**School of Population Health**

# Understanding Voluntary NSSI Disclosure

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**Declaration**

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

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 (2007) – updated 2018 and 2023. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Numbers # HRE2018-0615; HRE2019-0050; HRE202 0-0078; HRE2021-0241; HRE2021-0429.

Signature:

Date: 24/05/2024

**Acknowledgement of Country**

I acknowledge that Curtin University works across hundreds of traditional lands and custodial groups in Australia, and with First Nations people around the globe. I wish to pay my deepest respects to their ancestors and members of their communities, past, present, and to their emerging leaders.

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Between completing my Honours and applying for my PhD I was experiencing burnout and thought it was time to take a break and do some of that "relaxing" people kept talking about. A few weeks turned into a few months, procrastination, doubt, and a pandemic kicking in (NOT what I meant when I thought it would be cool to live through a historical event by the way universe!). I was really unsure about whether I should proceed with my PhD application, was I even smart enough? Eventually I bit the bullet and emailed Professors Penny Hasking and Mark Boyes, who had supervised my Honours dissertation. I asked if they were still interested in supervising my PhD after my hiatus and luckily for me, they were. Fast forward, I apply, get accepted, and begin my PhD, and it was not long before Professor Stephen P. Lewis joins the supervising team. With my supervisors' knowledge, expertise, support, and belief in me I have achieved things in the past few years I would not have previously imagined. Thank you for helping to keep me grounded and reminding me that contrary to my belief, I a) am not expected to know everything innately, and b) I am not falling behind!

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**List of Papers**

**Journal Articles** (* included in thesis)

1. Staniland, L., Hasking, P., Lewis, S. P., & Boyes, M., & **Mirichlis, S**. (2023). Crazy, Weak, and Incompetent: A Directed Content Analysis of Self-Injury Stigma Experiences, *Deviant Behavior, 44*(2), 278-295, https://doi.org/10.1080/01639625.2022.2038022

2. **\* Mirichlis, S.,** Hasking, P., Lewis, S. P., & Boyes, M. E. (2022). Correlates of disclosure of non-suicidal self-injury amongst Australian university students. *Journal of Public Mental Health, 21(*1*),* 70-81. https://doi.org/10.1108/JPMH-07-2021-0089

3. **\*Mirichlis, S.,** Boyes, M., Hasking, P., & Lewis, S. P. (2023). Why Are Individuals Who Have Not Disclosed Self-Injury Comfortable Discussing Their Experiences in Research? *The Journal of Nervous and Mental Disease, 211*(7), 473-478. https://doi.org/10.1097/NMD.0000000000001648

4. Hasking, P., Lewis, S. P., Staniland, L., **Mirichlis,** S., Hird, K., Gray, N., Arai, M., Pemberton, E., Preece, D., Boyes, M. (2023). Further silencing the voiceless: The role of gatekeepers in accessing information about self-injury. *The Journal of Nervous and Mental Disease, 211*(1), 5-10. https://doi.org/10.1097/NMD.0000000000001575

5. Robinson, K., Dayer, K. F**., Mirichlis, S.,** Hasking, P. A., & Wilson, M. S. (2023). Who are we missing? Self-selection bias in nonsuicidal self-injury research. *Suicide & Life-Threatening Behavior*, *53*(5), 843–852. https://doi.org/10.1111/sltb.12987

6. \***Mirichlis, S.,** Boyes, M., Hasking, P., & Lewis, S. P. (2023). What is important to the decision to disclose nonsuicidal self-injury in formal and social contexts? *Journal of Clinical Psychology, 79,* 1816–1825. https://doi.org/10.1002/jclp.23503

7. ***Mirichlis, S.,** Hasking, P., Boyes, M., Lewis, S. P., & Hon, K. (Under Review). Does the Decision to Disclose Non-Suicidal Self-Injury Align with Decision-Making Frameworks of Personal Information Disclosure? A Directed Content Analysis.

8. ***Mirichlis, S.,** Lewis, S. P., Boyes, M., & Hasking, P. (Under Review). Exploring Voluntary Disclosure of NSSI: A Thematic Analysis.

9. **Mirichlis, S.,** Burke, T. A., Bettis, A. H., Dayer, K., & Fox, K. R. (Under Review). Barriers to Youth Disclosing Self-Injurious Thoughts and Behaviors: A Focus on the Therapeutic Context.

**Conference Presentations** (* presenting thesis findings)

1. **\*Mirichlis, S.,** Hasking, P., Boyes, M., Lewis, S., & Hon, K. (2023). *Does Self-injury Disclosure Decision-Making Align with Existing Frameworks of Personal Information Disclosure?*. Western Australian Psychological Science Conference. Conference Presentation. Perth, Australia. https://sites.google.com/view/wapsc/home

2. **Mirichlis, S.,** Fox, K., & Dayer, K. (2023). *Barriers to Youth Disclosing SITBs to their Therapists*. International Society for the Study of Self-injury Annual Conference. Annual Conference. Conference Presentation. Vienna, Austria. https://www.itriples.org/conferences https://www.itriples.org/conferences

3. **\*Mirichlis, S.,** Lewis, S. P., Boyes, M., & Hasking, P. (2023*). Deciding to Disclose NSSI: What's in a Decision?* International Society for the Study of Self-Injury Annual Conference. Annual Conference. Conference Presentation. Vienna, Austria. https://www.itriples.org/conferences https://www.itriples.org/conferences

4. **Mirichlis, S.,** Fox, K., & Dayer, K. (2023). *Barriers to Youth Disclosing Self-Injurious Thoughts and Behaviours to Mental Health Professionals*. Suicide Research Symposium.

Annual Conference. Conference Presentation.

https://www.suicideresearchsymposium.com/srs23-recordings

5.  **\*Mirichlis, S.,** Hasking, P., Boyes, M., & Lewis, S. P. (2022). *Discussing NSSI in Research.* International Society for the Study of Self-Injury Annual Conference. Annual Conference. Conference Presentation. https://www.itriples.org/conferences

6.  **\*Mirichlis, S.,** Boyes, M., Hasking, P., & Lewis, S. P. (2022). *What is Important to the Decision to Disclose NSSI?* International Society for the Study of Self-Injury Annual Conference. Annual Conference. Conference Presentation. https://www.itriples.org/conferences

7.  **\*Mirichlis, S.,** Hasking, P., Boyes, M., & Lewis, S. P. (2021). *Correlates of Non-suicidal Self-Injury Disclosure*. Australian Association for Cognitive and Behaviour Therapy Annual Conference.Annual Conference. Conference Presentation. https://www.aacbt.org.au/national-conference-2021/

8.  **\*Mirichlis, S.,** Hasking, P., Boyes, M., & Lewis, S. P. (2021). *First Half of PhD Presentation.* Mark Liveris Seminar. Annual Conference. Conference Presentation. Perth, Australia.

9.  **\*Mirichlis, S.,** Hasking, P., Boyes, M., & Lewis, S. P. (2021). *Correlates of NSSI Disclosure*. International Society for the Study of Self-Injury Annual Conference. Annual Conference. Conference Presentation. https://www.itriples.org/conferences

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## Abstract

Non-suicidal self-injury (NSSI) is the deliberate damage caused to a person's own body without suicidal intent. Although NSSI can serve various functions, most commonly it is used to regulate emotion, despite this it is associated with a number of adverse outcomes. Mental health difficulties such as anxiety and depression are positively correlated with NSSI, as are later experiences of suicidal thoughts and behaviours. Amongst tertiary students, NSSI is also associated with poorer academic outcomes. Given the above correlates, there is interest in the provision of appropriate support for people with lived experience of NSSI. Voluntarily disclosing one's NSSI can be a key catalyst to gaining this support, whether it be informally amongst social relationships, or in seeking professional help. Despite this potential for accessing support, many individuals do not disclose their NSSI, with little research exploring the decision-making involved in NSSI disclosure. The aim of this program of research was to develop a better understanding of the voluntary disclosure of NSSI. The chapters of this thesis are summarised below.

**Chapter one:** Here the introduction to the thesis is presented, including a summary of the literature that contributed to this project. The aims of the thesis are outlined here. **Chapter two:** The extended literature review is provided in this chapter. **Chapter three:** Here my researcher positioning and the epistemological approach taken is discussed.

**Chapter four:** Nondisclosure of NSSI is reported in the literature despite participation in such research involving individuals to share their lived experience. The aim of this study was to identify why individuals who had not previously disclosed their NSSI felt comfortable to do so in a research context. Open-text responses from 70 participants ($M$age = 23.04 years, $SD$ = 5.90;

75.70% women) were analysed using inductive content analysis. Three key categories were identified: 1) The Nature of the Research, including the fact that participation was confidential; 2) The Perceived Value of Research; and 3) The Individual NSSI Context. These categories comprised a range of reasons why individuals could feel comfortable to disclose their NSSI in research. From this study we have gleamed notable considerations for facilitating NSSI research appropriately.

**Chapter five:** Given the negative outcomes associated with NSSI and the potential of disclosure to benefit those with lived experience, in this study I aimed to ascertain the correlates of NSSI disclosure. A sample of 573 university students completed online surveys featuring measures of socio-demographic, NSSI-related, socio-cognitive, and socio-emotional factors. It was found that having a mental illness diagnosis, intrapersonal functions of NSSI, more impactful NSSI, lower expectations that NSSI would result in communication, and greater social support from friends and significant others were associated with having disclosed NSSI. The identification of these correlates provide preliminary insights into which factors may be relevant to the decision to disclose NSSI.

**Chapter six:** There is variation in whom individuals disclose their NSSI to, with disclosures to informal sources (e.g., friends) being more common than those to formal sources (e.g., healthcare workers). The aim of this study was to assess the importance of a range of factors presented in the literature to the decision to disclose NSSI to: friends, family, significant others, and health professionals. A mixed-model ANOVA was used to compare the importance ratings reported by 371 participants. Between-factor differences were identified, with those related to interpersonal relationships generally being rated of most importance. As hypothesised, there were group differences between the different disclosure recipient groups, particularly when

comparing the personal relationship and health professional groups. These findings provide further evidence of the factors that contribute to a disclosure decision and highlight the differential considerations involved when disclosing to different people.

**Chapter seven:** Whilst the focus of the preceding studies largely reflected whether to disclose NSSI, in this study the aim was to explore the decision-making processes further from lived experience perspectives. Transcripts from 15 interviews with people who had previously disclosed their NSSI were analysed using Reflexive Thematic Analysis, with six themes reported. The themes consisted of: The Value of Trust in Disclosure; Context Matters- The Where, Me, and Who of NSSI Disclosure; Why Disclose?; Overcoming Barriers; Selective Sharing; and Perceptions of Disclosure. These inductive findings provide an understanding of NSSI disclosure decision-making informed by lived-experiences.

**Chapter eight:** Although conceptual frameworks of personal information disclosure informed parts of this thesis, there was no such framework specific to the voluntary disclosure of NSSI. The objective of this study was to assess the degree of fit between accounts of NSSI disclosure and these broader frameworks. The interview transcripts from the preceding study were coded deductively against the Disclosure Decision-Making and Disclosure Processes models using Directed Content analysis. All elements of the existing models were captured in the participants' accounts, though there were features of NSSI disclosure not regarded in these models. These findings informed the development of a novel disclosure framework specific to the voluntary disclosure of NSSI.

**Chapter nine:** Here the general discussion of the entire thesis is presented. In conclusion, this thesis offers insights into the dynamics of deciding to disclose NSSI voluntarily.

**Author's Note**

This thesis is presented in hybrid format, including papers that have been accepted for publication or are under review. As the thesis chapters are standalone manuscripts, there is some inevitable repetition throughout the thesis, particularly when describing the background and rationale for each paper. Where possible in the general introduction and discussion, effort has been made to reduce repetition. Each chapter is presented with a short introduction linking the individual chapters to create a cohesive body of work. There are minor differences in the formatting of each of the published chapters, according to the respective journals. Additionally, reference lists have been omitted from the individual papers and are presented together at the end of the thesis for cohesion.

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**Chapter 1: Thesis Introduction**

**Non-Suicidal Self-Injury (NSSI)**

Non-suicidal self-injury (NSSI; self-injury) is the deliberate damage someone causes to their own body without the intent of ending their life (International Society for the Study of Self-Injury [ISSS], 2022). NSSI excludes behaviours that are socially sanctioned (e.g., piercings, tattoos), though can manifest in a variety of forms, with cutting, burning, and self-battery being amongst the most commonly reported (Swannell et al., 2014). The reasons why people self-injure have been widely theorised, with Nock's (2008, 2009) models being central. Nock (2008) describes a model by which NSSI is reinforced by either intrapersonal (i.e., focused on self) or interpersonal means (i.e., focused on relatedness to others).  More recent evidence highlights that individuals may engage in self-injury for a range of reasons, including intrapersonal functions and interpersonal functions. Intrapersonal functions of NSSI (e.g., escaping unwanted or seeking wanted states) tend to be more common, with emotion regulation being the most commonly reported reason (Taylor et al., 2018). Conversely, communicating distress is amongst the most commonly reported interpersonal function (Taylor et al., 2018).

NSSI is a relatively common behaviour, with 17.2% of adolescents, 13.4% of young adults, and 5.5% of adults estimated to have self-injured in their lifetime (Swannell et al., 2014). More recently, in their meta-analysis, Deng et al. (2023) report that approximately 32.4% of adolescents and 15.7% of adults had self-injured, though it is not clear whether this reflected an onset of or continuing NSSI. More generally, first instances of NSSI most commonly occur in adolescence (14-15 years) and in early adulthood (20-24 years; Gandhi et al., 2018). The age of many first-year university students coincides with this secondary peak onset period, with approximately 10% of students engaging in self-injury for the first time during their first year of
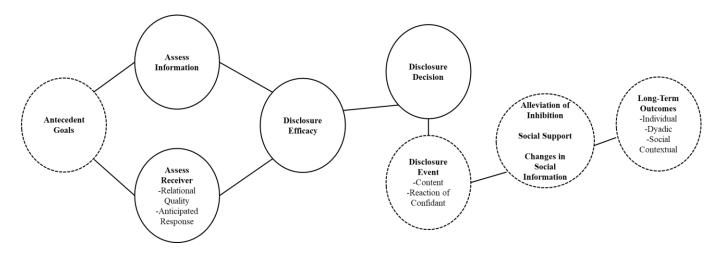
study (Kiekens et al., 2019). In addition to NSSI being associated with mental health difficulties and later suicidal thoughts and behaviours, university students who self-injure are also more likely to experience additional negative outcomes such as poorer academic performance as compared to their peers (Cipriano et al., 2017; Kiekens et al., 2016; Kiekens et al., 2018). Given the negative outcomes associated with NSSI and emphasis on strengths-based approaches in the field, there have been recent efforts in conceptualising a person-centred approach to NSSI recovery (Lewis & Hasking, 2020). The Person-Centred Model of Self-Injury Recovery (Lewis & Hasking, 2020) offers a non-linear, holistic framework for supporting individuals who have lived experience of NSSI, with a core component of this process involving disclosures of this experience (Hasking et al., 2023; Lewis & Hasking, 2020).

**Disclosure of Stigmatised Experiences**

Whilst literature on the disclosure of NSSI is relatively recent (Simone and Hamza, 2020), discourse about the disclosure of stigmatised experiences and identities broadly spans decades, if not centuries. Economou et al. (2020) credit the origins of the term "stigma" to the Greek, "stizo" (στίζω), a verb meaning to carve a symbol of shame and dishonour onto those considered deviant such as criminals and slaves. In Goffman's (1963) seminal text, he not only discusses mental illness stigma itself, but also the disclosure of such taboos. Jones et al. (1984) identified dimensions of stigma in terms of "marks", with Staniland et al. (2020) considering both literal markers (e.g., by way of scarring) as well as symbolic marking (e.g., social othering) of NSSI in their conceptualisation of stigma specific to NSSI. Underlying these conceptions of stigma, is the dilemma of whether to conceal one's markers of being a member of a stigmatised group, let alone the consideration of whether to actively disclose such information.

