People will think I don't need to hide it (11)	People have told me that I don't need to hide it (11)
People who have self-injured are able to talk about it (4)	*People who have self-injured are able to talk about it (13)*	I will never be free of self-injury (1)	People will force me to show them my self-injury (12)	People have forced me to show them my self-injury (12)
People who have self-injured don't need to talk about it (5)	People who have self-injured don't need to talk about it (14)	I cannot handle high stress situations (2)	*People will allow me to talk about my experiences of self-injury (13)*	*People have allowed me to talk about my experiences of self-injury (13)*
People who have self-injured can share their experiences with others (6)	*People who have self-injured can share their experiences with others (15)*	I should be forced to stop (3)	People won't want to hear about my experiences of self-injury (14)	People have told me they do not want to hear about my experiences of self-injury (14)
People who have self-injured are open about their experiences of self-injury (7)	*People who have self-injured are open about their experiences of self-injury (16)*	*I want to live (4)*	*People will let me share my experiences (15)*	*People have let me share my experiences of self-injury (15)*
People who have self-injured should not have to hide it (8)	*People who have self-injured should not have to hide it (17)*	I will never recover (5)	*People will invite me to share my experiences of self-injury (16)*	*People have invited me to share my experiences of self-injury (16)*
People who have self-injured should toughen up (9)	People who have self-injured should toughen up (18)	*I will recover/have recovered (6)*	*People will not think I should hide my self-injury (17)*	*People have not told me to hide my self-injury (17)*
People who have self-injured want to show off their scars (10)	People who have self-injured want to show off their scars (19)	I feel hopeless about my future (7)	People will think I should toughen up (18)	People have told me to toughen up (18)
People who have self-injured want people to see their scars (11)	People who have self-injured want people to see their scars (20)	I will never be able to cope (8)	People will think I am suicidal (1)	People have I must be suicidal (1)
People who have self-injured wouldn’t talk about it if they weren’t attention seeking (12)	People who have self-injured wouldn’t talk about it if they weren’t attention seeking (21)	*I can succeed in life (9)*	People will think I should just kill myself (2)	People have said that I should just kill myself (2)
Self-injury should be banned from social media (13)	Self-injury should be banned from social media (22)	*I feel hopeful about my future (10)*	People will think I will never be free of self-injury (3)	People have said I will never be free of self-injury (3)
People who have self-injured are suicidal (1)	People who have self-injured are suicidal (1)	I will never be able to manage my emotions (11)	People will think I can't handle high stress situations (4)	People have said I cannot handle high stress situations (4)
People who have self-injured don’t have the guts to kill themselves (2)	People who have self-injured don’t have the guts to kill themselves (2)	I am/was just going through a phase (12)	People will try to make me stop (5)	People have tried to force me to stop (5)
People who have self-injured will never be able to stop (3)	People who have self-injured will never be able to stop (3)	I deserve to have my body searched for signs of self-injury (13)	*People will think I want to live (6)*	*People have said that I want to live (6)*
People who have self-injured cannot handle high-stress situations (4)	People who have self-injured cannot handle high-stress situations (4)	*I am proud of myself (14)*	People will think I will never recover (7)	People have said I will never recover (7)
People who have self-injured should be forced to stop (5)	People who have self-injured should be forced to stop (5)	*I appreciate that recovery is not easy (15)*	*People will think I have recovered (8)*	*People have said I will recover (8)*
People who have self-injured want to live (6)	*People who have self-injured want to live (6)*	Recovery should be easy for me (16)	People will think I have a hopeless future (9)	People have said I have a hopeless future (9)
People who have self-injured will never recover (7)	People who have self-injured will never recover (7)	I am impulsive (1)	People will think I will never be able to cope (10)	People have said I will never be able to cope (10)
People who have self-injured will recover (8)	*People who have self-injured will recover (8)*	I am unpredictable (2)	*People will think I can succeed in life (11)*	*People have said I can succeed in life (11)*
People who have self-injured have a hopeless future (9)	People who have self-injured have a hopeless future (9)	I want to die (3)	*People will feel hopeful about my future (12)*	*People have said they feel hopeful about my future (12)*

