Adding Insult to Injury: The Accumulation of Stigmatizing Language on Individuals With Lived Experience of Self-Injury

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Abstract

Language is a powerful form of communication that not only conveys ideas and knowledge, but can assign meaning and value to the world around us. As such, language has the power to shape our attitudes towards individuals, behaviours, and ideas, by labelling them (indirectly or not) as "good" or "bad." In this way language can be used to propagate stigma and other unhelpful attitudes towards individuals who already experience stigma. One behaviour that may be particularly prone to the impact of unhelpful language is non-suicidal self-injury (NSSI). In this paper we draw on Staniland's NSSI stigma framework to demonstrate how an individual with lived experience of NSSI may be exposed to stigmatizing messaging through 30 different channels, and propose the accumulation of these messages may be particularly damaging. We conclude by offering practical tips for clinicians and researchers wishing to empathically work with individuals who self-injure.

Keywords: self-injury; NSSI; stigma; language

Non-suicidal self-injury (NSSI) is a growing concern among the general community, and has become more visible over the last few decades. Defined as self-inflicted damage to one's body tissue that is not socially or culturally sanctioned (ISSS, 2021), NSSI has increasingly been portrayed in songs (Brown et al., 2018), movies (Trewavas et al, 2010; Radovic & Hasking, 2013), social media (Lewis et al. 2011; Lewis & Seko, 2016, 2018; Pritchard et al., 2020), and mass media such as news outlets (Bareiss, 2014; Staniland et al., in press). NSSI is relatively common, with one in five adolescents, and one in ten adults reporting a history of self-injury (Swannell et al., 2014). In addition, although NSSI is explicitly non-suicidal in intent, the behaviour is associated with psychological difficulties (Bentley et al., 2015) and subsequent suicidal thoughts and behaviours (Kiekens et al., 2018; Whitlock et al., 2013). Given this, understanding the behaviour, and the experiences of individuals who self-injure, is imperative.

The increased research focus, as well as the portrayal across media outlets, has likely led to a greater awareness and understanding of NSSI (Ngune et al., 2021). Yet, despite this growth in awareness and recognition of NSSI, the stigma surrounding the behaviour and people who engage in it remains (Ngune et al., 2021). Recently, Staniland et al. (2021) provided a theoretical framework of NSSI stigma that allows us to understand how NSSI stigma develops and manifests. One way in which such stigma can foment is through the language used to talk about NSSI. The words we choose to use are important, as they provide meaning and value to concepts, ideas, people, and things. Wisely chosen words can promote hope and foster understanding, while other words can be hurtful and perpetuate stigma (Hasking & Boyes, 2018). As a behaviour that is highly stigmatized, the language we use to talk about NSSI and people who engage in the behaviour is important (Hasking et al., 2021; Hasking et al., 2019). Accordingly, the aim of this paper is to use Staniland et al.'s framework to better understand how

language may shape stigma across different channels through which NSSSI stigma may manifest. We first argue the importance of language in communicating about NSSI, then apply Staniland et al.'s stigma framework to understand how language may confer stigma. We conclude by offering practical implications for clinicians, and suggestions for future research to empirically test this framework.

The importance of language

The importance of language is recognised in a broader movement within the mental health field toward person-centred approaches, whereby individuals are not defined by a medical condition or behaviour; rather, they are considered holistically — as a person first, behaviour second (Gondek et al., 2016). Although some communities have embraced and reclaimed identity-first language (e.g., autistic individuals; Vivanti, 2020), the more common recommendation is to adopt person-centred language. In prioritizing personhood, an individual is recognised as an expert in their own experience. Healthcare providers, and others, work collaboratively with the person in consideration of their treatment goals and plans (Gask & Coventy, 2012). Commensurate with this person-centred approach, an extensive literature exists calling for person-first language when describing individuals living with mental health conditions (e.g., person with schizophrenia, rather than "schizophrenic") or engaging in behaviours associated with mental health difficulties (e.g., person who uses drugs, rather than "junkie"; Broyles et al., 2014). Despite this far-reaching movement, only recently have there been calls to adopt such an approach for NSSI (Lewis & Hasking, 2021).