This process of disclosing sensitive information has been conceptualised in frameworks such as the Disclosure Decision-Making Model (Greene, 2009) and the Disclosure Processes Model (Chaudoir & Fisher, 2010). While these frameworks are discussed in further detail later in the thesis (see Chapters 2 and 8) they are summarised in Figure 1 below. Essentially, the models postulate that individuals may engage in a series of cost-benefit analyses in considering whether to disclose stigmatised experiences. Specifically, Greene (2009) suggests that in deciding to disclose a health condition (e.g., HIV), individuals may evaluate information about the condition itself (such as its prognosis, symptomology, stigma), the recipient of the disclosure (i.e., their relationship and anticipated reaction), and the individual's confidence in their ability to disclose such information. Chaudoir and Fisher's (2010) framework complements this by the inclusion of disclosure goals and outcomes in defining the process of disclosure. Both the Disclosure Decision-Making and Disclosure Processes models have been drawn upon in the investigation of stigmatised identities and experiences of disclosures, including that of mental illness disclosures (e.g., Cooper et al., 2020; Rasmussen et al., 2022). Put simply, these frameworks offer a means to conceptualise voluntary disclosure of sensitive information.

**Figure 1**

*Adapted Depiction of the Disclosure Decision-Making and Disclosure Processes Models*



*Note.* Adapted from Greene (2009) shown in solid circles and Chaudoir and Fisher (2010) shown in dashed circles.

## NSSI Disclosure

Someone may learn of an individual's NSSI in various ways; broadly this may result from involuntary discovery (e.g., noticing scarring, witnessing them self-injure, unsolicited disclosure from a third party) or voluntary disclosures (Simone & Hamza, 2020). Voluntary disclosure of NSSI involves the individual with lived experience intentionally sharing this experience with another person, regardless of whether they are seeking help (Simone & Hamza, 2020). The way someone learns of an individual's NSSI holds differential impacts for those with lived experience. As such, involuntary discovery, voluntary disclosure, and help-seeking, should be understood as related, though distinct phenomena (Pugh et al., 2023; Simone & Hamza, 2020).

Estimates of voluntary NSSI disclosure (henceforth referred to as NSSI disclosure) vary greatly across the literature (i.e., between 17-89%), though in the general population it is estimated that 50-60% of people with lived experience of NSSI have disclosed this to at least one

person (Simone & Hamza, 2020). The variation in reported disclosure rates may reflect a combination of population differences (e.g., rates were higher for those engaged in help-seeking as compared to those who were not) and the way in which disclosure was operationalised in such research (e.g., voluntary disclosure as opposed to people knowing of one's NSSI at all). There is also breadth in who is disclosed to (i.e., recipients of disclosure), with informal sources (e.g., friends and family) generally being preferred over formal sources (i.e., professional interactions; Simone & Hamza, 2020). Amongst informal disclosure recipients, friends and significant others are commonly disclosed to, with family members also receiving disclosures although to a lesser extent particularly when individuals move into adulthood (Simone & Hamza, 2020). Mental health professionals are more likely to be disclosed to than medical care providers, though disclosures across these settings are theorised to be less common overall due to the presence of additional barriers such as difficulties accessing such providers (Long, 2018).

The proportion of non-disclosure of NSSI is also of interest given the potential benefits of disclosing such experiences. Specifically, disclosure of NSSI can facilitate the access to and provision of social supports, as well as professional help-seeking (Simone & Hamza, 2020). What is considered a "beneficial" response tends to vary. Some individuals may prefer tangible aid such as assistance with managing urges to self-injure (Simone et al., 2022), whereas others report emotional support as being helpful. Regardless, a calm and nonjudgemental approach to the disclosure is recommended (Simone & Hamza, 2020; Lewis & Hasking, 2021). Individuals who have disclosed their NSSI also report an enhanced sense of self-awareness (Simone et al., 2022), and in online settings, a reduced sense of social isolation (Lewis & Seko, 2016).

Despite the potential benefits of disclosing NSSI there are widely reported challenges associated with disclosure with stigma amongst the most salient (Simone & Hamza, 2020). This

barrier manifests both as internalised (e.g., shame) and anticipated stigma (e.g., fear of rejection and/or judgement; Rosenrot & Lewis, 2020). Indeed, there is the potential for such stigma to become enacted upon disclosure, via discrimination such as in the form of judgment (Park et al., 2020). In addition to the potential for disclosure to negatively affect the individual with lived experience, the impacts on others such as emotional burden, may also inform apprehension to disclose NSSI (Rosenrot & Lewis, 2020). Given that up to approximately half of people with NSSI lived experience do not disclose this, it appears as though such barriers are not always compensated by the potential benefits of disclosure.

Although the barriers and benefits of NSSI disclosure reported in the literature reflect the cost-benefit approach to disclosure outlined in the aforementioned frameworks (Chaudoir & Fisher. 2010; Greene, 2009), the processes and considerations underlying the decision to disclose NSSI are not well understood. Improving such understanding could be instrumental in not only contributing to a consensus of how to conceptualise voluntary disclosure of NSSI, but to also empower individuals with lived experience to disclose autonomously if they wish to, and to better inform responses to NSSI. In this thesis I report a series of five studies contributing to the advanced understanding of the voluntary disclosure of NSSI, before drawing on this evidence to propose a novel framework specific to NSSI disclosure decision-making to help address the above goals.

**Thesis Outline**

The aim of this project was to better understand the decision to voluntarily disclose NSSI. This thesis consists of nine chapters which are summarised as follows. Chapter one has provided a brief introduction setting up the aims of the thesis. Chapter two contains my extended literature review, presenting and critiquing the existing literature relevant to this program of research.

Chapter three outlines my positionality in engaging in this research, which has intentionally been included at the forefront of the thesis in the interest of transparency and to contextualise the nature of the subsequent chapters and their findings. Chapters four through to eight feature the studies of this program of research, beginning with, "*Why are Individuals who have not Disclosed Self-Injury Comfortable Discussing their Experiences in Research?*" in the fourth chapter. The aim of this study was to identify the reasons why individuals who had not previously disclosed their NSSI felt comfortable to do so in a research setting. This study is included here as it addresses an issue foundational to this program of research, being the inclusion of participants who have not previously disclosed NSSI participating in NSSI disclosure research. This chapter is published in a peer-reviewed journal.

Chapter Five features the study, "*Correlates of Disclosure of Non-Suicidal Self-Injury Amongst Australian University Students*" which is published in a peer-reviewed journal. The aim of this study was to identify what factors are associated with NSSI disclosure. This study is included in this thesis to inform what factors may be relevant to the decision to disclose NSSI.

Chapter Six presents the third study of my PhD, "*What is Important to the Decision to Disclose Non-suicidal Self-Injury in Formal and Social Contexts*". The aim of this study was to examine the relative importance of various considerations to the decision to disclose NSSI. This chapter is published in a peer-reviewed journal and was included in this thesis to gain insight into how such factors may be prioritised when considering disclosing NSSI within different relationships.

Chapter Seven details the fourth study, "*Exploring Voluntary Disclosure of NSSI: A Thematic Analysis*". The aim of this study was to explore lived experience perspectives of NSSI disclosure decision-making. This study is included in this thesis as it provides a bottom-up lived

experience informed approach to NSSI disclosure, broadening the factors of consideration. A Revise and Resubmit has recently been submitted to a peer-reviewed journal for this chapter.

The final study of this program of research is presented in Chapter Eight. This study is titled: "*Does NSSI Disclosure Decision-Making Align with Decision-Making Frameworks of Personal Information Disclosure? A Directed Content Analysis*". The aim of this study was to assess the degree to which lived experience perspectives of NSSI disclosure decision-making align with broader frameworks of disclosure. A Revise and Resubmit for this chapter has recently been submitted to a peer-reviewed journal. This study is included in this thesis as a means of integrating the theoretical and lived experience perspectives of disclosure.

In Chapter Nine, I conclude this thesis with a general discussion. In this discussion I synthesise the key findings of my research and detail their implications. The limitations and future research directions based on the remainder of the thesis are then outlined before the presentation of my final concluding remarks.

**Chapter 2: Literature Review**

In this chapter I review the extant literature relevant to this program of research. In the first part of this review, I present the definition of NSSI, as well as the characteristics and associated outcomes of the behaviour which necessitate its study. I then discuss the disclosure of stigmatised experiences, starting with the conceptualisation of stigma before exploring conceptual frameworks of the disclosure of personal information. In turn, literature pertaining to voluntarily disclosing NSSI is outlined. I define voluntary disclosure and then discuss rates, summarise known correlates, and outcomes of disclosure. The key messages of the literature review are then presented in its conclusion.

**NSSI**

NSSI is the deliberate damage a person causes to their own bodily tissue, specifically without suicidal intent (ISSS, 2022). NSSI differs from the broader, "self-harm" which encapsulates self-directed harm to the body regardless of suicidal intent and can include indirect harms to the body (e.g., via disordered eating; Klonsky, 2007). NSSI is also typically distinguishable from alterations to body tissue that are culturally or socially sanctioned, such as tattoos and piercings, as NSSI occurs beyond one's societal norms (Klonsky, 2007).

Individuals may engage in NSSI across the lifespan from childhood, well into adulthood (Cipriano et al., 2017; Martin et al., 2010). Generally, there are two peak onset periods of the behaviour, the first in adolescence and the second in early adulthood (20-24 years; Cipriano et al., 2017; Gandhi et al., 2018). In addition to the latter period coinciding with the age of many university students, approximately 10% of young people will self-injure for the first time in their initial year of university (Kiekens et al., 2019). Furthermore, university students are more likely than their peers to have lived experience of NSSI with estimates ranging from 20.2% to 45% of

university students reporting having self-injured in their lifetime (Swannell et al., 2014; Wester et al., 2018). More generally, 7.5% - 46.5% of adolescents, 13.4% of young adults, and 5.5% of adults have a lifetime history of NSSI (Swannell et al., 2014). In more recent reports, approximately 32.4% and 15.7% of adolescents and adults respectively self-injured in 2020 (Deng et al., 2023). Importantly, the way NSSI is measured can impact the degree to which the experience is reported. Specifically, checklist assessments as opposed to a single-item assessor of NSSI, are more likely to yield greater endorsement of NSSI lived-experience (Robinson & Wilson, 2020).

NSSI is diverse in the forms it can take, with most individuals engaging in multiple methods, though some methods are more common than others (Cipriano et al., 2017). Among the methods of NSSI that are reported most frequently are cutting, burning, and punching/hitting (Swannell et al., 2014). Sex differences have also been reported in the literature, including cutting as compared to self-battery being more commonly reported by females, with the inverse recorded amongst males (Ammerman et al., 2019). Individuals tend to self-injure on the abdomen, arms, and legs, though the behaviour can extend to other locations such as the face (Gardner et al., 2020). Approximately half of those with lived experience of NSSI have resulting scarring (Burke et al., 2016; 2020). Such scarring can be a source of both shame and pride for individuals with lived experience, with the ways in which people relate to their NSSI and scarring only recently being considered (Burke et al., 2020; Lewis & Mehrabkhani, 2016).

The reasons someone might self-injure are often misunderstood, and expectancies regarding outcomes of NSSI differ between those with and without lived experience (Akinola & Rayner, 2022; Dawkins et al., 2021). Indeed, a substantive amount of the theoretical and empirical NSSI literature has been dedicated to better understanding the functions of the

behaviour (e.g., Nock, 2009). Broadly, these functions can be organised into intrapersonal, that is those which impact the self, and interpersonal functions (i.e., those in which connections with others are the focus; Nock, 2009). Intrapersonal functions tend to be most common and include pursuit of an increase of positive states and/or decrease of negative ones, punishment of the self, and avoiding suicide (Taylor et al., 2018). Indeed, much of these functions reflect efforts to regulate one's emotions (Taylor et al., 2018). Other, more interpersonal examples include communicating distress and exerting influence over other individuals (Taylor et al., 2018). These more socially-related functions of NSSI reflect Nock's (2008) hypothesis that NSSI can serve to communicate a need to others (e.g., for support). Such functions are akin to some outcomes of disclosing one's NSSI (Simone & Hamza, 2020).

Although NSSI can provide functional benefits as outlined above, associations between the behaviour and negative experiences that have been identified across systematic reviews and meta-analyses, warrant consideration (Cipriano et al., 2017; Bentley et al., 2015; Wang et al., 2022). People who have self-injured are more likely to experience mental health difficulties including mood, personality, and eating disorders (Bentley et al., 2015). Whilst NSSI is associated with these difficulties and "NSSI Disorder" was put forward as a condition for consideration for the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), it is plausible that individuals find NSSI helpful in managing distress, rather than being a diagnosable condition itself. In addition to formal diagnoses of mental illness and other mental health difficulties, NSSI is associated with experiences of distressing and traumatic life events such as bullying and other forms of abuse (Cipriano et al., 2017; Wang et al., 2022). Although distinct from suicidal self-harm, NSSI is a predictor of later suicidal thoughts and behaviours; this is despite NSSI sometimes serving as a more proximal

protective factor against suicide (Griep & McKinnon, 2020; Kraus et al., 2020). Along with the aforementioned correlates, NSSI amongst university students is associated with interpersonal difficulties with friends and parents, as well as poorer academic grades (Hamza & Willoughby, 2014; Kiekens et al., 2016). Stigma towards NSSI and people who engage in the behaviour contributes to the difficulties encountered by those with lived experience. Psychological impacts of NSSI stigma include increased feelings of shame, isolation, and alienation, and depressed self-esteem and confidence in oneself (Meheli et al., 2021). The internalisation and fear of such stigma can hinder disclosure and help-seeking efforts, as well as disrupt engagement with treatment for those with lived experience of NSSI (Meheli et al., 2021; Simone & Hamza, 2020).

Given the difficulties that can be experienced by those who have self-injured, provision of appropriate supports is imperative. In their person-centred framework of NSSI recovery, Lewis and Hasking (2021) challenge cessation-based models of NSSI recovery to emphasise lived experience perspectives. In this contemporary framework, strengths-focused aspects of recovery such as promoting self-compassion are encouraged, and it is acknowledged that disclosures can form part of a person's lived experience of NSSI and recovery (Hasking et al., 2023). Herein lies a dilemma in which supports can be offered in overcoming the challenges associated with NSSI, including its stigmatisation and yet such stigma can pose a significant barrier to one's confidence in seeking support (Simone & Hamza, 2020).

**Voluntary Disclosure of Stigmatised Experiences**

Disclosure of personal information is described and experienced in myriad ways. For the purposes of this thesis, voluntary disclosure entails sharing of one's own information willingly and deliberately without necessarily seeking help. Although this has only recently been explored in NSSI research, contemplation about disclosure of stigmatised experiences by far precedes this

century (Simone & Hamza, 2020). To understand the disclosure of stigmatised identities, stigma must first be defined.

Although there is some dissensus regarding an exact definition of stigma, the term is thought to originate from the Greek word meaning to carve a symbol of shame onto social deviants such as criminals (Economou et al., 2020). This reference to marking stigmatised individuals as "other" and experiences of shame are reflected in Goffman's (1963) seminal text in which he considers the impacts and disclosure of stigmatised identities. In terms of what may underly stigma, Jones et al. (1984) proposed that this may be informed by beliefs about the origin, concealability, chronological change, relative danger, aesthetics, and interpersonal disruptiveness of an identity. Into the 21st century, the stigma of mental illness became of focus and Link and Phelan (2001) critiqued the utility of standing definitions of stigma and later proposed that people, groups, and things become stigmatised through a process of labelling, stereotyping, separation, and discrimination (Link et al., 2004). Applying this process to the context of mental illness stigma, an individual is marked as having a mental illness (e.g., via diagnosis), this mark becomes stereotyped as it is socially associated with undesirable traits (e.g., being considered untrustworthy, dangerous), separation occurs as others distinguish themselves from this undesirable other overtly (e.g., housing in asylums) or covertly (e.g., not aligning oneself with people who are considered mentally unwell). These experiences can culminate in discrimination against those who are stigmatised (Link et al., 2004).