People who have self-injured will never be able to cope (10)	People who have self-injured will never be able to cope (10)	I will always be at risk of suicide (4)	People will think I will never be able to manage my emotions (13)	People have said I will never be able to manage my emotions (13)
People who have self-injured can succeed in life (11)	*People who have self-injured can succeed in life (11)*	I am a bad influence on others (5)	People will tell me self-injury is just a phase (14)	People have said my self-injury is just a phase (14)
People who have self-injured have a hopeful future (12)	*People who have self-injured have a hopeful future (12)*	*I don't want to die (6)*	People will search my body for signs of self-injury (15)	People have searched my body for signs of self-injury (15)
People who have self-injured will never be able to manage their emotions (13)	People who have self-injured will never be able to manage their emotions (13)	I am reckless (7)	*People will say they are proud of me (16)*	*People have said they are proud of me (16)*
People who have self-injured are just going through a phase (14)	People who have self-injured are just going through a phase (14)	*I have a lot to offer to others (8)*	*People will acknowledge that recovery is not easy (17)*	*People have acknowledged that recovery is not easy (17)*
People who have self-injured should be checked for signs of self-injury (15)	People who have self-injured should be checked for signs of self-injury (15)	*I am careful (9)*	People will tell me recovery is easy (18)	People have said that recovery is easy (18)
People who have self-injured should be proud (16)	*People who have self-injured should be proud (16)*	I am dangerous (10)	People will think I copied it from someone else, even if I didn't (1)	People have said I must have copied it from someone else, even if I didn't (1)
People who have self-injured don't necessarily find recovery easy (17)	*People who have self-injured don't necessarily find recovery easy (17)*	I should be forced to see a mental health professional (11)	People will think I am impulsive (2)	People have said I am impulsive (2)
People who have self-injured should be able to easily recover (18)	People who have self-injured should be able to easily recover (18)	*I should be in control of my recovery (12)*	People will think I am unpredictable (3)	People have said I am unpredictable (3)
People who have self-injured copied the behaviour from someone else (1)	People who have self-injured copied the behaviour from someone else (1)	I should be put on suicide watch (13)	People will assume I learnt about it online, even if I didn't (4)	People have said I must have learnt about it online, even if I didn't (4)
People who have self-injured are impulsive (2)	People who have self-injured are impulsive (2)	I belong in a mental institution (14)	People will think I share pictures of my self-injury online, even if I don't (5)	People have said I share pictured of my self-injury online, even if I haven't (5)
People who have self-injured are unpredictable (3)	People who have self-injured are unpredictable (3)	I should be locked up (15)	People will think I want to die (6)	People have said I want to die (6)
People who have self-injured learnt about it online (4)	People who have self-injured learnt about it online (4)	My problems are not important (16)	People will think I am trying to kill myself (7)	People have said I am trying to kill myself (7)
People who have self-injured share pictures of their self-injury online (5)	People who have self-injured like sharing pictures of their self-injury online (5)	My self-injury is not important (17)	People will think I am at risk of suicide (8)	People have said I am at risk of suicide (8)
People who have self-injured want to die (6)	People who have self-injured want to die (6)	I should minimise contact with friends (18)	People will say I am a bad influence on others (9)	People have said I am a bad influence on others (9)
People who have self-injured are trying to kill themselves (7)	People who have self-injured are trying to kill themselves (7)	I should not be allowed around children (19)	*People will think I do not want to die (10)*	*People have said I do not want to die (10)*
People who have self-injured will always be at risk of suicide (8)	People who have self-injured will always be a risk of suicide (8)	I do not care about my appearance (1)	People will think I am reckless (11)	People have said I am reckless (11)
People who have self-injured are a bad influence on others (9)	People who have self-injured are a bad influence on others (9)	I am unattractive (2)	*People will think I have a lot to offer others (12)*	*People have said I have a lot to offer others (12)*
People who have self-injured don't want to die (10)	People who have self-injured don't want to die (10)	I have ruined my body (3)	*People will think I am careful (13)*	*People have said that I am careful (13)*
People who have self-injured are reckless (11)	People who have self-injured are reckless (11)	I am repulsive (4)	People will think I am dangerous (14)	People have said they think I am dangerous (14)
People who have self-injured have a lot to offer others (12)	*People who have self-injured have a lot to offer others (12)*	My self-injury is ugly (5)	People will think I need to see a mental health professional (15)	People have forced me to see a mental health professional (15)
People who have self-injured are careful (13)	*People who have self-injured are careful (13)*	My self-injury represents strength (6)	*People will allow me to control my recovery (16)*	*People have allowed me to control my recovery (16)*
People who have self-injured are dangerous (14)	People who have self-injured are dangerous (14)	*I do care about my appearance (7)*	I will be put on suicide watch, even if I am not suicidal (17)	People have put me on suicide watch, even though I was not suicidal (17)
People who have self-injured should be forced to see a mental health professional (15)	People who have self-injured should be forced to see a mental health professional (15)	*I am attractive (8)*	People will think I belong in a mental institution (18)	People have said that I belong in a mental institution (18)

People who have self-injured should be in control of their recovery (16)	People who have self-injured should be in control of their recovery (16)	*I am beautiful (9)*	People will say I should be locked up (19)	People have said I should be locked up (19)
People who have self-injured should be put on suicide watch (17)	People who have self-injured should be put on suicide watch (17)	*I haven't ruined my body (10)*	People will dismiss my problems (20)	People have dismissed my problems (20)
People who have self-injured belong in a mental institution (18)	People who have self-injured belong in a mental institution (18)	I don't deserve intimacy with others (11)	People will dismiss my self-injury (21)	People have dismissed my self-injury (21)
People who have self-injured should be locked up (19)	People who have self-injured should be locked up (19)	I am not capable of looking after others (1)	People will not want me around their friends (22)	People have said that do not want me around their friends (22)
People who have self-injured do not have important problems (20)	People who have self-injured do not have important problems (20)	I cannot maintain close relationships (2)	People will stop me from being around children (23)	People have stopped me from being around children (23)
Self-injury is not important (21)	Self-injury is not important (21)	I am not/would not be a suitable romantic partner (3)	People will think I don't care about my appearance (1)	People have said I don't care about my appearance (1)
People who have self-injured should minimise contact with friends (22)	People who have self-injured should minimise contact with friends (22)	I am not/would not be a suitable parent (4)	People will think I am unattractive (2)	People have said that I am unattractive (2)
People who have self-injured should not be allowed around children (23)	People who have self-injured should not be allowed around children (23)	I waste valuable medical resources (5)	People will think I have ruined my body (3)	People have said that I have ruined my body (3)
People who have self-injured do not care about their appearance (1)	People who have self-injured do not care about their appearance (1)	I don’t deserve medical treatment for my self-injury (6)	People will think I am repulsive (4)	People have said that I am repulsive (4)
People who have self-injured are unattractive (2)	People who have self-injured are unattractive (2)	I waste my friends' time (7)	People will stare at my self-injury (5)	People have stared at my self-injury (5)
People who have self-injured have ruined their body (3)	People who have self-injured have ruined their body (3)	I am a drain on the health system (8)	People will think my self-injury is ugly (6)	People have said my self-injury is ugly (6)
People find self-injury scars repulsive (4)	People find self-injury scars repulsive (4)	I don't care if I upset friends and family (9)	*People will think my self-injury represents strength (7)*	*People have said that my self-injury represents strength (7)*
People can’t help but stare when they see self-injury (5)	People can’t help but stare when they see self-injury (5)	I am unlovable (10)	*People will think self-injury scars are no different to other types of scars (8)*	*People have said that self-injury scars are no different to other types of scars (8)*
Self-injury is ugly (6)	Self-injury is ugly (6)	*I am caring (11)*	*People will think I care about my appearance (9)*	*People have said I do care about my appearance (9)*
Self-injury scars represent strength (7)	*Self-injury scars represent strength (7)*	I am selfish (12)	*People will think I am attractive (10)*	*People have said that I am attractive (10)*
Self-injury scars are no different to other types of scars (8)	*Self-injury scars are no different to other types of scars (8)*	I drain loved ones of emotional resources (13)	*People will think I am beautiful (11)*	*People have said that I am beautiful (11)*
People who have self-injured care about their appearance (9)	*People who have self-injured care about their appearance (9)*	*I can maintain close relationships (14)*	*People will think I have not ruined my body (12)*	*People have said that I have not ruined my body (12)*
People who have self-injured are attractive (10)	*People who have self-injured are attractive (10)*	I deserve to be asked uncomfortable questions about my self-injury (15)	People won't want to be intimate with me (13)	People have not wanted to be intimate with me (13)
People who have self-injured are beautiful (11)	*People who have self-injured are beautiful (11)*	*I am dependable (16)*	People will think I am not capable of looking after others (7)	People have said I am not capable of looking after others (1)
People who have self-injured have not ruined their body (12)	*People who have self-injured have not ruined their body (12)*	*I am selfless (17)*	People will not want to be close to me (8)	People have not wanted to be close to me (2)
People who have self-injured do not deserve intimacy with others (13)	People who have self-injured do not deserve intimacy with others (13)	I don't deserve to have friends (1)	People will think I am not a suitable romantic partner (9)	People have told me I am not a suitable romantic partner (3)
People who have self-injured are not capable of looking after others (1)	People who have self-injured are not capable of looking after others (1)	I am angry with myself (2)	People will think I am not/would not be a suitable parent (10)	People have told me I am not/would not be a suitable parent (4)
People who have self-injured cannot maintain close relationships (2)	People who have self-injured cannot maintain close relationships (2)	I need to be controlled (3)	People will think I waste valuable medical resources (11)	People have told me I waste valuable medical resources (5)
People who have self-injured are not suitable romantic partners (3)	People who have self-injured are not suitable romantic partners (3)	I cannot be trusted to be alone (4)	People will think I don't deserve medical treatment (12)	People have said I don't deserve medical treatment (6)

