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

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. (2020) 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 (M^{age} = 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.

Keywords*: Stigma; nonsuicidal self-injury; testing theory; directed content analysis; conceptual framework*

Nonsuicidal self-injury (NSSI) is the intentional, self-directed damage done to one's own body without suicidal intent (ISSS, 2021), 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, 2021). 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., 2020).

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 et al., 2009; Schomerus et al., 2011), sexual deviance (Jahnke & Hoyer, 2013), and self-injury (Staniland et al., 2020).

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., 2020) 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 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).

While the NSSI Stigma Framework (Staniland et al., 2020) 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 (HRE2018-0615) 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 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 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 assessed using Gwet's first-order agreement coefficient (AC_1; Gwet, 2008) calculated with the *irrCAC package* for R (version 1.0; Gwet, 2019) over three rounds. Each round demonstrated high agreement[1]. 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 and 4).

[1] 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 AC_1 was subsequently used.

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.

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., 2020).

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.

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*."

[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.

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 we 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)[3]. "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., 2020) does not intend to account for stigma outcomes. Therefore, this data did not serve to extend the framework. 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

[3] See supplemental materials for classifications of reported emotions

The aim of this study was to investigate the applicability of the NSSI Stigma Framework (Staniland et al., 2020) 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, 2015;

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. (2020) 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. (2020) 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., 2020), 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. (2020) 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 (Hatzenbuehler et al., 2013) 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.

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Table 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 realize 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

Table 2

An Example of the Analytic Process

	Response	Data Units	Code
Example 1	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
Example 2	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
Example 3	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
Example 4	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 & Enacted Stigma - Course
		[and not attention seeking]	Enacted Stigma - Origin

Table 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 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 to go to those people 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]