Although there has been a plethora of work in targeting mental illness stigma (as outlined in Schomerus et al., 2022), NSSI stigma is less well understood (Staniland et al., 2020). In an effort to rectify this literature gap Staniland et al. (2020) drew on foundational conceptualisations of stigma to propose a framework for NSSI stigma. In this framework, Jones et al.'s (1984)

constructs are considered in turn against four levels of stigma: Public (i.e., attitudes/perceptions of the public), Self (i.e., internalisation of broader stigmatising attitudes to oneself), Anticipated (i.e., expecting to be stigmatised), and Enacted (i.e., instances when stigma manifests, such as by discrimination). Some initial reviewing of the framework in light of people's experiences of NSSI stigma highlighted concerns regarding disclosing one's NSSI. Of particular concern to participants was the anticipation of negative responses from others about their NSSI in the event of a disclosure (Staniland et al., 2022). The different aspects of stigma explored by theorists provide some insights into why individuals with stigmatised experiences, such as NSSI, may be dissuaded from disclosing this.

### *Frameworks of Disclosure*

In Omarzu's (2000) paper they provide a brief history of the interest in self-disclosure in psychology, describing disclosure as a means of accessing information and as a form of social exchange by way of the sharing and listening dynamic it necessitates. An early example of this interest in self-disclosure is Jourard and Lasakow's (1958) self-disclosure questionnaire in which respondents report the extent to which they have disclosed a range of topics to others. The self-disclosure questionnaire spans attitudes towards social issues, personal preferences (e.g., about foods), work experiences, finances, aesthetics, and wellness, with Jourard and Lasakow (1958) arguing that assessment of such self-disclosure would be invaluable to theoretical knowledge. Indeed, various theoretical proposals about self-disclosure followed, including Derlega and Grzelak's (1979) Functional Theory of Disclosure in which the reasons for disclosure were considered. In the interest of expanding on understandings of what precipitates disclosures across contexts, Omarzu (2000) proposed their Disclosure Decisions model. Despite the ongoing discourse about stigmatised experiences and self-disclosure, only in 2008 was the decision to

disclose a stigmatised experience explicitly presented in a conceptual model. Ragins (2008) proposed three central considerations for disclosing concealable stigmatised identities in workplace contexts: intrapersonal psychological factors (e.g., seeking affirmation of one's identity), expected outcomes of the disclosure (e.g., sense of relief, job loss), and environmental supports (e.g., presence of others who have disclosed in this setting). Moving beyond the employment context, Greene (2009) presented a framework of disclosure decision-making pertaining to the self-disclosure of stigmatised health diagnoses (e.g., HIV).

  **The Disclosure-Decision Making Model.** The Disclosure Decision-Making Model (Greene, 2009) expands on previous works such as Ragins (2008) in that the nature of the information being disclosed (including its stigmatisation), one's own efficacy to self-disclose, and characteristics of the potential receiver of the disclosure are all considered. Greene (2009) emphasises the active role of the person disclosing their information in describing the evaluative process they engage in when considering the aforementioned factors when deciding whether to self-disclose. More specifically, when considering the nature of the information to be disclosed, Greene (2009) outlines that generally a person may be more likely to conceal rather than disclose the information if it is stigmatised. This hesitancy to disclose stigmatised information may however be challenged by other considerations such as to whom the disclosure is made to, as explored later in the framework. These competing considerations are some examples of the cost-benefit type analysis at the core of contemporary disclosure frameworks.

  The second aspect of the information being disclosed proposed by Greene (2009) is the extent to which an individual was prepared to receive such information (e.g., as a medical diagnosis). For example, an individual may have conducted their own informal research about the diagnosis, and so may be more inclined to disclose their diagnosis with the knowledge they

have accrued. At the same time, now having gained this knowledge they be more hesitant to disclose (e.g., learning of its stigma). Conversely, a lack of preparedness may also spur a disclosure in seeking relief (Greene, 2009).

Thirdly, Greene (2009) outlines the prognosis of the diagnosis, or more broadly the impact or course of the experience to be disclosed. Here the nature of the condition is considered, such that the degree of certainty about its treatability and expected progression may inform the likelihood of a disclosure. Greene (2009) proposes that the greater uncertainty here may deter disclosures, though this may too be impacted by other considerations such as how the disclosure recipient is expected to respond.

Greene (2009) goes on to present the symptoms of the condition as another aspect of the information that may inform disclosure decisions. The symptomology is considered both in terms of the progression of disease and its visibility. As such, the symptomology may impact the timing of a disclosure due to an increased difficulty in concealing the condition as the individual may become reliant on others as their health declines and/or as physical signs become more obvious (e.g., skin blemishes).

The final aspect of information that Greene (2009) proposes is the relevance of the information to others. Here, the individual considering disclosure is posited to face a moral and ethical dilemma, with the potential impact of the condition on others being critical. A recent example of this would be disclosing to a friend who is immunocompromised that one has tested positive for COVID-19 before inviting them into the house. Given that COVID is a communicable disease, your friend may become infected with the virus if they were to visit, hence this information is of relevance to them.

Aside from assessing the information itself, Greene (2009) proposes that individuals evaluate whom would be an ideal disclosure recipient. One aspect considered here is the quality of the relationship between the individual disclosing and the recipient. Generally, individuals are more likely to disclose to people with whom they have a close relationship though there are exceptions to this. That is to say that a close relationship alone is not necessarily sufficient to disclose personal information, and conversely individuals may disclose to those whom they do not have a quality relationship. Quality of relationship aside, how a recipient is anticipated to react to a disclosure is also of importance in Greene's (2009) model. For example, if an individual expects a positive reaction from a particular disclosure recipient, they may be more inclined to disclose to them, especially if they have a close relationship with this person. Greene (2009) proposes that these considerations relative to whom to disclose to may be useful in overcoming barriers to disclosure such as perceived stigmatisation of the information.

The final major component of Greene's (2009) model is that of disclosure efficacy. Before deciding whether to disclose personal information, an individual may appraise their confidence and skills to actually communicate this information to their chosen recipient. Other considerations outlined in the model such as stigma and anticipated responses may inform this appraisal. For example, an individual who concludes that their information is not highly stigmatised and believes their chosen disclosure recipient would respond well may have greater self-efficacy to disclose this information, as compared to an individual who is considering disclosing a strongly stigmatised experience to a recipient with whom they do not have a close relationship. Greene's model concludes with the decision of whether to disclose personal information and does not consider the potential outcomes of such a disclosure, the Disclosure

Processes Model (Chaudoir & Fisher, 2010) extends on this by integrating pre-disclosure factors with disclosure outcomes.

**Disclosure Processes Model.** Chaudoir and Fisher (2010) also presented a framework with the assumption that a cost-benefit analysis underpins the disclosure of stigmatised information. The Disclosure Processes Model (Chaudoir & Fisher, 2010) addresses what was a key gap in the self-disclosure literature at the time in that both the antecedents and outcomes of a disclosure were explored in conjunction, rather than discretely. This conceptualisation of disclosure allowed not only a more comprehensive illustration of the process of disclosure as a whole, but also facilitated consideration of when a disclosure may be beneficial as opposed to harmful (Chaudoir & Fisher, 2010).

The first major component of Chaudoir and Fisher's model (2010) is that of antecedent goals. Here, the functional nature of disclosure is emphasised such that a disclosure of stigmatised identity is underpinned by one of two forms of goals. Approach-focused goals are those in which individuals are seeking positive outcomes. For example, disclosing to gain social support. In contrast, avoidance-focused goals reflect efforts to minimise or prevent a negative outcome such as interpersonal conflict.

Chaudoir and Fisher (2010) go on to outline aspects of the disclosure event itself including the depth (i.e., degree of information that is shared intimately), breadth (i.e., range of topics discussed), duration, and emotional content of a disclosure. Further, the reaction of the disclosure recipient is discussed at this stage both in terms of how anticipated responses may inform disclosure decisions as well as what may inform particular reactions, rather than exclusively being proposed in the decision-making stage as was the case in Greene (2009).

Extending beyond the decision-making and eventual disclosure, the Disclosure Processes Model incorporates the potential outcomes of such disclosures. These outcomes are organised into individual (i.e., psychological, behavioural, health), dyadic (i.e., liking, intimacy, trust), and social contextual (cultural stigma, disclosure norms). Chaudoir and Fisher (2010) propose that these longer-term outcomes may in fact be elicited via three intermediate processes being: the alleviation of inhibition, social support, and changes in social information. The alleviation of inhibition describes the propensity for disclosing a stigmatised identity to allow the individual to live as their authentic selves, releasing them from the burden of concealing their experiences (Chaudoir & Fisher, 2010). In turn this intermediary process may facilitate longer term benefits for the individual's psychological wellbeing. Secondly, disclosure is described as a catalyst for receiving social support which in turn can also boast benefits to the individual's wellbeing as well as potentially reinforcing their relationship with the disclosure recipient. Finally, disclosures present the recipient with new information, the knowledge of which is of course shared between them and the individual who disclosed it. This process too may facilitate individual and dyadic benefits, as well as presenting the opportunity to advocate for the issue at hand.

**Evidence for Disclosure Models.** Both the Disclosure Decision-Making and the Disclosure Processes models have been explored in the context of the disclosure of mental health difficulties and suicidal self-harm (e.g., Love et al., 2021; Love & Morgan, 2021; Pahwa et al., 2017; Toth et al., 2021). Pahwa et al. (2017) investigated whether factors from Greene's (2010) Disclosure Decision-Making Model were associated with wanting to disclose mental illnesses. The factors were organised into individual and interpersonal levels as indicated in the model. Individual level factors associated with a preference to disclose mental illness included a lack of internalised stigma *(OR = .88)* and expecting social support *(OR = 1.31)*. Conversely,

relationship type was amongst the interpersonal factors associated with disclosure preferences. Toth et al. (2021) also investigated mental illness disclosure, though their study was informed by Chaudoir and Fisher's (2010) Disclosure Processes Model. Specifically focusing on disclosures to work supervisors, Toth et al. (2021) found support for the major components of the model (e.g., there being antecedent goals), whilst also identifying further disclosure considerations. One such departure from the original model was the shift from "mediating processes" to "short term" outcomes, addressing a critique of the framework raised earlier in this literature review.

Aiming to better understand disclosure of suicidal thoughts and behaviour to romantic partners, Love et al. (2021) also drew on the Disclosure Decision-Making model. Love et al. (2021) compared what aspects of the model those who had disclosed focused on, as opposed to those who had previously disclosed their experience to their partner. Although individuals who had disclosed previously were more inclined to focus on stigma and symptoms of suicidal experiences, people who did not disclose tended to focus on the prognosis and relevance of the information to their partner. Additional considerations such as emotional capacity to disclose were also identified. When studying suicidal thoughts and behaviours disclosures in a therapeutic setting, Love and Morgan (2021) applied participants' experiences to the Disclosure Processes Model. Findings consistent with the model included the presence of antecedent goals. Whilst other findings are presented in terms of other aspects of the model (e.g., mediating processes), these do not necessarily directly align with the contents prescribed by Chaudoir and Fisher (2010).

Of note, neither the Disclosure Decision-Making (Greene, 2009) nor the Disclosure Processes (Chaudoir & Fisher, 2010) models were specifically informed by experiences of disclosing NSSI. Further, Greene's (2009) propositions are largely grounded in a medical model

approach not accounting for the impact of broader social contexts, with seeming overlap across various components of the framework (e.g., preparation as opposed to self-efficacy). Additionally, Chaudoir and Fisher (2010) explicitly refer to the likes of "alleviation of inhibition" as "mediating processes" whereas it may be more apt to describe these as short-term disclosure outcomes. There is therefore scope to explore the decision-making of NSSI disclosure specifically.

### *Voluntary Disclosure of NSSI*

Theoretical frameworks such as the Disclosure Decision-Making (Greene, 2009) and Disclosure Processes models (Chaudoir & Fisher, 2010) are helpful in conceptualising voluntary disclosure of sensitive information and offer insights into how this is distinct from the likes of help-seeking behaviours and involuntary disclosure experiences. This distinction is sometimes overlooked or not specifically operationalised in NSSI disclosure research (e.g., Jackman et al., 2018; Martin & Swannell, 2016). In their 2020 literature review of NSSI disclosure, Simone and Hamza note the importance of distinguishing between voluntary disclosures, help-seeking, and involuntary disclosure experiences. Although voluntary disclosures of NSSI can help facilitate help-seeking, not everyone who discloses their NSSI does so with the intention of receiving support. Further, advice may be sought about NSSI without an individual directly disclosing their own engagement in the behaviour (Simone & Hamza, 2020). Online platforms such as question and answer forums provide space for this help-seeking in a way that can be anonymous and accessible for many (Frost et al., 2016). Simone and Hamza (2020) also acknowledge that individuals can learn of another person's self-injury without that person willingly sharing that information with them. Involuntary discovery experiences can manifest in various ways including observing wounds/scarring, or locating items used to engage in NSSI (Pugh et al.,

2023; Simone & Hamza, 2020). Similarly, an individual may voluntarily share their experiences with one party only to have them forward disclose that information to others (Simone & Hamza, 2020). Although involuntary disclosure experiences can be impactful in themselves (Pugh et al., 2023), the importance of voluntary disclosures of NSSI should not be understated.

Although the rate of NSSI disclosure is estimated to be between 50-60% in community samples and 40-60% amongst university students, there is extensive variation in the rates of NSSI disclosure reported in the literature, with proportions ranging from 17-89% of those with lived experience of NSSI sharing this with others (Simone & Hamza, 2020). The specificity to which disclosure is operationalised would in part contribute to this dissensus, with studies in which broader definitions were adopted (e.g., number of people who know about one's self-injury; Turner et al., 2014) capturing greater proportions of NSSI disclosure, compared to those with more precise definitions (e.g., having disclosed to a particular recipient; Frey et al., 2018). Additionally, greater rates of NSSI disclosure were reported amongst people already involved in help-seeking (e.g., Martorana, 2015). Further, several factors are associated with NSSI disclosure, with the presence (or lack thereof) in research samples also potentially contributing to this variance in disclosure rates (Ammerman et al., 2021; Simone & Hamza, 2020; 2021). Regarding NSSI experiences, those who engage in NSSI more frequently, for intrapersonal reasons *(OR =* 1.06)*,* or experience greater pain from self-injury *(OR =* 2.31) are more likely to disclose their engagement in the behaviour (Ammerman et al., 2021; Armiento et al., 2014; Hasking et al., 2015a). Although the average rate of suicide ideation disclosure is on par with that of NSSI disclosure, a recent meta-analysis reported that individuals who have experienced suicidal thoughts or behaviours are more likely to disclose NSSI (Ammerman et al., 2021; Hallford et al., 2023). NSSI disclosure may be prompted in different contexts for an individual

who is experiencing suicidal thoughts or behaviours. In addition to potentially disclosing NSSI to loved ones in the process of requesting professional supports, directly asking whether an individual has engaged in self-harm once in a care setting is associated with greater rates of disclosure (Fox et al., 2022; Simone & Hamza, 2020). Fitting with Lewis and Hasking's (2021) framework of NSSI recovery, a desire to stop self-injuring, as well as greater self-esteem are both associated with disclosing NSSI (Simone & Hamza, 2020). Interpersonally, having more friends who have self-injured and greater levels of social support are correlated with disclosure. Taking a longitudinal approach, Simone and Hamza (2021) established that previous NSSI disclosures predicted a greater likelihood of later NSSI disclosures *(OR = 4.55),* the potential reasons for which to be considered further in this literature review.