In line with this person-centred approach, a growing body of work is recognising the importance of language in the context of discussing NSSI. Written and spoken language are

among the most powerful forms of communication, allowing us to develop shared meanings and understandings of the world around us. Words are incredibly powerful, and activate not just the semantics, but a complex network of associated meanings and ideas, as any speechwriter would attest. Unfortunately, much of the language used to discuss NSSI and individuals who engage in NSSI stems from a medicalized, deficit-based approach. Researchers have previously written about the need to avoid medical terminology, with a specific focus on words like 'relapse' or 'contagion' (Hasking & Boyes, 2018). This medical, reductionist, approach to discussing NSSI portrays NSSI as a disease that needs to be 'cured', rather than a behaviour with varied and complex motivations/functions. While NSSI recovery means different things to different people, individuals with lived experience of NSSI explain that it is much more nuanced than the behaviour itself and encompasses more than what might be viewed through a medical lens (Lewis & Hasking, 2019; 2021).

Further, language can add value to a concept, denoting it as 'good' or 'bad'. Value-laden terms such as 'maladaptive' or 'weak' used to describe NSSI convey the impression that the behaviour, or the person, is broken in some way (Hasking et al., 2019). There is a risk then, that an individual with lived experience of NSSI may internalize these messages, fostering self-stigma, shame, and reduce support seeking. Lastly, labelling language, in which an individual is identified by a condition or behaviour, also reduces the individual to this one aspect of themselves (Link & Phelan, 2013). Labels such as 'cutter' or 'self-injurer' can invoke stereotypes and serve to ignore other aspects of an individual, including the many strengths an individual with lived experience of NSSI possesses, and creates an impression that all individuals with lived experience are the same (Lewis, 2017).

Unfortunately, despite a recognition that person-centred language is important, many researchers and clinicians fail to routinely use terms they recognize to be important to individuals who self-injure (Hasking et al., 2021). Importantly, we do not suggest that people use this language maliciously, but rather rarely stop to consider the impact it may have on an individual hearing it. Further, what may be perceived as a single off-hand remark needs to be considered in the context of all the other single off-hand remarks that person may hear, see, or overhear. As with the accumulation of negative life events – when it is the accumulation of negative experiences rather than the experience itself that is related to distress (Appleyard et al., 2005) – the accumulation of hurtful or stigmatizing language likely has a compound effect on the recipient of these comments. While the importance of language is increasingly being recognised, to date there has not been a theoretical framework allowing us to characterize the accumulation of words and phrases that may most significantly impact an individual with lived NSSI experience.

Using the stigma framework to understand language

Staniland et al. (2021) argued that NSSI stigma is potentially stronger than stigma toward other behaviours for a number of reasons. First, NSSI is associated with mental illness (accurately or not) so attracts the stigma that comes with mental illness. Second, the behaviour often leaves visible marks in the form of scarring. NSSI scars tend to be easily recognizable (Ho et al., 2018) and activate stigma associated with physical disfigurement and NSSI stereotypes (Shokrollahi, 2015). Third, the behaviour is deliberately enacted by the individual, leading to perceived personal responsibility (Lloyd et al., 2018). Behaviours that appear under the individual's control tend to attract more stigma than behaviours not under an individual's control (e.g., drug use; Corrigan et al., 2009). This conflation of mental illness, physical scarring, and

124 volitional behaviour means that NSSI attracts more stigma than other injuries (Burke et al.,
125 2019).

126 Drawing from other stigma models, Staniland and colleagues (2021) proposed that NSSI
127 stigma manifests in four forms: public stigma (what the public thinks about NSSI), self-stigma
128 (what an individual with lived experience thinks about NSSI), anticipated stigma (what an
129 individual expects others to think and do about NSSI), and enacted stigma (acts of
130 discrimination, prejudice, or inappropriate behaviours). We propose that there is a fifth channel
131 through which NSSI stigma may manifest: vicarious stigma, in which an individual sees or
132 overhears something about NSSI that is not directed at them, but which still conveys a
133 stigmatizing message. While driven by public stigma, vicarious stigma specifically concerns the
134 impact of this on people with lived experience. This can arguably lead to internalized stigma,
135 when individuals are exposed to stigmatizing language and behaviours enacted towards
136 'individuals like me'.