People who have self-injured are not suitable parents (4)	People who have self-injured are not suitable parents (4)	*I should be treated as I am usually treated (5)*	People will think I am a waste of time (13)	People have said I am a waste of time (7)
People who have self-injured waste valuable medical resources (5)	People who have self-injured waste valuable medical resources (5)	I should be avoided (6)	People will think I am a drain on the health system (14)	People have said I am a drain on the health system (8)
People who have self-injured don't deserve medical treatment (6)	People who have self-injured don't deserve medical treatment (6)	I deserve poor treatment (7)	People will think I don't care if I upset them (15)	People have said I don't care if I upset them (9)
People who have self-injured waste their friends' time (7)	People who have self-injured waste their friends' time (7)	I should not have children (8)	People will think I refuse to accept help (16)	People have said that I refuse to accept help (10)
People who have self-injured are a drain on the health system (8)	People who have self-injured are a drain on the health system (8)	I am a time-waster (9)	People will think I am unlovable (17)	People have said I am unlovable (11)
People who have self-injured don't care if they upset their friends and family (9)	People who have self-injured don't care if they upset their friends and family (9)	I do not deserve support for my self-injury (11)	*People will think I am caring (18)*	*People have said I am caring (12)*
People who have self-injured refuse to accept help (10)	People who have self-injured refuse to accept help (10)	People should stay away from me (12)	People will think I am selfish (19)	People have said I am selfish (13)
People who have self-injured are unlovable (11)	People who have self-injured are unlovable (11)	I do not care about others (13)	People will think I drain loved ones of emotional resources (1)	People have said that I am a drain on their emotional resources (14)
People who self-injure are caring (12)	*People who have self-injured are caring (12)*	I am a burden to loved ones (14)	*People will think I can maintain close relationships (2)*	*People will say that I can maintain close relationships (15)*
People who self-injure are selfish (13)	People who have self-injured are selfish (13)	*I am compassionate (15)*	People will ask me uncomfortable questions about my self-injury that I do not want to answer (3)	People have asked me uncomfortable questions about my self-injury that I did not want to answer (16)
People who have self-injured drain loved ones of emotional resources (14)	People who have self-injured drain loved ones of emotional resources (14)	I should be ignored (16)	*People will think I am dependable (4)*	*People have said I am dependable (17)*
People who have self-injured can maintain close relationships (15)	*People who have self-injured can maintain close relationships (15)*	I should not be allowed to talk about my self-injury (17)	*People will think I am selfless (5)*	People have said I am selfless (18)
People who have self-injured should answer questions about self-injury, even if they are uncomfortable (16)	People who have self-injured should answer questions about self-injury, even if they are uncomfortable (16)	I should avoid talking about my self-injury (18)	People will not want to be friends with me (6)	People have not wanted to be friends with me (19)
People who have self-injured are dependable (17)	*People who have self-injured are dependable (17)*		People will be angry with me (1)	People have been angry with me (1)
People who have self-injured are selfless (18)	*People who have self-injured are selfless (18)*		People will try to control me (2)	People have tried to control me (2)
People who have self-injured don't deserve to have friends (1)	People who have self-injured don't deserve to have friends (19)		People will not trust me to be alone (3)	People did not trust me to be alone (3)
People who have self-injured deserve anger (2)	People who have self-injured deserve anger (1)		People will "walk on eggshells" around me (4)	People have "walked on eggshells" around me (4)
People who have self-injured need to be controlled (3)	People who have self-injured need to be controlled (2)		*People will treat me as they usually do (5)*	*People have treated me as they usually do (5)*
People who have self-injured cannot be trusted to be alone (4)	People who have self-injured cannot be trusted to be alone (3)		People will avoid me (6)	People have avoided me (6)
People who have self-injured need to be treated delicately (5)	People who have self-injured need to be treated delicately (4)		People will treat me poorly (7)	People have treated me poorly (7)
People who have self-injured should be treated as they are usually treated (6)	*People who have self-injured should be treated as they are usually treated (5)*		People in the health care profession will treat me poorly (8)	I have been treated poorly by health care professionals (8)
People who have self-injured should be avoided (7)	People who have self-injured should be avoided (6)		People will tell me I should not have children (9)	People have said that I should not have children (9)
People who have self-injured deserve poor treatment (8)	People who have self-injured deserve poor treatment (7)		People will tell me I am a time-waster (10)	People have said I am a time-waster (10)