Recipients of disclosures have been broadly conceptualised as being either "informal sources", that is those which comprise personal relationships, or "formal sources" concerning disclosures to professionals (Simone & Hamza, 2020). Across the lifespan, NSSI disclosures are more commonly made to informal sources including friends, significant others, and family members (Simone & Hamza, 2020). Broadly, friends and/or peers tend to be most commonly disclosed to, though this shifts to significant others/romantic partners as individuals move into adulthood (Simone & Hamza, 2020). Amongst family members, mothers are more likely to receive NSSI disclosures, though disclosures to family members also becomes less common with age (Simone & Hamza, 2020). Such shifts in primary confidants are reminiscent of changes in microsystems across the lifespan. Bronfenbrenner (1977) describes the proximal setting in which an individual develops as their microsystem, with members of the microsystem interacting reciprocally with the developing individual such that opportunities to disclose NSSI could present themselves. Empirical evidence suggests that who people consider to be part of their

"inner circle" does in fact shift with age, with family members such as siblings being less likely to form part of a person's microsystem, whereas spouses are more likely to be considered here, as individuals develop further into adulthood (Antonucci et al., 2019).

When individuals do disclose to formal sources this tends to be to mental health professionals including therapists, although to a lesser extent other health professionals such as medical doctors are also disclosed to (Simone & Hamza, 2020). In a university context, students have also reported disclosure to professors, whereas teachers may be disclosed to in primary and secondary educations settings (Simone & Hamza, 2020). The comparatively lower likelihood of disclosing to formal sources than to informal may reflect poorer access to professionals as opposed to the personal relations that form individuals' microsystems whether that be due to poor availability or financial barriers inhibiting access to health professionals (Simone & Hamza, 2020). Factors impacting the accessibility of professional supports such as a mental healthcare provider typically do not directly involve the developing individual but impact them nonetheless, and can include policies and government initiatives such as those dictating confidentiality procedures and subsidies for healthcare access. Such factors can have implications for whether an individual could access a healthcare professional, and if so whether they would feel comfortable disclosing their NSSI to them. These broader sociocultural factors that impact an individual, in the context of nondisclosure of NSSI to health professionals, could include the stigmatising views held towards those who self-injure, with individuals with lived experience citing concerns that medical professionals would label them as being mentally ill if they were to disclose to them (Long, 2018).

In addition to confiding to informal and formal sources in-person, individuals may disclose their NSSI online (e.g., Sutherland et al., 2014). Online disclosures can offer anonymity

that is not possible with other forms of disclosure, providing a means of distancing oneself from

what is a stigmatised experience (Simone & Hamza, 2020). Online disclosures of NSSI can take

place via a variety of mediums such as instant messaging with peers or professionals, peer

support in forums and chat rooms, or by engagement with online personalities who have

disclosed their NSSI (e.g., in comment threads; Frost et al., 2016; Lewis et al., 2012).

Individuals with lived experience of NSSI may utilise the internet to seek help in various

ways such as to seek guidance and information, and validation and acceptance (Frost et al., 2016;

Lewis et al., 2012; Lewis & Michal, 2016; Lewis & Seko, 2016). More recently, research into

online disclosure of NSSI has expanded to investigate sharing imagery (e.g., Brown et al., 2020).

Brown et al. (2020) considered motives for sharing pictures of NSSI online as being based on

social (e.g., to raise awareness) or self-orientation terms (e.g., documentation of experience).

Online disclosures of NSSI can provide a reduced sense of isolation as well as a greater feeling

of connection to a non-judgemental culture when engaging with a more private means of

disclosure (Frost et al., 2016). Young people reported gaining harm-minimisation guidance, as

well as general information about self-injury that they would otherwise be too intimidated to ask

about (Frost et al., 2016). Brown et al. (2020) provide more specific examples of positive

reactions to online sharing of NSSI including expressions of empathy, with validation and

support provision also reported in the literature (De Riggi et al., 2018; Lewis & Michal, 2016;

Lewis et al., 2012). Beneficial outcomes of online NSSI disclosure are consistent with those

observed in offline peer supports for self-harm (Abou Seif et al., 2021) although similar

drawbacks are also reported across virtual and face-to-face peer led support. Sharing NSSI online

has at times resulted in stigmatisation and harassment, triggering urges, and the presentation of

graphic information regarding how to engage in self-injury (Brown et al., 2020; Kim & Yu,

2022). The contestable nature of online sharing of NSSI has also been highlighted in discussions of inappropriate censorship by social media platforms (Hasking et al., 2023). In addition to the potential benefits and drawbacks of disclosing NSSI online, are those reported for voluntary disclosure of NSSI generally.

Although the motivations for and functions of NSSI disclosure are not well understood, desirable responses and broader benefits of NSSI disclosures have been reported (Simone & Hamza, 2020). Lived experience perspectives on desirable responses to NSSI disclosures are characterised by active, non-judgemental listening in which the disclosure recipient communicates clearly and calmly (Simone & Hamza, 2020). These factors align with Lewis and Hasking's (2021) recommendations for adopting a person-centred approach to understanding NSSI. Lewis and Hasking (2021) offer a strengths-based approach to communicating with individuals about their experiences of NSSI, in which the individual is recognised to be the expert of their own lived experience and as such disclosure recipients are guided to reflect the language that individual uses to describe themselves and their experience, as well as other means of validating their experience. Further, the difficulty that can come with discussing one's NSSI ought to be acknowledged (Lewis & Hasking, 2021).

Beyond the proximal response, NSSI disclosure can lead to a number of potential benefits. Support is a key outcome reported in the literature, though what is sometimes overlooked is the fact that this support can take a range of forms (Simone & Hamza, 2020). Support following a NSSI disclosure may resemble social or emotional support such as provision of physical comfort (e.g., a hug; Simone & Hamza, 2020; 2021; Simone et al., 2022). NSSI disclosures may also catalyse more tangible forms of support such as to access professional services (e.g., therapy; Ammerman & McCloskey, 2020). Additionally, NSSI disclosures can

promote senses of acceptance, connectedness, and self-awareness for individuals with lived

experience and disclosure recipients alike (Simone et al., 2022). These disclosure outcomes

perhaps reflect Chaudoir and Fisher's (2010) references to alleviation of inhibition and changes

in social information processes. Similarly, it has been suggested that disclosures of NSSI could

contribute to a broader destigmatisation of the behaviour (Burke et al., 2019).

   In contrast to the potential benefits of NSSI disclosure are the barriers and negative

outcomes reported in the literature. As discussed, NSSI stigma is a salient issue with internalised

stigma in the form of shame, concern of burdening the disclosure recipient, or otherwise

upsetting them presenting a key barrier to the disclosure of NSSI (Simone & Hamza, 2020).

Similarly, many individuals with lived experience of NSSI are apprehensive towards disclosing

their NSSI due to the anticipation of stigma whether in fear of rejection, judgement, or of the

impact it could have on their future life opportunities (e.g., work; Park et al., 2020; Simone &

Hamza, 2020). In addition to these particular concerns, there are more generalised reports that

the prospect of disclosing one's NSSI can be challenging and anxiety inducing, as well as the

additional risk of one's autonomy becoming compromised, if for example a disclosure recipient

were to forward disclose (Simone & Hamza, 2020).

   Such concerns raised by individuals with lived experience of NSSI can eventuate, with

negative responses to NSSI disclosures being reported. Harmful responses to NSSI disclosures

include placing judgement and/or blame on the person with lived experience, assuming that they

are dangerous, threatening to, or actually ending, a relationship due to the NSSI, and strong

emotional reactions such as intense anger, sadness, worry, or shock (Park et al., 2020; Simone &

Hamza, 2020. Of note, a negative response to a NSSI disclosure is not necessarily intense, and

instead may manifest as silence or avoidance of the topic or person altogether (Park et al., 2020).

Negative experiences such as these can impede future likelihood of disclosing NSSI, let alone help-seeking and healing (Park et al., 2020; Simone & Hamza, 2020).

**Conclusion**

NSSI is a relatively common behaviour which despite its short-term functionality is associated with longer term negative outcomes (Ciprinao et al., 2017). Empowering those with lived experience to disclose their NSSI could be instrumental in promoting their wellbeing, whilst facilitating access to appropriate supports, potentially mitigating the negative impacts of NSSI. The stigmatisation of NSSI presents a considerable barrier to leveraging these strengths of disclosure and presents its own challenges to those who have self-injured. Looking to broader theoretical approaches of stigmatised information disclosure may help to inform how to overcome stigma and other barriers of NSSI disclosure. As such the aim of this PhD is to better understand the decision to voluntarily disclose NSSI.

**Chapter 3: Positionality**

Understandably, there is much discourse around objectivity in psychological research; however it would be remiss to not acknowledge that true objectivity cannot be achieved as all researchers have at least some interest in their chosen field (van Dongen & Sikorski, 2021; Collins & Stockton, 2022). I have had the honour of working in a lab group that prioritises a strengths-based approach to understanding self-injury, with lived experience perspectives being central to this. My interest in the area started long before I ever joined the group as an Honours student in 2019. I first learned about self-injury, as many people would, when it was shared with me that a person ████████████ had hurt themself. I must have been aged around 11 years old at the time and I did not understand much about it, but some things were very apparent, 1) a person I cared about was going through a really difficult experience, 2) I was uneasy that I learned about this from someone else, who heard from yet another person (what if my loved one did not want all of these people to know?), and 3) I wanted to help but was not sure how. Since then, I have had different people in my life share their experiences with me and have seen others face a similar uncertainty of what to do when someone discloses self-injury to them. Like any conversation, it can be difficult to know how to respond if you do not know what sparked the dialogue in the first place and so I have become increasingly interested in the lead-up to a NSSI disclosure. I have had that experience of sitting across from a general practitioner and being asked, "Have you ever hurt yourself on purpose?", which may seem like a simple yes or no question, but in my mind, that was not the case. In a matter of seconds, I mentally tousled with an array of thoughts such as, "well it depends what you mean by hurt", and "I have wanted to hurt myself in the way I think you mean, but did not act on that urge-does that count?", and "how recently are we talking?". Despite this rush of thoughts, how did I respond in the end? "No".

Many decisions in life are not straightforward, so why expect the decision to disclose self-injury to be any different?

**Epistemology**

Crotty (1998) discusses that good fit between the four elements of research, being: epistemology, theoretical perspective, methodology, and methods, is central to quality research. One's epistemological position (i.e., the lens through which we define knowledge as truth), therefore informs their engagement with the research, but may also shift according to the nature of the aim of the research. I like to think that I generally assume a social constructionist view to knowledge, meaning that rather than understanding knowledge to be completely objective or subjective, I consider it to fall somewhere in the middle, with notions generally regarded as a 'given' to be essentially a social construction (Crotty, 1998). This epistemological positioning aligns with the mixed methods approach taken across this program of research, such that people's lived experiences were explored qualitatively, with quantitative investigation complementing these insights. In this way I developed my understanding of individual experiences and perspectives of NSSI disclosure, whilst also examining how these constructions manifested across a sample. Further, my research aims were addressed both inductively and deductively, so that parts of the thesis were informed by conceptual frameworks of personal information disclosure, whilst other parts were data-driven.

**Chapter 4: Why are Individuals who have not Disclosed Self-Injury Comfortable**

**Discussing their Experiences in Research?**

**Introduction to Chapter 4**

NSSI disclosure research raises an interesting paradox, wherein individuals report not having disclosed their NSSI to anyone, whilst sharing their NSSI experiences by participating in research. In this study we set out to explore factors which may cultivate a comfortable setting for individuals to disclose their NSSI in research. From this, we have gained insights into the experience of participating in NSSI research and have offered recommendations for researchers.

This study is published in the *Journal of Nervous and Mental Disease*. A copy of the ethical approval for the data used in this survey, a copy of the survey items used in this study, and copyright information from the journal are provided in Appendices A, B, and C.

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**Authorship**

All signed authors acknowledge that the below table is an accurate representation of each person's contribution to this research output.

| Author | Contribution | Acknowledgement |
|---|---|---|
| Sylvanna Mirichlis | Development of research question, data collection, data management, data analysis, interpretation of results and discussion, manuscript preparation, reviewing and editing of drafts. | |
| Mark Boyes | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Penelope Hasking | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Stephen P. Lewis | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |

**Abstract**

Not everyone who shares their lived experience of NSSI in research has disclosed this previously out of a research context. Our objective was to identify reasons people who have not previously disclosed their NSSI felt comfortable discussing their self-injury in research contexts. The sample consisted of 70 individuals with lived experience of self-injury who had not previously disclosed this experience outside of research ($M$age = 23.04 years, $SD$ = 5.90; 75.70% women). Using content analysis of open-ended responses we identified three reasons participants felt comfortable discussing their NSSI in research. Most commonly, participants did not anticipate negative consequences discussing their NSSI due to the way the research was conducted (e.g., confidentiality). Secondly, participants valued NSSI research and wanted to contribute to such work. Thirdly, participants referenced feeling mentally and emotionally prepared to discuss their NSSI. The findings indicate that individuals who have not previously disclosed their NSSI may wish to discuss their experience in research for a variety of reasons. Such findings highlight implications for how we foster safe spaces in research for people with lived experience of NSSI.

*Keywords:* non-suicidal self-injury disclosure, voluntary self-disclosure, self-injury disclosure, research participation

**Introduction**

Non-suicidal self-injury (NSSI), is the intentional damage (e.g., cutting, burning, scratching) to one's own body without suicidal intent (International Society for the Study of Self-Injury, 2022). Approximately 17.2% of adolescents, 13.4% of young adults, and 5.5% of adults have self-injured (Swannell et al., 2014). Although serving numerous functions, NSSI is most often used for emotion regulation (e.g., relief from aversive emotions; Taylor et al., 2018). Of concern, engagement in NSSI is associated with mental-health difficulties and later suicidal thoughts and behaviour (Kiekens et al., 2018; Klonsky et al., 2014).

Attention has been drawn towards voluntary disclosure of NSSI – that is, choosing to tell another person about one's experience of NSSI (Simone & Hamza, 2020). Such disclosure can lead to obtaining social and professional support, with voluntary disclosure suggested to play a role in NSSI recovery (Hasking et al., 2015a; Lewis & Hasking, 2020; Simone & Hamza, 2021). However, sharing experiences of NSSI can leave individuals open to stigma, which could involve disruptions to their relationships, loss of agency in decisions affecting them, or other forms of discrimination (Park et al., 2020; Staniland et al., 2022). Expectations of these negative outcomes have been identified as potential barriers to NSSI disclosure (Mirichlis et al., 2022; Simone & Hamza, 2020). This notwithstanding, many individuals who have not disclosed their NSSI elsewhere discuss their experiences in NSSI research (Simone & Hamza, 2020).

Little is understood about why people who have not previously disclosed their NSSI elect to do so in research. Participants in NSSI research generally report benefits of participation, including feeling helped, the opportunity to help others, enjoyment in participating, finding the research interesting, and appreciating the opportunity to self-reflect and learn more about themselves (Hasking et al., 2015b; Lloyd-Richardson et al., 2015). For individuals who have not

previously disclosed, these benefits may outweigh perceived risks of discussing their NSSI in research or indeed, potential risks of disclosure generally. As such, researchers have a responsibility to create and maintain safe spaces for participants. A potential starting point for this could be to better understand why individuals who have not previously disclosed their NSSI choose to discuss their experiences in research. Using these insights to inform safe spaces in research participation could be pivotal in capturing more diverse experiences of self-injury, offering a context for people who may not otherwise disclose their experiences to voice their perspective (Lewis & Hasking, 2019). Indeed, this would reflect perspectives of research participation shared by people with lived experience, such that participating in NSSI research gave a sense of purpose (Hasking et al., 2015b; Lloyd-Richardson et al., 2015). Hence, consistent with recent recommendations (Mirichlis et al., 2022), the aim of this study is to identify reasons people with lived experience of NSSI who have not previously disclosed this felt comfortable in sharing their self-injury experiences in research.