137 The mechanisms underlying NSSI stigma are proposed within six domains, or sources, of
138 stigma. Informed by Jones et al. (1984), these domains are as follows. Origin: behaviours under
139 volitional control are more highly stigmatized; Concealability: the more visible the behaviour,
140 the more stigmatized; Course: behaviours seen to be resistant to recovery or worsen over time
141 are more highly stigmatized; Peril: behaviours associated with increased risk of harm to self
142 and/or others are stigmatized; Aesthetics: marks seen to be physically unattractive are highly
143 stigmatized; Disruptiveness: behaviours that negatively impact relationships and others in the
144 social environment are highly stigmatized. For an individual who self-injures these domains may
145 manifest as someone believing that they have a mental illness (origin), have visible scarring
146 caused by skin-cutting (concealability), that will get worse or lead to suicide (course), that is

147 ‘contagious’ and will spread to other people (peril), that is ugly to look at (aesthetics) and that
148 the individual is wasting other people’s (e.g. healthcare professionals) time (disruptiveness).

149 By combining the five forms and six domains of stigma, we see there are potentially 30
150 different channels through which an individual with lived experience may experience hurtful,
151 inappropriate, or stigmatizing messages (Staniland et al., 2021; see Table 1). For example, on
152 any given day an individual may see a TV episode in which NSSI is depicted as attention
153 seeking, be told to cover their scars when in public, or overhear someone describe people who
154 self-injure as crazy. While each comment or event might be considered a single off-hand remark,
155 taken together, the potential power this language has on an individual with lived experience of
156 NSSI cannot be understated. As noted previously, an accumulation of such messages may be
157 internalized, resulting in feelings of guilt, shame, and reduced support seeking.

158 Accumulation of stigma messages from different domains and experienced in different
159 forms has parallels with intersectionality – where individuals may belong to multiple
160 marginalized or stigmatized groups (e.g., African-American women; an individual with a mental
161 illness who is also homeless; Oxele et al.,2018). In addition to attracting stigma due to self-injury
162 itself, physical scarring, and assumed mental illness, individuals who self-injure can receive
163 stigmatizing messages across an array of contexts dependent on the domain and form of stigma.
164 In other areas of intersectional stigma (e.g., HIV and mental illness), different types of stigma
165 have been noted to exacerbate each other (Walkup et al., 2004), and are related to poorer health
166 outcomes (Turan et al., 2019). Extending to NSSI stigma, similar multiplicative effects of
167 experiencing stigma from a variety of channels may be related to poorer NSSI recovery
168 outcomes. Given this, we call on all clinicians and researchers— indeed all people — to be

considerate of the language they are using when discussing NSSI or people who engage in the behaviour.

Practical implications

Our call stems from the potential for people with lived experience to be exposed to stigma through 30 different channels within any given time period. We may all contribute to NSSI stigma inadvertently, simply by failing to recognize that we have informed one of those channels. Therefore, we call on all people, and particularly those with privileged and prioritized voices (such as clinicians and researchers) to be mindful of the language used when talking about NSSI and individuals who engage in the behaviour, noting that your voice is not the only one an individual may hear. Clinicians, who may be working therapeutically with clients who have lived experience of self-injury, and researchers, who may be collecting data from people with lived experience, are two key orators whose language can have significant impact.

A clinician's words are critical to the psychological wellbeing of their clients. Clients turn to clinicians for support and guidance, and see them as experts on psychological matters. The messages conveyed by clinicians, whether intentional or otherwise, are held in high regard by clients. Because of the high degree of trust and vulnerability within a therapist-client relationship, the weight of such messages may be more substantial than if it was conveyed by someone or something else. Therefore, a seemingly innocuous comment has the potential to cause further harm by contributing to other damaging messages to which the client has been exposed, reinforcing stigma and disrupting the therapeutic alliance. Unfortunately, while clinicians recognize a need for person-centred language, this may not always be adapted into practice (Crocker et al., 2019; Hasking et al., 2021). Clinicians who use person-centred language

are likely to find it is easier to develop rapport, and if adopting a calm, dispassionate demeanor, and a respectful curiosity (Walsh, 2012), will find that they are conveying empathy toward clients. Such an approach could easily be incorporated into clinical training, alongside the general need for person-centred language in the broader mental health field. Further, clinicians can model appropriate behaviour to more junior clinicians or students and foster a workplace that is respectful, non-judgmental, and inclusive. Of course, the language preferred by clients is also a consideration, and efforts should be made to match what a client views as appropriate, and not invalidate their experiences.