People who have self-injured deserve to be treated poorly by health care professionals (9)	People who have self-injured deserve to be treated poorly by health care professionals (8)	People will think I do not deserve medical treatment for my self-injury (11)	People have said I do not deserve medical treatment for my self-injury (11)
People who have self-injured should not have children (10)	People who have self-injured should not have children (9)	People will think I do not deserve support for my self-injury (12)	People have said I do not deserve support for my self-injury (12)
People who have self-injured are time-wasters (11)	People who have self-injured are time-wasters (10)	People will stay away from me (13)	People have stayed away from me (13)
People who have self-injured do not deserve medical treatment for self-injury (12)	People who have self-injured do not deserve medical treatment for self-injury (11)	People will think I do not care about others (14)	People have told me I do not care about others (14)
People who have self-injured do not deserve support for self-injury (13)	People who have self-injured do not deserve support for self-injury (12)	People will think I am a burden to loved ones (15)	People have said I am a burden on loved ones (15)
I should stay away from people who self-injure (14)	I should stay away from people who self-injure (13)	*People will think that I am compassionate (16)*	*People have said that I am compassionate (16)*
People who have self-injured do not care about others (15)	People who have self-injured do not care about others (14)	People will ignore my self-injury (17)	People have ignored my self-injury (17)
People who have self-injured are a burden to loved ones (16)	People who have self-injured are a burden to loved ones (15)	People will refuse to talk to me about my self-injury (18)	People have refused to talk to me about my self-injury (18)
People who have self-injured are compassionate (17)	*People who have self-injured are compassionate (16)*	People will avoid talking about self-injury with me (19)	People have avoided talking about self-injury with me (19)
People who have self-injured should be ignored (18)	People who have self-injured should be ignored (17)		
People who have self-injured should not be allowed to talk about their self-injury (19)	People who have self-injured should not be allowed to talk about their self-injury (18)		
People who have self-injured should avoid talking about it with others (20)	People who have self-injured should avoid talking about it with others (19)		

Note. Italicised items are positively worded and reflect an absence of stigma.

Appendix K
Chapter 5 Ethical Approval

Research Office at Curtin

GPO Box U1987
Perth Western Australia 6845

Telephone +61 8 9266 7863
Facsimile +61 8 9266 3793
Web research.curtin.edu.au

27-May-2020

Name: Penelope Hasking
Department/School: School of Psychology
Email: Penelope.Hasking@curtin.edu.au

Dear Penelope Hasking

RE: Ethics approval
Approval number: HRE2020-0267

Thank you for submitting your application to the Human Research Ethics Office for the project **Validating a Self-Injury Stigma Questionnaire**.

Your application was reviewed by the Curtin University Human Research Ethics Committee at their meeting on .

The review outcome is: **Approved**.

Your proposal meets the requirements described in National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*.

Approval is granted for a period of one year from **27-May-2020** to **26-May-2021**. Continuation of approval will be granted on an annual basis following submission of an annual report.

Personnel authorised to work on this project:

Name	Role
Hasking, Penelope	Supervisor
Staniland, Alexandra	Student
Boyes, Mark	Supervisor
Lewis, Stephen	Supervisor

Standard conditions of approval

1. Research must be conducted according to the approved proposal
2. Report in a timely manner anything that might warrant review of ethical approval of the project including:
    - proposed changes to the approved proposal or conduct of the study
    - unanticipated problems that might affect continued ethical acceptability of the project
    - major deviations from the approved proposal and/or regulatory guidelines
    - serious adverse events
3. Amendments to the proposal must be approved by the Human Research Ethics Office before they are implemented (except where an amendment is undertaken to eliminate an immediate risk to participants)
4. An annual progress report must be submitted to the Human Research Ethics Office on or before the anniversary of approval and a completion report submitted on completion of the project
5. Personnel working on this project must be adequately qualified by education, training and experience for their role, or supervised

Appendix L

Chapter 5 Factor Structure Output for NSSI Social Exposure Scale

Total Variance Explained

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.168	51.678	51.678	4.792	47.918	47.918
2	1.489	14.892	66.570	1.144	11.442	59.360
3	.799	7.989	74.559			
4	.556	5.560	80.119			
5	.478	4.781	84.900			
6	.411	4.113	89.014			
7	.334	3.343	92.357			
8	.288	2.877	95.234			
9	.255	2.550	97.783			
10	.222	2.217	100.000			

Total Variance Explained

Factor	Rotation Sums of Squared Loadings[a]
	Total
1	4.092
2	3.980
3	
4	
5	
6	
7	
8	
9	
10	

Extraction Method: Maximum Likelihood.

a. When factors are correlated, sums of squared loadings cannot be added to obtain a total variance.

Factor Matrix[a]

	Factor	
	1	2
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 1. I am personally familiar with individuals who engage/have engaged in some form of NSSI	.748	-.347
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 2. I have seen internet forums or blogs about NSSI	.668	.145
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 3. I have heard references to NSSI in music lyrics	.714	.263
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 4. I have seen references to different forms of NSSI in movies	.759	.465
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 5. I have seen, heard, or read news reports about NSSI	.611	.356

Factor Matrix[a]

	Factor	
	1	2
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 6. I have seen references to NSSI on TV (sitcoms, dramas, serials - not movies on TV or news programs)	.674	.457
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 7. I have friends who engage in NSSI	.718	-.330
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 8. I have observed someone engage in a form of NSSI (in person, not on TV or in a movie)	.428	-.164
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 9. I have talked about NSSI with other people (regardless of whether they engaged in the behaviour)	.752	-.243
We are interested in how much familiarity you have with NSSI. Please indicate how often each of the below has applied to you. - 10. I have talked about NSSI with people who have done it	.780	-.433

Extraction Method: Maximum Likelihood.

a. 2 factors extracted. 4 iterations required.