## Method

### Participants

The sample comprised 70 people who had not previously disclosed their NSSI outside of research, 2.9% of whom identified as an Australian First Nations person. Twenty-two were students from an undergraduate research participation pool, the rest recruited via social media. Participants were aged 17-47 years ($M = 23.04$, $SD = 5.90$), with most identifying as women (75.7%); 15.7% as men, and 8.6% as another gender. The average age at NSSI onset was 14.59 years ($SD = 3.05$), with 48 participants reporting that they had self-injured at least once in the 12 months preceding participation. The three most commonly reported NSSI methods were cutting ($n = 48$), self-battery ($n = 42$), and pinching ($n = 39$).

**NSSI Measure**

The Inventory of Statements About Self-Injury (Klonsky & Glenn, 2009) was used to assess NSSI experiences including the method of self-injury, age of NSSI onset, and recency. Test-retest reliability is good for such assessment ($r = 0.85$; Klonsky & Olino, 2008).

**Procedure**

Data were collected as part of a larger NSSI disclosure survey, which received ethical approval from an institution review board. Participants were recruited via a university participation pool and social media; only course credit points were provided as reimbursement for students. They completed an online survey that took approximately 30 minutes. Individuals with lived experience of NSSI were asked whether they had ever voluntarily disclosed their NSSI to another person face-to-face, and were also asked, "Why did you feel comfortable in discussing your self-injury in this research?".

**Analysis**

Inductive conventional content analysis was used to identify the reasons participants felt comfortable in discussing NSSI experiences in research (Elo & Kyngas, 2008; Erlingsson & Brysiewicz, 2017; Hsieh & Shannon, 2005). In this form of content analysis, a bottom-up approach is used. Single words and/or phrases formed the units of analysis. Participant responses were read multiple times. In the organisation phase, keywords were highlighted and initial notes were made about why participants felt comfortable to discuss their NSSI in research. This informed the coding of responses, with a temporary label being created for each code. These initial codes formed a coding scheme, which was then used to check against the responses to ensure all data were coded appropriately. After verifying that the initial codes aligned with the coding scheme, the scheme was used as a framework to describe codes and group them into

broader sub-categories, and categories. This categorisation was further refined in the development of Figure 2.

**Positionality**

Collectively the authors have extensive experience in NSSI research and share a passion for amplifying lived experience voices both within and beyond research. By extension of this, the research team strives to foster research engagement for people with diverse experiences of NSSI. The first author is currently completing a PhD investigating NSSI disclosure, observing that better understanding perspectives of those who have not disclosed their self-injury is of great importance, in addition to exploring the experiences of those who have previously disclosed their NSSI. In this study, we have adopted a Critical Realist epistemological position such that by asking participants to record why they felt comfortable in participating in this research we gained accounts of their internal thoughts (Zhang, 2022). The research team works closely with people who have lived experience of NSSI.

<div align="center">

**Results**

</div>

Participants cited three key reasons for feeling comfortable discussing their self-injury experiences in research. The most frequently referenced reason was that due to the way the study was conducted, participants did not anticipate that there would be negative consequences from discussing their self-injury experiences. For example, confidentiality mitigated concerns that others would learn that they had self-injured and thus prevent any potential discrimination or stigma that could have led on from that. This finding is captured in the category, "Nature of Research". The second reason participants felt comfortable discussing their NSSI in research was that they valued the importance and potential impacts of such investigation and wanted to contribute to the field. In this category, "Perceived Value of Research", individuals reflected on

how participation was helpful to themselves, (i.e., "Personal Benefits", e.g., learning more about

their own experiences); their personal aims for participating including to help others and

contribute to research; as well as broader potential implications of NSSI research as a whole

(e.g., interventions). The third reason participants felt comfortable discussing their NSSI in

research concerned their specific NSSI experiences (e.g., time since NSSI onset) and the way in

which they related to them. These characteristics of NSSI and notions of recovery are captured in

the category, "Individual NSSI Context".

       Figure 2 depicts these reasons organised by categories and sub-categories. The codes are

summarised in Table 1, including their name, definition, and exemplars.

**Table 1.**

*Reasons for Feeling Comfortable to Discuss NSSI Experiences in Research*

| Categories | Codes | Description | Example |
|---|---|---|---|
| **Nature of Research** | | The most prevalent category, featuring approximately 63% of all responses captured how the nature of the research encouraged comfort in sharing. Some aspects pertain to the ethical procedures typically adapted in modern research (e.g., confidentiality), whilst other aspects reflected the particular design of this study (e.g., the setting and nature of inquiry). | - |
| | ➢ Lack of Repercussions | A contributing factor to feeling comfortable to discuss experiences in this research for some participants was the perceived lack of repercussions of doing so. Anticipating negative reactions to disclosure was the main concern avoided. The lack of repercussions for research participation may in part be fostered by the confidentiality of the research process and relatedly, that they were sharing their experiences with a stranger. | "because it wont [sic] effect my real life. I also know I wont [sic] have to see anybody's reaction to what i say"<br><br>"knowing there is no way to be judged" |
| | ➢ Confidentiality | Overall, the most commonly stated reason for feeling comfortable to share experiences was participant confidentiality, an integral part of conducting research such as this study. | "the understanding this study will remain confidential"<br><br>"it's anonymous, i think i'm comfortable as long as i'm not known for doing it and nobody will know that i have or do i guess" |

| Categories | Codes | Description | Example |
|---|---|---|---|
| | ➤ Sharing with Stranger | Some participants explained that since they were sharing their experiences with a stranger they felt more comfortable to discuss them, perhaps because they did not anticipate disruption to their personal relationships or lives. | "It doesn't bother me telling people who I don't know" "I am not disclosing to people that I know (i.e. family, friends etc)" |
| | ➤ Nature of Inquiry | Some participants noted that they felt comfortable due to the non-invasive form of questioning that was used. The approach used was more 'hands off' and may have minimised feelings of vulnerability. This preference for an impersonal approach contrasts some of the other codes identified in this analysis such as those related to personal aims of participating. | "objective research" "it's neutral, clinical" "It doesn't feel like I'm talking to an actual person, which is the source of my anxiety" |
| | ➤ Research Setting | The setting in which the study took place also facilitated sharing for some. Participants highlighted a number of ways in which individuals with lived experience who have not previously disclosed this could be made to feel more comfortable in NSSI research. | "it's online" "Because it was not face to face" |
| Total $n = 45$ | | | |
| **Perceived Value of Research** | | Just over 42% of responses were categorised as pertaining to the perceived value of research, both generally and with regards to NSSI research specifically. The reasons that participants cited being comfortable in sharing their experiences reflected research outcomes | - |

| Categories | Codes | Description | Example |
|---|---|---|---|
| | | at both a broader societal ("General Importance of NSSI Research", "Practical Implications"), and personal level ("Personal Benefit"), as well as their personal aims for participating. | |
| Broader Impact | ➤ General Importance of NSSI Research | Some participants stated that they were encouraged to share their experiences in NSSI research, because it was an important area to be studied. | "As its important to spread awareness about self-injury"<br><br>"…it contributes to good research" |
| | ➤ Practical Implications | Some participants shared specific ways they believed NSSI research as a whole could hold important implications for understanding lived experience and for intervention. These potential impacts were referenced as reasons participants felt comfortable in discussing their experiences in such research. | "I am happy to participate in anything that may help address these barriers"<br><br>"Because, I know it will help people like you guys understand people who are struggling like me." |
| Personal Benefit | | There were instances in which participants reflected on how participation in research was personally beneficial to them. These participants shared that the introspection required to participate led to a better understanding of their experiences. | "I feel their [sic] is a sense of relief in analysing how you felt during the act of self-injury, what it lead to and how it also affected yourself and others."<br><br>"so this way it's a first step to understanding it without voicing it to anyone that I know" |
| | ➤ Help Others | Altruistic motives were also identified with regards to the individual reasons many of our participants chose to share their experiences in research. For example, wanting to help others | "And if there's something in my psychology/answers that will help figure this stuff out for other people, then good." |

| Categories | Codes | Description | Example |
|---|---|---|---|
| Personal Aims | | who have lived experience of NSSI or mental health difficulties generally. | "I am interested in taking part in studies to help more information on the subject to help more people" |
| | ➤ Contribute to NSSI Research | The most commonly reported personal aim of sharing NSSI experiences in research was that participants wanted their insights to contribute to NSSI research. | "I also know that any bit of extra information will help in the research part of this process"<br><br>"I try to be involved in what I can- my stats might just be the one number that is needed to prove something!" |
| | ➤ Share Experiences | A couple of participants expressed that they were drawn to discuss their experiences in research as it provided a means to share their experiences for their own personal reasons. | "I wish i had the ability to feel comfortable enough with myself to talk to those around me about it to get that extra support but i dont [sic] have it so I'll try help in at least this way" |
| Total $n = 30$ | | | |

| Categories | Codes | Description | Example |
|---|---|---|---|
| **Individual NSSI Context** | | Participants sometimes referred to their experience of NSSI when explaining why they felt comfortable discussing their NSSI in research. Some of these statements reflected characteristics of the behaviour itself, such as the recency, onset, or duration of their self-injury. In other instances participants referred to feeling recovered and/or a self-efficacy to discuss their NSSI now, though they might not have felt able to previously. Generally, participants indicated that the prospect of sharing their experiences of self-injury was conceivable as they were at a stage of feeling comfortable with their NSSI whether that be because it was not currently part of their life, or they had come to terms with what it meant to be a person who has self-injured. | - |
| <u>Relationship with their NSSI</u> | ➢ NSSI Characteristics | Many of those who referred to characteristics of their NSSI, expressed that having not self-injured for an extended period of time made them more comfortable to discuss their self-injury in research.<br><br>One participant mentioned that the duration that NSSI had been a part of their life was a contributing factor to their sharing. | "Also because I stopped self-injury over 5 years ago so it feels easier to talk about now than it did when it was happening"<br><br>"I felt comfortable enough to discuss my experience and feelings with self-injury because it is something that I have been dealing with for many years now" |

| Categories | Codes | Description | Example |
|---|---|---|---|
| | ➢ Feeling Recovered/ready to reflect | The relationship that participants had with their NSSI also formed part of the individual context that was described to encourage their sharing. That is to say, the way the individual viewed and felt about their self-injury contributed to their comfort in discussing it in research. Sub-ordinate to this, were the descriptions of feeling recovered from NSSI, or at least feeling better equipped to reflect on and share their experience of it. Notions of recovery and/or readiness to share mentioned, seemed to relate to the characteristics of the behaviour itself with the passage of time referenced across these codes. | "I feel as if i had overcome it and it almost feels like a thing of the past"<br><br>"12 months recovered"<br><br>"My self-injury is no longer quite to [sic] difficult to talk about as it once was" |
| Total *n* = 12 | | | |

*Note.* Here "*n*" denotes the number of responses containing that code/category, hence a single response may be counted multiple times if it contains more than one code. **Bold sub-headings are used for category names,** whilst underlined font denotes sub-categories, and regular font denotes code names.

**Figure 2.**

*Categorisation Map*

**Discussion**

In this study we explored why individuals with lived experience of NSSI who have not previously disclosed this, felt comfortable discussing their NSSI in research. The reasons spanned from the individual to the societal level and offer insights for creating safe spaces for people who may be hesitant to disclose their NSSI. Facilitating such sharing could potentially promote understandings of NSSI beyond the experiences of individuals who are typically open to discussing their self-injury.

The "Nature of Research" category provides insight into how research can be conducted to foster comfort to discuss self-injury experiences; such findings may be considered in other contexts (e.g., clinically) to promote disclosure more generally. The findings identified suggest that the way the study was conducted largely countered known barriers to disclosure (Simone & Hamza, 2020). For example, "lack of repercussions" suggests that participants were not concerned about being stigmatised (Rosenrot & Lewis, 2020). References made to the importance of the study being online and not involving direct interpersonal interactions reflected previous reports of virtual contexts facilitating NSSI disclosure, in part due to the anonymity they can offer (Simone & Hamza, 2020). Relatedly the importance of confidentiality, indicative of ethical research and practice, was flagged by participants. This reinforces the importance of appropriately responding to disclosure, as poor disclosure experiences can have negative outcomes such as disruption to relationships and decreased help-seeking (Simone & Hamza, 2020). Not only do participants' comments provide important support for the upholding of current ethical principles (e.g., American Psychological Association, 2017; Council for International Organizations of Medical Sciences [CIOMS], 2016), they signpost implications for future research in the interest of promoting involvement of people who have not previously disclosed NSSI.

The category, "Perceived Value of Research" suggests that participants appreciate NSSI research. For example, they highlighted NSSI research being beneficial to themselves (e.g., self-discovery) and broader society (e.g., to improve understandings of NSSI). Furthermore, individuals with lived experience appreciate the opportunity to contribute for altruistic reasons such as to improve understandings and practice (Hasking et al., 2015b; Lloyd-Richardson et al., 2015). As such, when seeking informed consent, emphasising the potential outcomes of a study with concrete examples could be useful to highlight to individuals how their input could be impactful. The potential research impacts outlined by participants further highlight the importance of capturing the voices of those who have not previously disclosed their NSSI. For example, participants offered lived experience-informed suggestions for future research and practice such as, de-stigmatising self-injury.

The "Individual NSSI Context" category suggests that prior to engaging in NSSI research, individuals may evaluate whether they feel mentally and emotionally prepared to reflect on and share these experiences. Given that participation in a study such as this asks participants to reflect on their experiences of NSSI, it is understandable if individuals felt comfortable in doing so if they self-injured less recently. This again highlights the importance of adequately informing individuals of what participation in research will involve, so that they can evaluate how comfortable they would be to share their experiences, given their current relationship with their NSSI. Furthermore, participants referenced where they were in their own recovery as a reason for feeling comfortable discussing their self-injury experience. Aspects of NSSI recovery, such as self-acceptance (Lewis & Hasking, 2020), may circumvent known barriers to disclosure such as internalised shame (Simone & Hamza, 2020). Future efforts to foster comfort in sharing experiences of self-injury should take a strengths-based approach, for example by emphasising non-judgement when discussing individuals' experiences of NSSI (Lewis & Hasking, 2021;

Simone & Hamza, 2020). Cultivating safe spaces for research participation in these ways may help empower individuals in feeling they are making a meaningful contribution to the field and being afforded the opportunity to have their voice be heard (Lewis & Hasking, 2019). Sharing in research from individuals who have not previously disclosed their NSSI is valuable to the field itself, as these individuals may offer further insights into barriers to disclosure and contribute to a more diverse understanding of experiences of NSSI. Such insights could contribute to better supports for individuals with lived experience of NSSI.

**Limitations, Future Research, and Implications**

Participants self-selected to participate in this survey study, which was explicitly advertised as being about NSSI disclosure; therefore, there may be a bias favouring positive views of NSSI research, particularly due to the phrasing of the question asked of participants. Furthermore, participants were only asked whether they had previously disclosed face-to-face though it is possible that they may have disclosed their NSSI by some other means (e.g., online, phone-call). Future research could use more neutral language and explicitly investigate motivations for and deterrents to participating in all forms of NSSI research (e.g., experimental and momentary assessment designs, rather than just online studies) and the characteristics of those who are interested in participation such that the creation and maintenance safe spaces in research can be better informed.