In clinical practice, experiences of stigma may be recorded as part of a functional assessment of self-injury. Functional assessment is one recommended way of addressing self-injury, identifying the antecedents, motives, and consequences of self-injury for that individuals (Andover et al., 2017). Within this approach, clients could record instances of exposure to stigma (vicarious or enacted), the impact that it had, and how it impacted their relationships, with both themselves and others, and with their self-injury. This could allow the client and clinician to see patterns in these experiences, and potentially identify situations in which stigma is more likely, or the reaction to it is more severe. This could open the door to honest communication about how hurtful stigma can be, or alert clients to individuals who may not be non-judgmental recipients of self-injury disclosure (e.g. overhearing someone expressing stigmatizing thoughts of self-injury).

Anecdotally, we are aware that some individuals view stigma regarding behaviours such as self-injury to be helpful – that by stigmatizing a behaviour, society expresses its discouragement, and that individuals who wish to be accepted by society will be less likely to engage in it. In this way, stigma could be viewed as a form of prevention. As authors, we have had this response from anonymous reviewers, who have rebutted our claim that we should work to reduce self-

injury stigma. We are also aware of this view being expressed in educational workshops, both provided by us and others. We argue that this viewpoint underscores a misunderstanding about self-injury, and likely fosters greater shame, isolation, and rejection often experienced by individuals who self-injure (Jiang et al., 2021; Sheehy et al., 2019). In this way, we argue that stigma can magnify the risk of self-injury, and further distances individuals from the understanding and support they may need.

Suggestions for future research

As the foundation of knowledge and understanding, research plays a fundamental role in the development and dissemination of information about psychological matters. As such, researchers have the power to shape discourse about mental health, mental illness, and associated behaviours. The language that researchers use has a flow-on effect at all stages of the research process and must be carefully considered. For research participants with lived experience, information sheets, questionnaires, and debrief sheets all have the potential to convey hurtful and harmful messages, contributing to the potentially stigmatizing messages received through other channels. Researchers should turn to advisory networks and people with lived experience to ensure that their language is appropriate and non-stigmatizing. Research participants are more likely to provide high quality responses when they perceive the research as sensitive and appropriate, which, in turn, better meets our goal toward a better understanding of NSSI.

While we have a theoretical understanding of how language may manifest stigma through various channels, empirical testing of the model is required. Of note, it would be interesting to determine which channel(s) is most salient to individuals with lived experience. Interviews with individuals with lived experience would be critical to understanding how these messages are

received and the impact they have. Alternatively, we could ask individuals who self-injure to keep a diary and record instances when they are exposed to a message that fits the framework (or any others they find stigmatizing that do not fit the framework). This would give us an indication of how often stigma is perceived by individuals with lived experience. This may even challenge our beliefs that NSSI is highly stigmatized, and reveal a greater rate, for example, of anticipated stigma than enacted stigma.

Additionally, understanding which messages are most likely to be afforded attention would be important to elucidate. One way to do this experimentally would be using a dual messaging paradigm, in which different messages are played in either the left or right ear, at the same time. After taking into account other factors such as emotional valence, lateralization effects, and carefully controlling prosody effects, this may allow the researcher to assess which message is most often attended to, or remembered. Similarly, researchers could compare how participants, with and without a history of self-injury, remember and respond to social vignettes of accepting, neutral, or stigmatizing situations. Here the vignettes could be manipulated to reflect different domains or forms of stigma[1]. While these are only potential examples, they do indicate how NSSI-related stigma could be systematically investigated under controlled laboratory conditions.

Conclusion

Language is a powerful way to communicate that conveys more than just the meaning of the words. Language can also assign value to concepts, people, and things, and be used to empower people or diminish people. In the context of NSSI, the conflation of the five forms stigma may take and the six domains through which it may be caused, can combine to produce an array of

[1] We thank an anonymous reviewer for this suggestion

channels through which someone with lived experience may experience NSSI stigma. The accumulation of all of these messages, even if each on its own seems benign, is likely to foster shame, internalized stigma, and reduce disclosure or support seeking. For these reasons we call on all researchers, clinicians, and human beings to simply be mindful of the impact that their words can have on another individual.

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