Appendix M

Chapter 5 Participant Information Sheets

Study One

HREC Project Number:	HRE2020-0267
Project Title:	*Attitudes Toward Self-Injury*
Chief Investigator:	*Prof Penelope Hasking*
Associate Investigator(s):	*Dr Mark Boyes & A/Prof Stephen Lewis (U of Guelph)*
Student researcher:	*Alexandra (Lexy) Staniland*
Version Number:	*1*
Version Date:	*15/05/2020*

What is the Project About?
Attitudes play an important role in how we think and feel about mental illness and other related issues. In this project, we are interested in understanding people's attitudes toward and experiences with nonsuicidal self-injury. Nonsuicidal self-injury refers to deliberating damaging one's body without intending to end one's life.

In this study, we will ask you to complete an online survey about your attitudes toward and experience of self-injury. The data we collect will be used to develop an accurate measure of attitudes toward self-injury and help us understand how these attitudes relate to a range of psychological outcomes, such as self-esteem. We will also look at how people's experiences relate to their attitudes.

Who is doing the Research?
This project is being conducted by a team of researchers, including Prof Penelope Hasking, A/Prof Stephen Lewis, Dr Mark Boyes, and PhD candidate Alexandra (Lexy) Staniland. This study will be used as part of the requirements to obtain a Doctor of Philosophy in Psychology at Curtin University, Western Australia, and is funded by the Australian Government.

Why am I being asked to take part and what will I have to do?
You are being invited to complete an online survey about attitudes toward self-injury. If you choose to participate, you will be asked a series of questions relating to mental health, self-injury, and your attitudes relating to self-injury. We are interested to hear from people who do and do not have a lived experience of mental illness and/or self-injury.

Are there any benefits' to being in the research project?
Apart from your time, there will be no direct cost to you to participate in this study. If you are completing this survey as a worker on Amazon's Mechanical Turk platform, then you will be paid in accordance with the information on the page that linked you here. You must complete the entire survey before payment will be made. If you only complete part of the survey, you will not be paid for the part you have completed.

While there may be no direct benefits to participating in this research, some people find it helpful to share their thoughts about mental health issues. Furthermore, you will be contributing to a vital area of research interested in improving the wellbeing of people with a history of self-injury.

Are there any risks, side-effects, discomforts or inconveniences from being in the research project?
We have been careful to make sure the questions in this survey cause minimal distress, however you may still experience some discomfort while completing the survey. This discomfort should not be long-lasting and we encourage you to reach out to the supports provided if you feel this would be of use. You may take a break from the survey and return to it at any time within 14 days of starting, and you can choose to stop completing the survey at any time simply by closing your browser. The data you have provided up until that point may be used in our analyses.

Sometimes just thinking about mental health and self-injury can be upsetting. If you choose not to be in this research but feel distressed from considering participation, please visit: https://checkpointorg.com/global/ for contact details of mental health supports in your area.

Who will have access to my information?
If you are completing this survey as a worker on Amazon's Mechanical Turk platform, you will need to provide your 12-digit MTurk ID at the end of the survey so that we can process payment. This ID will be stored alongside your data so that we can ensure that you have completed to entire survey prior to payment. Your data will be confidential and only accessible by the research team. After the survey has closed, and payment has been processed, your ID will be removed from the data set and your data will become anonymous.

Any information we collect may be used in this and other similar projects. The following people will have access to the information we collect in this research: the research team and, in the event of an audit or investigation, staff from the Curtin University Office of Research and Development.

Electronic data will be stored on Curtin's secure research hard drive and will be password protected. This information will be kept for up to 9 years and will be stored on Curtin's secure Research Drive.

The results of this research may be presented at conferences or published in professional journals. You will not be identified in any results that are published or presented.

Will you tell me the results of the research?
If you are interest in obtaining a summary of the results of this research, please contact the researchers after October 2020.

Do I have to take part in the research project?
Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project at any time simply by closing your browser. We may use any data you have entered prior to this point.

What happens next and who can I contact about the research?
If you have questions or concerns relating to this project, or if you have any issues accessing the survey or research material, please contact Alexandra Staniland at alexandra.staniland@postgrad.curtin.edu.au.

Curtin University Human Research Ethics Committee (HREC) has approved this study (*HRE2020-0267*). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Study Two

HREC Project Number:	HRE2020-0267
Project Title:	*Validating a Self-Injury Stigma Questionnaire*
Chief Investigator:	*Prof Penelope Hasking*
Associate Investigator(s):	*Dr Mark Boyes & A/Prof Stephen Lewis (U of Guelph)*
Student researcher:	*Alexandra (Lexy) Staniland*
Version Number:	*1*
Version Date:	*17/03/2020*

What is the Project About?

Attitudes play an important role in how we think and feel about mental illness and other related issues. Attitudes also play an important role in how we think and feel about ourselves and others. In this project, we are interested in understanding people's experiences with mental illness and self-injury as well as how attitudes toward mental illness and self-injury may relate to psychological health.

In this study, we will ask you to complete an online survey about your attitudes toward and experience of mental illness and self-injury. The data we collect will be used to develop an accurate measure of attitudes toward self-injury and help us understand how these attitudes relate to a range of psychological outcomes, such as self-esteem. We will also look at how people's experiences relate to their attitudes.

Who is doing the Research?

This project is being conducted by a team of researchers, including Prof Penelope Hasking, A/Prof Stephen Lewis, Dr Mark Boyes, and PhD candidate Alexandra (Lexy) Staniland. This study will be used as part of the requirements to obtain a Doctor of Philosophy in Psychology at Curtin University and is funded by the Government.