Researchers should strive to conduct such future research in an inclusive manner which empowers individuals with lived experience of NSSI to share their experiences, even if they have not previously disclosed their self-injury. In doing so, researchers should be mindful of power relations with participants and the broader community, to work collaboratively with people who have lived experience of NSSI (e.g., in co-designed projects) to ascertain appropriate strategies to create and maintain safe spaces for sharing experiences. Certainly, there has been a recent push

for more participant-driven and inclusive research designs in the field (e.g., Lewis & Hasking, 2019). Given the current findings, curation of safe spaces in research could include providing not only a confidential, but also a non-judgemental means to engage with research taking a genuine interest in learning about what individuals have to share, inclusive to a broad range of experiences. Such an approach aligns with previous calls for person-centred understandings of NSSI (Lewis & Hasking, 2021). For example, including open-ended questions so participants can share parts of their experiences that may not be otherwise captured in forced-choice questions, de-stigmatising phrasing (inclusive of tone, e.g., Hasking et al., 2021), and being open to feedback. Whilst such person-centred practices may initially require greater commitment from a research team, they offer the potential for greater benefits by way of more comprehensive and diverse perspectives being captured in research, and the respect for participants being prioritised (CIOMS, 2016). Opportunities to share one's lived experience in person-centred research can in turn gratify motivations to contribute to a cause bigger than oneself, whilst being welcomed to express oneself authentically (Lewis & Hasking, 2019). Furthermore, the findings from this study may offer some initial insights into how engagement in other sensitive and stigmatised research topics may be facilitated. For example, given the existing stigma of mental illness, and the comorbidity of mental health difficulties amongst people with lived experience of NSSI, providing a safe space for research participation is crucial (Staniland et al., 2020). As such the transferability of the current findings to research of other stigmatised experiences should be explored in future research. Further to this, given that positive disclosure experiences can prompt ongoing disclosure (e.g., Simone et al., 2022), fostering supportive spaces to disclose NSSI in research may help to facilitate further disclosures outside of this context, which in turn could catalyse recovery efforts (Lewis & Hasking, 2021).

**Conclusions**

The findings from this study illustrate that fostering comfort for individuals who have not previously disclosed their NSSI, to share their experiences in self-injury research can be beneficial, not just to the study of the behaviour, but to the individuals themselves. The comments shared by participants convey an eagerness to contribute to the field and indicate potential means by which researchers could foster participation by creating safe and inclusive practices. Ultimately, the findings offer a timely reminder for the importance of person-centred practice in the research of NSSI and beyond.

## Chapter 5: Correlates of Disclosure of Non-Suicidal Self-Injury Amongst Australian University Students

### Introduction to Chapter 5

Having established that people who have not previously disclosed their NSSI participate in NSSI research and the reasons why, we can proceed to make comparisons between this group and those who have previously disclosed their NSSI. Prior to investigating the decision-making involved in disclosing NSSI, we wanted to build a foundation of understanding what considerations are associated with NSSI disclosure generally. Although some correlates (e.g., function of NSSI, suicide ideation; Ammerman et al., 2021; Armiento et al., 2014) had previously been identified in the literature we wished to expand on this research by incorporating additional considerations such as cognitions about NSSI. As such the aim of this study was to identify the socio-demographic, NSSI-related, socio-cognitive, and socio-emotional correlates of NSSI disclosure.

This study is published in the *Journal of Public Mental Health*, a peer-reviewed journal. The supplementary materials of this paper and a copy of the ethical approval for the data used in this survey, a copy of the survey items used in this study, and copyright information from the journal are provided in Appendices D, E, F, and G.

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### Authorship

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| Author | Contribution | Acknowledgement |
|---|---|---|
| Sylvanna Mirichlis | Development of research question, data management, data analysis, interpretation of results and discussion, manuscript preparation, reviewing and editing of drafts. | |
| Penelope Hasking | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Stephen P. Lewis | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Mark Boyes | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |

**Abstract**

Non-suicidal self-injury (NSSI) is associated with psychological disorders and suicidal thoughts and behaviours; disclosure of NSSI can serve as a catalyst for help-seeking and self-advocacy amongst people who have self-injured. This study aims to identify the socio-demographic, NSSI-related, socio-cognitive, and socio-emotional correlates of NSSI disclosure. Given elevated rates of NSSI amongst university students, this study aimed to investigate these factors amongst this population. Australian university students ($n = 573$) completed online surveys; 80.2% had previously disclosed self-injury. NSSI disclosure was associated with having a mental illness diagnosis, intrapersonal NSSI functions, specifically marking distress and anti-dissociation, having physical scars from NSSI, greater perceived impact of NSSI, less expectation that NSSI would result in communication and greater social support from friends and significant others. Expanding on previous works in the area, this study incorporated cognitions about NSSI. The ways in which individuals think about the noticeability and impact of their NSSI, and the potential to gain support, were associated with the decision to disclose self-injury. Addressing the way individuals with lived experience consolidate these considerations could facilitate their agency in whether to disclose their NSSI and highlight considerations for health-care professionals working with clients who have lived experience of NSSI.

*Keywords*: non-suicidal self-injury disclosure, voluntary self-disclosure, self-injury disclosure.

**Introduction**

Self-harm refers to the poisoning or injury to oneself regardless of intent, thus including both non-suicidal self-injury and suicidal behaviour (National Institute for Health and Care Excellence, 2013). Non-suicidal self-injury (NSSI) is the deliberate damage to one's own body without suicidal intent, often by cutting, burning and/or scratching (International Society for the Study of Self-Injury, 2020; Swannell et al., 2014). An individual may be intrapersonally (e.g., emotion regulation) or interpersonally motivated (e.g., communicating distress) to self-injure (Taylor et al., 2018). Approximately 5.5% of adults, 13.4% of young adults, and 17.2% of adolescents report a history of NSSI (Swannell et al., 2014). Typically commencing during adolescence, a second peak onset period occurs amongst between 20 and 24 years of age, coinciding with the age of many university students (Gandhi et al., 2018). This is reflected in the prevalence of NSSI in this population, with 20.2% of university students having lived experience and with 10% of students engaging in self-injury for the first time in their first year of university (Kiekens et al., 2019; Swannell et al., 2014). NSSI is associated with various mental health difficulties, and later suicidal thoughts and behaviour, including amongst university students (Fox et al., 2015; Klonsky et al., 2014). NSSI is also associated with poorer academic outcomes (Kiekens et al., 2016).

Disclosing NSSI may facilitate a range of benefits, for example catalysing support seeking, empowerment, and acceptance in the face of NSSI stigma (Burke et al., 2019; Rosenrot & Lewis, 2020). What is considered to be appropriate in terms of how support is provided can vary across individuals and situations; however empathetic strength-based approaches are encouraged (e.g., Lewis & Hasking, 2021). Engaging in this way with individuals who disclose their self-injury could provide a welcoming space to explore empirically supported interventions for NSSI, such as dialectical behaviour therapy (Fortune et al., 2021; Turner et al., 2014) which

could in turn mitigate the negative outcomes specifically associated with NSSI-such as suicide (Ammerman et al., 2021; Lewis & Hasking, 2021). Despite the potential benefits of NSSI disclosure there are several barriers. Among these are internalised stigma and concerns about how disclosure might impact recipients, anticipated stigma (e.g., fear of judgement), and anxiety related to disclosure (e.g., Long, 2018; Rosenrot & Lewis, 2020).

Understanding factors associated with NSSI disclosure amongst students could be instrumental in identifying ways to help reduce barriers and foster beneficial outcomes in this population. In their research with undergraduate students, Armiento et al. (2014) and Ammerman et al. (2021) found suicide ideation and risk were associated with higher likelihood of NSSI disclosure, as were pain and severity of tissue damage, better friendship quality, support from a significant other, and fewer depressive symptoms. Armiento et al. (2014) reported disclosure to be associated with interpersonal functions of NSSI, whilst Ammerman et al. (2021) found intrapersonal functions to be linked to disclosure.

**Other Factors?**

Psychological theorists suggest additional factors could play a role in the decision to disclose personal information (Chaudoir & Fisher, 2010; Greene, 2009). As cognition is featured heavily in such models, it is possible that a student's decision to disclose their NSSI to another person would, at least in part, be driven by their perceptions and thoughts about their self-injury. Indeed, the way individuals conceptualise their own self-harm has been a topic of exploration within and beyond psychology (e.g., Simopoulou & Chandler, 2020). Salient cognitions might include expected and perceived outcomes of the behaviour, self-efficacy to resist NSSI, and anticipation or internalisation of stigma (Greene, 2009; Hasking et al., 2017; Rosenrot & Lewis, 2020). For example, if an individual expects to be judged for having self-injured, they may be less likely to disclose that they have done so, whilst perceiving negative outcomes of their self-

injury may encourage disclosure (i.e., to potentially seek support). Visibility (e.g., scarring) and wellbeing (e.g., resilience, self-esteem) are among the other considerations featured in Greene's (2009) and Chaudoir and Fisher's (2010) models. If such considerations contribute to the understanding of NSSI disclosure, this could further promote its beneficial outcomes.

**The Current Study**

The aim of this exploratory study was to identify correlates of NSSI disclosure among university students by investigating socio-demographic, NSSI-related, socio-cognitive, and socio-emotional constructs. The correlates considered were informed by prior research (Ammerman et al., 2021; Armiento et al., 2014), whilst also aiming to expand on this work, by inclusion of such cognitive factors such as self-efficacy and expected outcomes of NSSI, as well as presence of scarring and resilience.

<div align="center">

**Method**

</div>

**Participants**

Using Peduzzi et al.'s (1996) formula for a priori power analyses, it was determined that a minimum sample size of 300 participants would be required. A sample of 573 university students with lived experience of NSSI was aggregated across three surveys; 80.6% were women, 15.2% were men, and 4.2% identified as another gender (Table 2). Participants were aged between 17 and 52 years ($M = 23.66$, $SD = 6.55$) with 62.5% reporting a previous mental illness diagnosis (most commonly depression/anxiety disorders). The mean age of NSSI onset was 13.96 years ($SD = 3.91$) and the three most common primary forms of self-injury were cutting (52.4%), self-battery (14%), and severe scratching (8.9%). Most participants (57.1%) had self-injured within the past year. Of the 460 (80.2%) who had previously disclosed their NSSI, 77.8% did so to a friend, 57.8% to a mental health professional; 55.7% to their partner; 40.2% to a parent; 29.3% to a general practitioner; 19.8% to a sibling; 8% to a teacher; 6.5% to another relative.

**Procedure**

Following ethical approval, the surveys were advertised via the university's research participation pool. Participants provided informed consent before completing online surveys which took approximately one hour. Participants were awarded with course credit and were provided with coping resources (e.g., contacts for support services). The surveys were completed in separate collections of data after which data were aggregated such that the final sample comprised only of those with lived experience. Although students could complete more than one of the surveys, we removed duplicate cases from the data set to ensure each student had only one response in the data.

**Measures**

The factors investigated are organised into theoretically informed groups (i.e., Chaudoir & Fisher, 2010; Hasking et al., 2017). Demographic information is presented in terms of "socio-demographic" factors. Information about individuals' self-injury is referred to as "NSSI-related" factors. Cognitions about NSSI are presented under "socio-cognitive factors, and social and emotion-related factors are grouped within "socio-emotional".

*Disclosure*

Participants were asked whether they had ever told anyone of their NSSI and were asked to indicate each person they had told from a list (friend, parent, sibling, other relative, partner, teacher, mental health professional, general practitioner, other).

*NSSI-Related Factors*

The Inventory of Statements About Self-Injury (ISAS; Klonsky & Glenn, 2009) was used to collect the following NSSI information: primary method, whether participants experience pain from the behaviour, and the amount of time that elapses between experiencing the urge and engaging in the behaviour. Participants were also asked, "How many times have you self-injured

in the last year?" This section of the ISAS has good test-retest reliability ($r$ = .85; Klonsky &

Olino, 2008). Section two of the ISAS assesses NSSI functions, on a scale from 0 = not relevant

to 2 = very relevant. Good test-retest and internal reliability has been demonstrated for

intrapersonal and interpersonal subscales ($r$ = .60-.82, $\alpha$ = .80-.87; Glenn & Klonsky, 2011;

Klonsky & Glenn, 2009). The intrapersonal ($\alpha$ = .83) and interpersonal ($\alpha$ = .90) scales

demonstrated excellent internal consistency in the current sample.

To measure impact of NSSI, participants responded on a scale from 1 = strongly disagree

to 5 = strongly disagree, to: "causes me significant distress", "causes other people significant

distress", "causes interference in my interpersonal life", "causes interference in my academic

life", and "causes interference in other important areas of my life"; (total $\alpha$ = .81). Participants

were also asked "Do you have any physical scarring as a result of your self-injury?".

The Internalised Stigma of Mental Illness Inventory (Ritsher et al., 2003) was adapted to

assess whether participants believe that stigmatising views of NSSI apply to themselves. Items

(e.g., "I can't contribute anything to society because I have self-injured") were responded to on a

five-point scale (1 = strongly disagree, 5 = strongly agree). Validity has been established and the

measure has demonstrated excellent test-retest reliability ($r$ = .92) and internal consistency ($\alpha$ =

.90; Ritsher et al., 2003). Internal consistency was excellent in the current sample ($\alpha$ = .91).

The 10-item awareness subscale of the Self-Stigma of Mental Illness Scale (Corrigan et

al., 2006) was adapted to assess the degree to which participants perceive the general public holds

stigmatising beliefs about NSSI. Items (e.g., "I think the public believes: most people who self-

injure cannot be trusted") were responded to on a nine-point response scale (1 = strongly

disagree, 9 = strongly agree). Higher scores indicated stronger belief that NSSI is stigmatised by

the public. Validity and good test-retest reliability ($r$ = .73), and internal consistency ($\alpha$ = .91) has

been demonstrated for the subscale (Corrigan et al., 2006). Internal consistency was excellent in the current sample ($\alpha$ = .95).

### Socio-Cognitive Factors

The NSSI Expectancy Questionnaire (Hasking & Boyes, 2018) is a 25-item measure of expected outcomes of engaging in self-injury. A scale from 1 = extremely unlikely to 4 = extremely likely is used across the five subscales of expectancies about NSSI: affect regulation, negative social outcomes, communication expectancies, pain, and negative self-beliefs, with higher scores indicating stronger outcome expectancies. Good convergent and discriminant validity, and good subscale internal consistency has been demonstrated (Hasking & Boyes, 2018). Internal consistency was good in the current sample ($\alpha$ = .70-.90).

An adaptation of Czyz et al.'s (2014) measure of Self-Efficacy to Avoid Suicidal Action was used to assess self-efficacy to resist engaging in self-injury. Responses to the six items (e.g., How certain are you that you will not self-injure in the future?) are rated from 1 = very uncertain to 6=very certain, with higher scores indicating higher self-efficacy to resist NSSI. Good convergent validity of the original scale has been demonstrated, as has excellent internal consistency, $\alpha$ = .96 (Czyz et al., 2014). The adapted scale has been used previously in NSSI research (Hasking & Rose, 2016), and internal consistency was excellent in the current sample ($\alpha$ = .90).

### Socio-Emotional Factors

The K10 (Kessler et al., 2002) is a ten-item measure of psychological distress. Items (e.g., "About how often did you feel tired out for no good reason?") are responded to using a five-point scale (1 = none to 5 = all of the time), with higher scores indicating higher levels of distress. Validity and good internal consistency of the K10 has been established ($\alpha$ = .93; Kessler et al., 2002). Internal consistency in the current sample was excellent ($\alpha$ = .92).

The Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) measures perceived social support from family, friends, and significant others. Twelve items (e.g., "There is a special person who is around when I am in need"), are rated on a scale from 1 = very strongly disagree to 7 = very strongly agree with higher scores reflecting higher levels of social support. Zimet et al. (1988) established moderate construct validity and good test-retest reliability across subscales (family, $r = .85$; friends, $r = .75$; significant other, $r = .72$). Internal consistency was excellent in the current sample ($\alpha = .93-96$).

Resilience was assessed with the six-item Brief Resilience Scale (Smith et al., 2008). Items, (e.g., "I tend to bounce back quickly after hard times") were responded to on a five-point scale (1 = strongly disagree to 5 = strongly agree), with higher scores indicating greater resilience. Validity and good internal consistency have been established, $\alpha = .80-.91$ (Smith et al., 2008). Internal consistency in the current sample was excellent ($\alpha = .86$).

The Rosenberg Self-Esteem Scale (Rosenberg, 1965) is a ten-item measure of one's negative and positive feelings towards themselves. Responses to items (e.g., "I feel that I have a number of good qualities") are scored on a scale from 1 = strongly disagree to 4 = strongly agree with higher scores indicating higher levels of self-esteem. The measure has been demonstrated to be valid, stable over time ($r = .69$), and internally consistent ($\alpha = .88-.90$; Robins et al., 2001). Internal consistency in the current sample was excellent ($\alpha = .91$).

**Analysis**

After screening and cleaning the data, the factors were grouped according to the broader (i.e., socio-demographic, NSSI-related, socio-cognitive, and socio-emotional) concepts with which they aligned. Aside from providing some consistency across the study, it is assumed that the dependent variables within each MANOVA analysis are related (Field, 2009). Given not all measures were included in each of the surveys, sample sizes differ across analyses. Chi-square

test of contingencies were used when variables were nominal, independent sample t-tests were used when there was one scale criterion variable, and MANOVAs were used when there were multiple related constructs. Bonferroni corrections were used where appropriate. All variables had less than 5% of data missing and expectation maximisation was used to impute missing scale data.

## Results

### Socio-Demographic Factors

Disclosure of NSSI was not associated with gender, $\chi^2(1, N = 549) = 2.17, p = .14$ or age, $t(571) = -.38, p = .70$ 95% CI [-1.62-1.09]. NSSI disclosure was associated with having a mental illness diagnosis, $\chi^2(1, N = 573) = 26.19, p<.001$; with participants who had not disclosed their NSSI being less likely to report a mental illness diagnosis.

### NSSI-Related Factors

In multivariate analyses, disclosure was associated with the function of NSSI, $\lambda = .95$, $F(13, 559) = 2.11, p = .012$, partial $\eta^2 = .047$; specifically, univariate analyses indicate an association between disclosure and greater use of NSSI as a means of marking distress, $F(1, 571) = 11.93, p = .001$, and for anti-dissociation, $F(1, 571) = 10.06, p = .002$.

Disclosure was not associated with frequency of NSSI, $\chi^2(5, N = 562) = 7.21, p = .21$, but participants who had not disclosed their NSSI were less likely to report having physical scars, $\chi^2(1, N = 426) = 15.07, p<.001$.

Fisher's exact test was used to examine relations between pain, and time elapsed between experiencing the urge to self-injure and engagement. NSSI disclosure was not associated with pain ($p = .07$) nor the elapsed time ($p = .13$). When examining the primary forms of NSSI, the Monte Carlo statistic was used. There was a moderate association between disclosure and the primary form of NSSI such that participants who did not disclose NSSI were more likely to

report cutting as a primary form of self-injury and less likely to report severe scratching as their primary form of self-injury, $\chi^2(12, N = 559) = 28.31$, $p<.05$, 95% CI [.004-.007].

Likelihood of disclosure increased with impact of NSSI, $t(425) = -3.34$, $p<.05$, 95% CI [-3.25, -.84]. Disclosure was not associated with anticipated public stigma nor internalised stigma, $\lambda = 1.00$, $F(2, 171) = .365$, $p = .695$.

**Table 2**

*Descriptive Statistics Disaggregated by Disclosure Status*

| Conceptual group | Factor | Mean (*SD*) | | Effect size |
|---|---|---|---|---|
| | | Disclosed | Not disclosed | |
| Socio-Demographic (*N*=549) | Gender[a] | - | - | $\varphi = .06$ |
| | Mental Illness Diagnosis[b]*** | - | - | $\varphi = .21$ |
| | Age[b] | 23.72 (6.49) | 23.45 (6.85) | $d = -.04$ |
| NSSI-Related | Marking Distress[b]** | 2.43 (1.87) | 1.77 (1.67) | partial $\eta^2 = .02$ |
| | Anti-Dissociation[b]** | 2.78 (2.03) | 2.11 (1.95) | partial $\eta^2 = .02$ |

| Conceptual group | Factor | Mean (*SD*) | | Effect size |
|---|---|---|---|---|
| | | Disclosed | Not disclosed | |
| | Pain[b] | - | - | Cramer's *V* = .10 |
| | Frequency (*N* = 562) | - | - | Cramer's *V* = .11 |
| | Main Form* (*N* = 559) | - | - | Cramer's *V* = .23 |
| | Time Elapsed (*N* = 571) | - | - | Cramer's *V* = .13 |
| | Scars*** (*N* = 426) | - | - | φ = .19 |

| Conceptual group | Factor | Mean (*SD*) | | Effect size |
| --- | --- | --- | --- | --- |
| | | Disclosed | Not disclosed | |
| | Impact* (*N* = 427) | 15.73 (4.73) | 13.68 (4.82) | *d* = -.85 |
| | Awareness of Public Stigma (*N* = 174) | 55.48 (19.96) | 52.39 (19.03) | |
| | Internalised Stigma (*N*=174) | 63.48 (18.67) | 61.45 (20.44) | partial η²< .00 |
| | NSSI Outcome Expectancy | | | |
| Socio-Cognitive | Communication [b]** | 9.84 (4.62) | 11.27 (4.98) | partial $\eta^2$= .01 |
| | Negative Social[b] | 12.06 (4.40) | 12.56 (4.57) | partial $\eta^2$<.00 |

| Conceptual group | Factor | Mean (*SD*) | | Effect size |
|---|---|---|---|---|
| | | Disclosed | Not disclosed | |
| | Pain[b] | 13.85 (3.81) | 12.86 (3.58) | partial $\eta^2 = .01$ |
| | Negative Self[b] | 13.67 (3.70) | 13.02 (3.85) | partial $\eta^2 < .00$ |
| | Self-Efficacy to Avoid NSSI[b] | 21.70 (8.37) | 22.22 (7.64) | partial $\eta^2 < .00$ |
| Socio-Emotional | Distress[b] | 29.51 (9.37) | 29.12 (8.52) | $d = -.04$ |
| | Social Support | | | |
| | Friend* | 20.76 (6.09) | 18.02 (6.48) | partial $\eta^2 = .03$ |
| | (*N*=253) | | | |

| Conceptual group | Factor | Mean (*SD*) | | Effect size |
|---|---|---|---|---|
| | | Disclosed | Not disclosed | |
| | Family (*N=253*) | 16.65 (7.29) | 15.95 (608) | partial $\eta^2$<.00 |
| | Significant other*** (*N=253*) | 21.42 (7.22) | 16.51 (6.90) | partial $\eta^2$= .06 |
| | Resilience (*N=253*) | 15.94 (4.82) | 15.41 (4.47) | partial $\eta^2$<.00 |
| | Self-Esteem (*N=253*) | 23.90 (6.12) | 22.44 (5.33) | partial $\eta^2$<.00 |

*Note.* [a]"Other" gender filtered out as violated expected frequencies assumption, [b]$N = 573$,*$p < .05$, **$p <.01$, ***<.001

**Socio-Cognitive Factors**

In multivariate analyses, disclosure was related to expected outcomes of NSSI and self-efficacy to avoid NSSI ($\lambda = .97$, $F(6, 566) = 2.58$, $p = .018$, partial $\eta^2 = .027$). More specifically, univariate analyses indicated that disclosure was associated with less of an expectation that NSSI would result in communication ($F(1, 571) = 8.37$, $p = .004$). Disclosure was not associated with the other outcome expectancies, nor self-efficacy to avoid NSSI.

**Socio-Emotional Factors**

Disclosure was not associated with psychological distress, $t(571) = -.4$, $p = .69$, 95% CI [-2.29, 1.51]. Multivariate analysis of social support, resilience, and self-esteem found an overall difference in disclosure status ($\lambda = 93$, $F(5, 247) = 3.67$, $p = .003$, partial $\eta^2 = .069$). Participants who had previously disclosed their NSSI reported greater social support from their significant other ($F(1, 251) = 16.11$, $p<.001$) and friends ($F(1,251) = 6.8$, $p = .01$). There was no difference based on perceived social support from family, resilience, or self-esteem.

## Discussion

Identifying factors which are associated with NSSI disclosure could be instrumental in promoting beneficial and mitigating negative outcomes of disclosure (Lewis & Hasking, 2021), thus the aim of this study was to investigate such factors including NSSI-cognitions among university students. Most participants (80.2%) had previously disclosed their NSSI and this was associated with having a mental illness diagnosis, engaging in NSSI for intrapersonal reasons, having physical NSSI scars, perceiving greater impact of one's self-injury, not expecting communicative outcomes from NSSI, and reporting greater support from significant others and friends. Addressing factors such as these could be useful in promoting disclosure, thus providing opportunity for intervention that could be utilised to reduce the associated suicide risk (Klonsky

et al., 2014). Note that not all factors (e.g., stigma) were associated with NSSI disclosure highlighting key distinctions between this and previous research, as addressed below.

Although characteristics of the sample (e.g., age of onset) were consistent with that of university student populations, the rate of disclosure in this sample was high given that rates of disclosure in the literature vary between 17 to 89%; notably, the rate at which NSSI was disclosed to formal sources was higher than what is generally observed (Simone & Hamza, 2020). It is plausible that different groups of people within the student population may be more likely to have disclosed their self-injury (Simone & Hamza, 2020). The majority of this sample reported having a mental illness and may have been more likely to engage with health professionals (i.e., formal source) as a result, thereby offering another setting in which disclosure could occur. Additionally, given that participants were not asked to specify the nature of the disclosure, instances of NSSI discovery could have been captured whereas these would have been excluded in some other research thus contributing to variance in disclosure rates. Future research should investigate rates of disclosure (clarifying whether voluntary) across diverse samples and recipients, which in turn would assist person-centered practice (Lewis & Hasking, 2021). An additional point for future consideration is the phenomenon of individuals participating in NSSI research such as this despite indicating not having previously disclosed their self-injury.

The present findings indicated that disclosure was associated with NSSI-related scarring, as well as social support. How noticeable one considers their NSSI to be could reflect signs such as scarring or the method of self-injury. Such factors could lead to the self-injury being discovered potentially against the individual's wishes, highlighting that navigating NSSI disclosure can have implications in terms of individuals' agency over sharing personal information. For example, if a student's NSSI scars were noticed by their lecturer, this could raise concerns about how the lecturer may then choose to use that information (e.g., sharing that

information on with others, discriminating against the student because they have self-injured).

Concerns about outcomes such as these have previously been identified as barriers to future

disclosures and thus may contribute to a reluctancy to seek support not only within the university

setting but externally (Simone & Hamza, 2020).

As per Ammerman et al. (2021) and Armiento et al. (2014) it seems that specific elements

relating to distress (e.g., suicide ideation) may contribute to disclosing NSSI, rather than general

distress assessed in the present study. Though similar to Ammerman et al. (2021), the lack of

association between stigma and disclosure contrasts the broader NSSI disclosure literature

(Rosenrot & Lewis, 2020). Furthermore, the association between disclosure and intrapersonal

functions of NSSI (rather than interpersonal) contributes to the literature (Ammerman et al.,

2021; Armiento et al., 2014). The associations between NSSI disclosure and self-injury serving to

mark distress, and to avoid dissociation are reflective of experiences of disclosure (Simone &

Hamza, 2020). If a student self-injures to indicate that they are distressed, disclosing this self-

injury could provide further opportunities to communicate what they are experiencing.

Furthermore, NSSI disclosure can be an emotional experience involving the presence of both the

student disclosing and their confidant, this generation of feeling is consistent with wanting to

avoid dissociation from emotional experiences (i.e., by way of NSSI). Future research would be

useful in clarifying nature of the relationships (or lack thereof) between NSSI disclosure and

stigma, as well as the underlying reason for engaging in NSSI.

Cognitive accounts of NSSI highlight a role for multiple NSSI-related outcome

expectancies, as well as self-efficacy to avoid self-injury (Hasking et al., 2017). However, in the

current study disclosure was only associated with lower communication expectancies (e.g., NSSI

making it easier to share feelings). It is possible that telling others about one's self-injury was

important if individuals did not believe that their engagement in NSSI itself would foster

communication, regardless of any perceived negative outcomes (Hasking & Boyes, 2018). The finding that the other cognitive factors investigated were not associated with disclosure, indicates that these may be less relevant to the process of navigating disclosure. Importantly, the current findings do not necessarily suggest that cognitive factors should be disregarded when targeting NSSI disclosure among students. It is plausible that the way individuals think about their self-injury (as well as factors related to it) and the prospect of disclosing it is relevant to voluntary disclosure, which the current study did not specifically examine. Broader health-psychology models of disclosure suggest this is the case when voluntarily disclosing personal information, and as such describe the types of mental evaluations an individual might make when deciding whether to such information (e.g., Chaudoir & Fisher, 2010; Greene, 2009). Drawing on these models in the future could contribute to a more comprehensive understanding of NSSI disclosure, specifically voluntary disclosure, and potentially provide malleable targets for intervention where the goal is to facilitate disclosure.

**Implications, Limitations and Future Research**

A few key implications have been illuminated in this study, one being the importance of mental health professionals as well as other people working with university students being prepared to respond appropriately to NSSI disclosure and helping them to navigate future disclosures. The potential value of support more broadly as well as the need to foster one's own agency in deciding to disclose their self-injury, and to whom, has also been highlighted, as well as the complexity of such a decision. There are some limitations to bear in mind when considering the findings and implications of this research. Future research should broaden the scope of investigation, for example by drawing on other disciplines such as sociology, to identify additional constructs that could be important to NSSI disclosure. Possible avenues include cognitive factors such as self-efficacy to disclose and disclosure outcome expectancies, as well as

a broader examination of the social setting and/or characteristics of disclosure recipients (Chaudoir & Fisher, 2010; Greene, 2009). This study did not differentiate between factors which contributed to the decision to disclose, as compared to outcomes of disclosure, or being otherwise associated with disclosure. It is possible that different factors would be relevant to specific aspects of the disclosure experience, thus when applying these findings to practice a practitioner (e.g., university-based counsellors) should work with the student/client to tailor their approach (Chaudoir & Fisher, 2010; Lewis & Hasking, 2021). Interviews could be used in future to learn about people's lived experiences of NSSI disclosure.

Nonetheless, the findings of this study indicate that the potential NSSI has for fostering interactions with others, the impact that NSSI may have on the individual, and the support they receive from friends and significant others, could be important to university students' decisions to disclose NSSI. Such findings bear importance for health-care providers and university staff working with students/clients who self-injure, highlighting potential factors to consider when working collaboratively towards person-centred care and recovery (Lewis & Hasking, 2021). Given disclosure of NSSI has the potential to promote self-advocacy amongst individuals with lived experience of NSSI, understanding barriers and facilitators to disclosure is important (Rosenrot & Lewis, 2020). Future research could benefit from being grounded in broader conceptual models of disclosure and informed by individuals with lived experience of self-injury (Lewis & Hasking, 2019).

**Chapter 6: What is Important to the Decision to Disclose Non-suicidal Self-Injury in**

**Formal and Social Contexts?**

**Introduction to Chapter 6**

In Study One, we identified considerations for providing a safe space for NSSI disclosure research participation and in doing so have noted potential considerations for disclosing NSSI both within and beyond research settings. The relevance of such considerations was demonstrated in Chapter 5, which involved both participants who had and had not previously disclosed their NSSI. In that fifth chapter, correlates of NSSI disclosure were reported, which along with the findings from Chapter 4 and existing literature are suggestive of factors which may inform the decision to disclose NSSI. However, there are some key limits to the findings from the preceding studies of this thesis. For one it is unclear whether these factors are indeed relevant to the decision to disclose NSSI, or if they are otherwise associated with the experience of NSSI disclosure. Secondly, it is not yet established whether some factors are of greater importance to the decision to disclose NSSI than others. The aim of this study to gain lived experience perspectives on the relative importance of a range of factors to the decision to disclose NSSI. Additionally, it was sought to identify whether this importance differed according to potential disclosure recipient. In doing so, the findings of this study provide an initial understanding of how individuals may approach NSSI disclosure decision-making.

This study is published in the *Journal of Clinical Psychology*. The supplementary materials of this paper and a copy of the ethical approval for the data used in this survey, a copy of the survey items used in this study, and copyright information from the journal are provided in Appendices A, B, H, I, and J.