There will be no cost to you to participate in this study. If you are an undergraduate student recruited through the SONA pool, you will receive 3 SONA points for participating. If you are recruited through another source (e.g., Facebook), you will not be reimbursed for your time. Your participation is vital to our understanding of the relationships between attitudes, mental health, and self-injury.

Why am I being asked to take part and what will I have to do?

You are being invited to complete an online survey that should take no longer than 45 minutes to complete. If you choose to participate, you will be asked a series of questions relating to your attitudes toward and experience of mental illness and self-injury. We are interested to hear from people who do and do not have a lived experience of mental illness and/or self-injury.

Are there any benefits' to being in the research project?
While there may be no direct benefits to participating in this research, some people find it helpful to share their thoughts about mental health issues. Furthermore, you will be contributing to a vital area of research interested in improving the wellbeing of people with mental illness and/or a history of self-injury.

Are there any risks, side-effects, discomforts or inconveniences from being in the research project?
We have been careful to make sure the questions in this survey cause minimal distress, however you may still experience some discomfort while completing the survey. This discomfort should not be long-lasting and we encourage you to reach out to the supports provided if you feel this would be of use. You may take a break from the survey and return to it at any time within 14 days of starting, and you can choose to stop completing the survey at any time simply by closing your browser. The data you have provided up until that point may be used in our analyses.

Sometimes just thinking about mental health and self-injury can be upsetting. If you choose not to be in this research but feel distressed from considering participation, please contact Lifeline 13 11 14, Beyond Blue 1300 224 636, or Kids Helpline (<25 years old) 1800 551 800. If you are a Curtin student or staff member, you also have access to on-campus counselling, which you can contact on 9266 7850.

If you are completing this outside of Australia, please head to: https://checkpointorg.com/global/ for contact details of mental health supports in your area.

Who will have access to my information?
If you are completing this survey in return for SONA points, we will ask you to record your student ID number so that your points can be awarded. At the end of the survey you will be directed to a new webpage to enter these details, and they not be linked to the data you provide in answering the survey. The information will remain confidential, and will be deleted after your points have been allocated in the SONA system. If you are not completing this survey in return for SONA points, no identifying information will be collected, and your data will be anonymous. We will not be able to identify you from the information collected.

Any information we collect will be treated as confidential and will be used in this and other similar projects. The following people will have access to the information we collect in this research: the research team and, in the event of an audit or investigation, staff from the Curtin University Office of Research and Development.

Electronic data will be stored on Curtin's secure research hard drive and will be password protected. This information will be kept for up to 9 years and will be stored on Curtin's secure Research Drive.

The results of this research may be presented at conferences or published in professional journals. You will not be identified in any results that are published or presented.

Will you tell me the results of the research?
If you are interest in obtaining a summary of the results of this research, please contact the researchers after October 2020.

Do I have to take part in the research project?

Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project at any time simply by closing your browser. We may use any data you have entered prior to this point. If you choose not to take part or start and then stop the study, it will not affect your relationship with the University, staff or colleagues.

What happens next and who can I contact about the research?

If you have questions or concerns relating to this project, or if you have any issues accessing the survey or research material, please contact Alexandra Staniland at alexandra.staniland@postgrad.curtin.edu.au.

Curtin University Human Research Ethics Committee (HREC) has approved this study (*HRE2020-0267*). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Appendix N

Chapter 5 Consent

Study One

I have read the information above and agree to participate in this anonymous survey about my experience of self-injury.

- Yes, I would like to complete the survey
- No, I am not interested

Study Two

We just want to double check you understand what we are asking you to do.

What is this study about?

- Attitudes toward mental illness and self-injury
- Attitudes toward politics
- Self-injury and social media

What will you be asked to do if you participate?

- Participate in an interview
- Complete an online questionnaire
- Post messages online

True of false?
All response provided are confidential.

- True
- False

I have read the information sheet and understand what participating in this study involves.

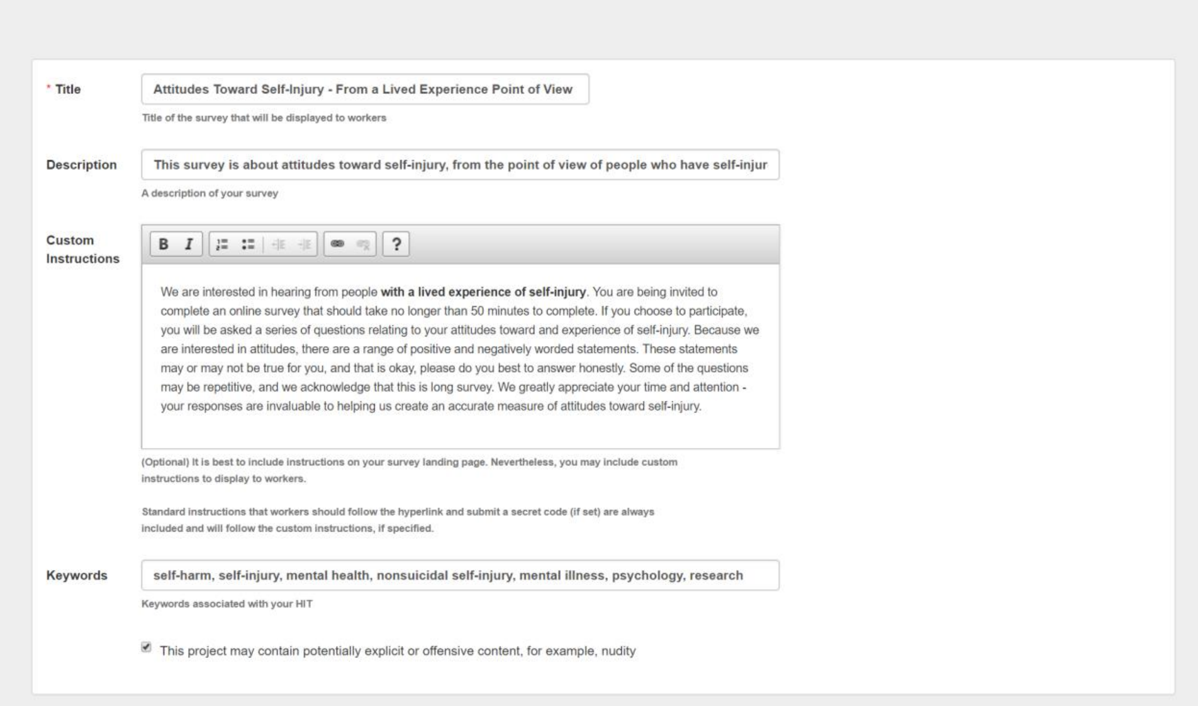
- I consent to completing the questionnaire
- I do not want to complete the questionnaire

Appendix O

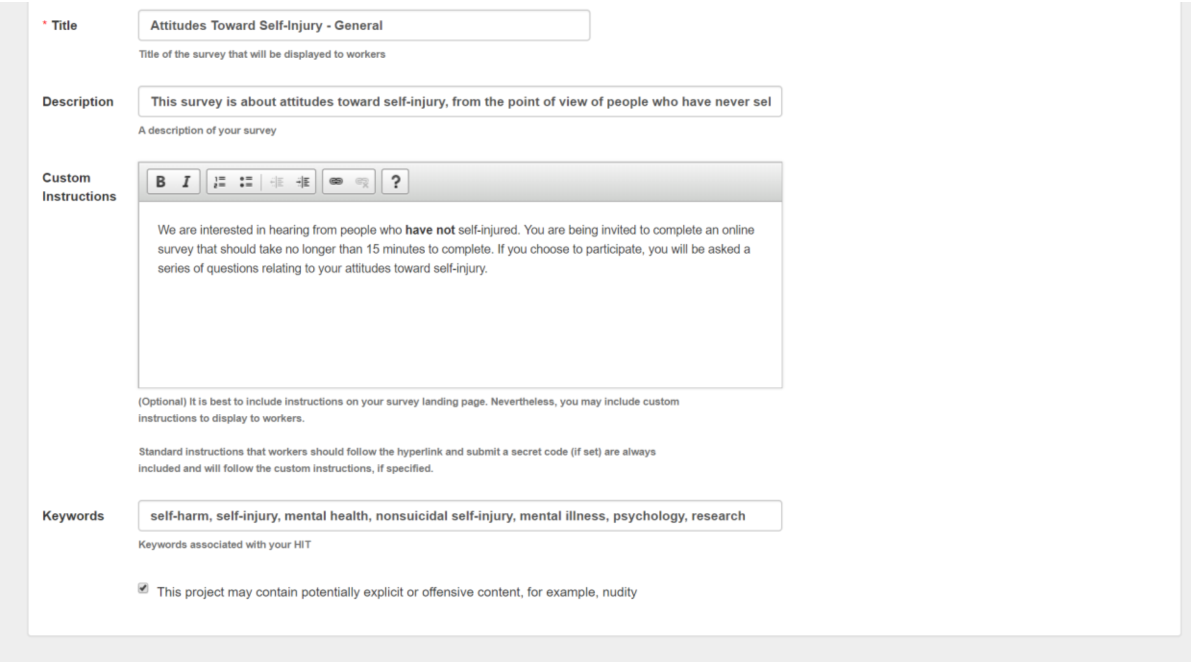
Chapter 5 Study Advertisements

Study One

Description for Individuals with Lived Experience



Description for Individuals with No Lived Experience



Study Two

SONA

Study name: Attitudes, mental health, and non-suicidal self-injury
Description: If you choose to participate in the study, you will be asked to complete an online survey asking about your about mental health, self-injury and some of your attitudes about these things. We are interested to hear from people who do and do not have a lived experience of self-injury. If you have engaged in self-injury, you will be asked about that experience. The questionnaire should take no longer than 40 minutes to complete.
Eligibility: All students are eligible
Duration: 40 minutes
Points: 3 points
Preparation: No preparation required.
Researchers: Prof Penelope Hasking, Dr Mark Boyes, A/Prof Stephen Lewis (U of Guelph), PhD Candidate Alexandra Staniland
HREC Approval Number: HRE2020-0267
Curtin University Human Research Ethics Committee (HREC) has approved this study (HRE-XXXX). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Reddit

Reddit is an online forum where people can create "threads" that are themed (also called "SubReddits"). People can post to these threads with text and photos. The content found on Reddit varies widely and covers both entertainment and education. There is an existing SubReddit called "StopSelfHarm" which has 7,677 followers. This thread is aimed at peer support. Other researchers are taking advantage of this platform to share their online questionnaires (see Figure 5). Reddit allows post such as these. We plan to post the following information to the "StopSelfHarm" thread and the "PsychologicalResearch/Surveys" thread: Nonsuicidal self-injury (NSSI) refers to the deliberate damage caused to oneself without suicidal intent. People have a range of thoughts and beliefs about NSSI that we are interested to learn more about. The School of Psychology at Curtin University is conducting a study to better understand people's attitudes toward self-injury. If you would like to share your views, we invite you to take part in a series of online questionnaires. You will be asked about how you experience emotion, your attitudes toward self-injury and mental illness, and whether you have any experience with self-injury. We are interested to hear from people who do and do not have a lived experience of NSSI.

Twitter

Twitter is an online information sharing platform that allows people to share messages with others. These messages are capped at 280 characters, and only seen by people who follow the profile. A number of NSSI support groups exist on Twitter. We aim to contact these groups to ask permission for posting our advert for participant recruitment. Our research team has an existing Twitter account called NSSI_RG. Twitter's terms of service allow sharing of promotional material. See https://help.twitter.com/en/rules-and-policies/twitter-rules for more information. We plan to post a link to our Survey with a short description, which will be seen by our followers: *We are conducting a study to explore attitudes toward nonsuicidal self-injury and mental illness. If you are interested in taking part, please go to [survey link].*

Facebook

Facebook is a platform allowing individuals to create an account where they can post information including status updates, photos, videos and links. Posts can be shared by other individuals or groups, where a replication of the original post appears on another individual's page. Adaptable privacy settings mean that information posted may be available to the public, or to a selection of individuals as chosen by the owner of the account. Groups can be created which allow information to be accessible only from individuals eligible for inclusion. There are a number of self-injury support groups and education pages available. We aim to advertise for participants on such pages following permission from the pages administration. We have a dedicated Facebook page for self-injury research and will use that page for this study. All utilised forms of social media will be linked directly to our Facebook page, which will hold the link to the online survey itself. Advertisements are permissible by Facebook, given they adhere to the guidelines stated in their policies. See https://www.facebook.com/policies/ads/?ref=u2u for more information. The following will be posted as an advertisement for recruitment:
Nonsuicidal self-injury (NSSI) refers to the deliberate damage caused to oneself without suicidal intent. People have a range of thoughts and beliefs about NSSI that we are interested to learn more about these. The School of Psychology at Curtin University is conducting a study to better understand people's attitudes toward self-injury. If you would like to share your views, we invite you to take part in a series of online questionnaires. You will be asked about how you experience emotion, your attitudes toward self-injury and mental illness, and whether you have any experience with self-injury. We are interested to hear from people who do and do not have a lived experience of NSSI.

Instagram

Instagram is an image-based social media platform. People using this platform share photographs or other images, including text and quotes, to their feed, and other users can interact with these posts by liking them or commenting on them. Posts can be shared by other individuals or groups, where a replication of the original post appears on another individual's page. People find post by using hashtags (e.g., #mentalhealth) which are used like keywords to help users find content they might be interested in. Advertisements are permissible by Instagram, provided they adhere to the guidelines stated in their policies. See https://help.instagram.com/537518769659039?helpref=page_content for more information. An NSSI research page has been established, with the view to post intermittent content including links to the survey alongside motivational and positively valanced content. Instagram has made some recent changes to their policies disallowing images related to self-harm. Although we do not intend to ever post any images of self-harm, this policy change limits our ability to use hashtags related to the topic. Therefore, we will not use the terms "self-injury" or "self-harm" in our posts at all and refer only to "mental health-related difficulties". A similar procedure has been followed by other PhD students within the School, and we plan to follow a similar posting plan (see https://www.instagram.com/overcomingperfectionism/). The following will be posted as an advertisement for recruitment:
We are interested to hear about your thoughts and feelings about mental health, emotions and other mental-health related issues. If you'd like to share your views, please head to the link in our bio to find out more. #mentalhealth #depression #anxiety #psychology #research

Appendix P

Chapter 5 Questionnaire

Study One

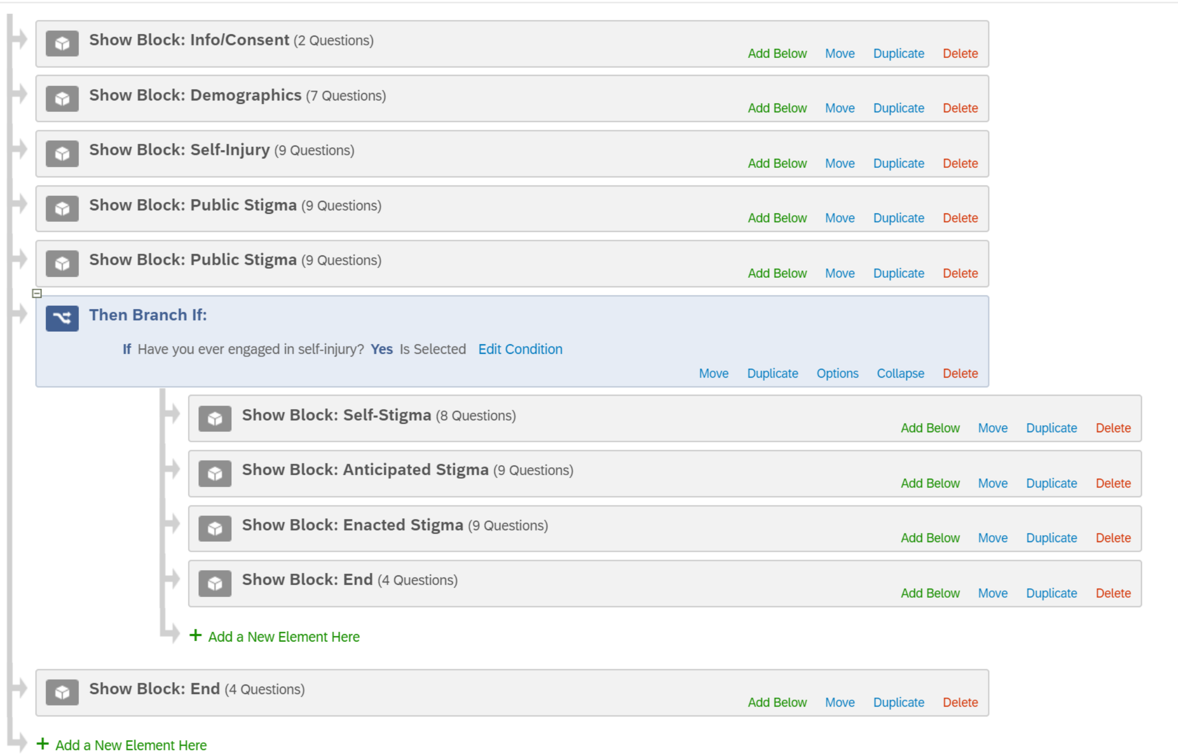
Due to the length of the questionnaire, I had chosen to exclude a copy of it from the thesis; however, it can be viewed here:
https://osf.io/mdcu2/?view_only=6c82200a85b240cbae7706a5dbbccf1

Study Two

Due to the length of the questionnaire, I had chosen to exclude a copy of it from the thesis; however, it can be viewed here:
https://osf.io/kx7tv/?view_only=6c82200a85b240cbae7706a5dbbccf1

Appendix Q
Chapter 5 Study Flow

Study One



Study Two