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**Authorship**

All signed authors acknowledge that the below table is an accurate representation of each

person's contribution to this research output.

| Author | Contribution | Acknowledgement |
|---|---|---|
| Sylvanna Mirichlis | Development of research question, data collection, data management, data analysis, interpretation of results and discussion, manuscript preparation, reviewing and editing of drafts. | |
| Mark Boyes | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Penelope Hasking | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Stephen P. Lewis | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |

**Abstract**

**Objective:** Disclosure of Non-Suicidal Self-Injury (NSSI) is associated with a range of both positive (e.g., help-seeking) and negative (e.g., discrimination) outcomes. The aim of this study was to assess the importance of a range of factors concerned with: NSSI experiences, self-efficacy to disclose self-injury, interpersonal factors, and reasons for or expectations of disclosure, to the decision to disclose self-injury to friends, family members, significant others, and health professionals. **Methods:** 371 participants with lived experience of NSSI completed a survey in which they rated the importance of the aforementioned factors to the decision of whether to disclose NSSI to different people. A mixed-model ANOVA was conducted to investigate whether the factors differed in importance and if this importance differed across relationship types. **Results:** All factors held importance, though to differing degrees, with those related to relationship quality being most important overall. Generally, factors relating to tangible aid were considered more important when considering disclosure to health professionals than to other people. Conversely, interpersonal factors, particularly trust, were more important when disclosing to individuals in social or personal relationships. **Conclusion:** The findings provide preliminary insight into how different considerations may be prioritised when navigating NSSI disclosure, in a way that may be tailored to different contexts. For clinicians, the findings highlight that clients may expect tangible forms of support and non-judgement in the event that they disclose their self-injury in this formal setting.

*Keywords***:** non-suicidal self-injury disclosure, voluntary self-disclosure, self-injury disclosure

## Introduction

Non-suicidal self-injury (NSSI) is the intentional damage caused to a person's own body that is not suicidal in nature, nor does it align with their particular cultural or societal norms (e.g., cutting, burning, and self-battery; International Society for the Study of Self-Injury, 2022; Swannell et al., 2014). There are many functions that NSSI may serve, including both intrapersonal functions, such as to regulate one's emotions, and interpersonal functions, for example seeking support (Taylor et al., 2018). Further, the behaviour is associated with a number of challenging experiences including mental health difficulties and later suicidal ideation and behaviour (Kiekens et al., 2021; Klonsky et al., 2014). Given that approximately 5% of adults, 13% of young adults, and 17% of adolescents have lived experience of NSSI, many people are likely to know or come to know someone who has self-injured (Swannell et al., 2014).

NSSI disclosure can be associated with a number of potential positive outcomes including social and professional support, and self-advocacy (Burke et al., 2019; Rosenrot & Lewis, 2020). In these ways, disclosing one's experience of NSSI could contribute to opportunities to mitigate negative outcomes associated with self-injury whether that be in accessing interventions and/or addressing stigma. However, disclosure of self-injury is a complex phenomenon with various barriers such as stigma, and anticipated impact on the recipient of the disclosure, being identified (Simone & Hamza, 2020).

Amongst people commonly disclosed to are friends, significant others, and family members, and in formal settings, health professionals such as psychologists (Simone & Hamza, 2020). Disclosures of NSSI are associated with characteristics of the behaviour, including the function of NSSI and visibility of scars, (Mirichlis et al., 2022; Simone & Hamza, 2021). The nature of a disclosure experience may differ depending on the setting; for example disclosing one's self-injury online can provide an anonymity that is difficult to achieve face-to-face (Frost et

al., 2016). While disclosure of self-injury may be a first step in seeking support or be motivated by the need for medical care (Armiento et al., 2014; Hasking et al., 2015), NSSI stigma and internalised shame have been identified as barriers to disclosing one's self-injury (Long, 2018; Rosenrot & Lewis, 2020). Similarly, the anticipated impact on the recipient of the disclosure (e.g., distress, placing burden), and the individual's relationship with them, may factor into whether, and to whom, someone discloses a history of self-injury (Armiento et al., 2014; Mirichlis et al., 2022; Simone & Hamza, 2020).

Whilst existing literature has provided valuable insight into factors associated with disclosing NSSI, relatively little is known about what considerations inform the *decision* to voluntarily disclose one's experience of self-injury, or how these factors may be prioritised in the decision to disclose (Simone & Hamza, 2020). The Disclosure Decision-Making (Greene, 2009) and Disclosure Processes models (Chaudoir & Fisher, 2010) outline key factors that could be important in this regard. In these models, it is proposed that before deciding whether to share sensitive personal information individuals evaluate: aspects of the information itself (including potential stigma, course of the behaviour, visibility); who to tell and why (e.g., the information is relevant to them, nature of the relationship); their own self-efficacy to disclose the information; and potential outcomes or goals of the disclosure (Chaudoir & Fisher, 2010; Greene, 2009). This cognitive decision-making process is seen as integral in the disclosure of personal information, and may also underlie the decision to disclose a history of NSSI (Mirichlis et al., 2022). However, this approach and the importance of the factors within these models to the decision to disclose self-injury are yet to be investigated.

Beyond those outlined in the above models, several other factors may be relevant to decision-making concerning NSSI disclosure, including NSSI-related factors (e.g., visibility of scars), interpersonal factors (e.g., trust), reasons for disclosure (e.g., seeking help) and/or

expectations of disclosure, (e.g., experiencing stigma; Simone & Hamza, 2020). Understanding what individuals consider to be important to the decision of whether to disclose NSSI could aid in supporting individuals navigating disclosures, across social (e.g., to friends and loved ones) and more formal contexts (e.g., clinical settings, workplaces).

Following the above, we examined the relative importance of factors such as stigma, NSSI experiences, disclosure self-efficacy, relationships, and expectations and goals of disclosure in the decision of whether to disclose NSSI to different people. We hypothesised that stigma-related factors, the perceived visibility of one's NSSI, and factors related to support seeking would be rated amongst the most important factors to the decision to disclose NSSI (Simone & Hamza, 2020). We also predicted that the importance of factors would vary depending on the prospective disclosure recipient; for example, we expected that concerns about how the disclosure might impact the recipient or the individual's relationship would be less important when disclosing to a professional, compared to when disclosing to a friend.

## Materials and Methods

### Participants

A priori power analyses indicated that a sample size of at least 147 participants would be required to detect a medium sized effect (Faul et al., 2007). The sample comprised 371 individuals in Australia with lived experience of NSSI, 89 of whom were university students who received credit points for participation. The majority of the sample identified women (80.6%), 7.5% identified as men, and 11.9% identified as another gender, commonly non-binary. The age of participants ranged from 17 to 72 years ($M = 23.94$, $SD = 6.33$). The majority (87.33%) of the sample were born in Australia, with 4.0% identifying as Aboriginal or Torres Strait Islander. The majority of the sample (79.8%) indicated having at least one mental illness diagnosis, with the

three most commonly reported diagnoses being related to depression ($n = 202$), anxiety ($n = 196$), and post-traumatic stress ($n = 80$).

**Measures**

*Demographics and Mental Illness*

In the first block of questions, participants were asked about their age, gender identity, country of birth, and whether they identified as Aboriginal or Torres Strait Islander. Participants were also asked to indicate whether they had any mental illness diagnoses and if so what the diagnosis was, as well as whether they had ever sought professional help (and from whom) for their mental health.

*NSSI*

After confirming that they had a history of self-injury, participants were asked the number of times that they had self-injured within the last year. The Inventory of Statements About Self-Injury (ISAS; Klonsky & Glenn, 2009) was used to assess which methods of NSSI participants had engaged in and which (if any) of these were their primary form of self-injury; the ages at which they first and most recently self-injured; whether they experience physical pain when they self-injure, and whether they are alone when they self-injure. Good test-retest reliability has been established for this part of the ISAS ($r = 0.85$; Klonsky & Olino, 2008). Participants were asked whether they had ever sought professional help for self-injury before being presented the second section of the ISAS which assesses NSSI functions on a scale from 0: not relevant to 2: very relevant. Good test-retest reliability and internal consistency has been demonstrated for the function subscales ($r = 0.60\text{-}0.82$, $\alpha = 0.80\text{–}0.87$; Glenn & Klonsky, 2011; Klonsky & Glenn, 2009); in the current sample Cronbach's alpha for intrapersonal functions was $\alpha = .63$ and for interpersonal functions $\alpha = .76$.

*Disclosure Experience and Decision-Making*

Participants were asked whether they had ever voluntarily disclosed their self-injury to another person face-to-face, and if so to whom (i.e., friend, family member, significant other, health professional, or other). All participants were then presented with a range of factors (see Appendix I) informed by previous NSSI disclosure literature (e.g., Simone & Hamza, 2020) and broader models of disclosure of personal information (Chaudoir & Fisher, 2010; Greene, 2009). These factors were conceptualised as "Considerations about NSSI" including stigma, course, and visibility; "Self-Efficacy" to disclose; "Interpersonal" considerations (e.g., relationship quality); and "Reasons/Expectations of Disclosure", such as seeking professional help, or expecting a particular reaction (Chaudoir & Fisher, 2010; Greene, 2009; Simone & Hamza, 2020). Each factor was rated on a scale from 0 = not at all important to 100 = extremely important to the decision to disclose NSSI, and rated separately for disclosure to friend, family member, significant other, and health professional. The use of these relationship types was informed by existing NSSI disclosure literature (Simone & Hamza, 2020). If participants had never disclosed their NSSI, they were asked to imagine how important each factor would be to that decision.

**Procedure**

Upon gaining ethical approval the study was advertised via a university student research participation pool and social media pages. Participants recruited via the university pool were granted course credit. The advertisements linked individuals to the online survey on Qualtrics; here they were presented further information about the study and provided informed consent to participate. The survey took approximately 30 minutes to complete. At the end of the study, participants were debriefed and provided resources and contacts for support services.

**Analyses**

A mixed-model ANOVA was used to investigate whether the decision factors differed in importance, that is, whether this importance differed across relationship type in general, and

whether importance of each factor differed across relationship types. Post-hoc ANOVAs were used to investigate the nature of significant interactions. Given the number of comparisons, a conservative alpha level of .01 was used for these post-hoc analyses (Streiner, 2015).

## Results

### NSSI Characteristics

The average age at NSSI onset was 13.83 years ($SD = 3.56$), with the highest reported age of onset being 40 years. The majority of participants (71.43%; $n = 265$) had self-injured at least once in the past year, with 150 of these individuals reportedly self-injuring at least five times in this timeframe. The three most commonly reported methods of self-injury were; cutting ($n = 311$), self-battering ($n = 220$), and severe scratching ($n = 212$). The most strongly endorsed function of NSSI was affect regulation ($M = 4.97$, $SD = 1.20$).

### Recipients of Disclosure

The majority of the sample (81.2%) reported that they had previously disclosed their self-injury to at least one person and 42.0% indicated having previously sought professional help for NSSI specifically (compared to 88.4% who sought professional help for mental health difficulties generally). Of these disclosures, 63.6% were to friends, 54.7% were to health professionals, 47.7% were to one's significant other, 34.0% were to family members, and a further 5.1% were to other recipients such as, strangers, people in their workplace, and teachers[1]. Psychologists/therapists ($n = 87$), psychiatrists ($n = 48$), and medical doctors including specialists ($n = 72$) were amongst the most commonly disclosed to health professionals, though disclosures to counsellors ($n = 24$), nurses ($n = 10$), and other allied-health workers ($n = 2$) were also reported.

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[1] Note that the sum of these percentages exceeds 100 as people could report multiple disclosures.

**Main Effects of Variance of Importance**

Given within group variance was not equal for each group of disclosure recipients, the Huynh-Feldt Epsilon was used when interpreting main effects. There was a main effect of the importance of the various factors to the decision to disclose NSSI regardless of whom the disclosure would be to, $F(25.96, 38415.14) = 118.324$, $p < .001$, partial $\eta^2 = .074$. On average, the factor rated most important was relationship trust ($M = 78.59$, $SD = 30.04$); rated least important was expecting the relationship with the person to be positively impacted by the disclosure ($M = 40.70$, $SD = 34.17$). There was a between-groups effect such that, on average, the factors considered important differed across recipients of disclosure regardless of decision factor ($F(3, 1480) = 22.89$, $p < .001$, partial $\eta^2 = .044$). Yet, there was a significant interaction effect, indicating that the importance of individual factors to the decision to disclose NSSI differed depending on whom the disclosure would be to, $F(77.87, 38415.14) = 29.119$, $p < .001$, partial $\eta^2 = .056$.

**Post-hoc Comparisons of Importance across Disclosure Recipients**

The interaction effects ($\alpha = .01$) show the way that the importance of the factors differ across relationship types. These effects highlight the variability in importance of factors across relationship types (see Appendices I and J). All factors significantly differed by relationship type, apart from: being seen engaging in NSSI ($F(3, 1480) = 2.01$, $p = .110$, partial $\eta^2 = .004$), being confident in one's own knowledge to answer questions about NSSI ($F(3, 1480) = .106$, $p = .957$, partial $\eta^2 = .000$), having previously disclosed mental health difficulties ($F(3, 1480) = 1.741$, $p = .157$, partial $\eta^2 = .004$), confidence in being able to disclose NSSI ($F(3, 1480) = 3.788$, $p = .010$, partial $\eta^2 = .008$, having wounds seen ($F(3, 1480) = 2.694$, $p = .045$, partial $\eta^2 = .005$), and feeling they had recovered $F(3, 1480) = 3.162$, $p = .024$, partial $\eta^2 = .006$.

Of the 38 factors that differed by relationship type, 36 featured a difference between a health professional and other relationship types. For example, whilst amount of trust in the relationship was rated most important overall, when compared to the other relationship types the rating for this factor for health professionals was the lowest ($M = 71.17$, $SD = 31.88$). A similar trend can be observed for other interpersonal factors. In contrast, seeking tangible aid as a reason for disclosure was more important when disclosing to health professionals. For example, "wanting to seek professional help" was rated higher when disclosing to health professionals ($M = 77.63$, $SD = 30.04$) compared to disclosing to the other relationship types (overall $M = 59.46$, $SD = 35.07$). Though there were differences in importance of the factors amongst the social relationships (friends, significant other, and family), the only factor to differ between all four relationship types was: "Knowing whether this person has also self-injured". This factor was most important when considering disclosing to a friend.

Whilst friends and significant others were the most similar of the groups, the mean importance did differ on six factors. Seeking professional help, intensity of the NSSI, relevance of their NSSI to the disclosure recipient, the prospect of telling the recipient before they otherwise found out about their self-injury, and the impact of not telling this person were rated as being more important to the decision to disclose to a significant other compared to a friend. In contrast, knowing that the disclosure recipient had also self-injured was considered to be more important when disclosing to a friend, than to a significant other. The most important factor when considering disclosing to a friend was the quality of the relationship ($M = 82.94$, $SD = 24.98$), for family it was wanting to conceal their NSSI ($M = 78.47$, $SD = 30.41$), and for significant others it was the amount of trust in the relationship ($M = 83.19$, $SD = 27.99$).

**Discussion**

The aim of this study was to assess the relative importance of factors considered in the decision of whether to voluntarily disclose a history of NSSI to friends, family members, significant others, and health professionals. The factors investigated were drawn from NSSI disclosure literature as well as theoretical accounts of disclosing personal information (Chaudoir & Fisher, 2010; Greene, 2009; Simone & Hamza, 2020). Gaining a better understanding of how such considerations may be prioritised when disclosing to different people could hold implications for how disclosures may be better responded to in both social and formal contexts.

Although all factors were rated as important (with several factors not significantly differing across disclosure recipients) for the most part the extent of importance did vary. This suggests individuals make different cognitive evaluations as part of navigating whether they would disclose NSSI with a particular person, consistent with models of disclosure of personal information and recent NSSI disclosure research (Chaudoir & Fisher, 2010; Greene, 2009; Mirichlis et al., 2022). For example, an individual may be more inclined to disclose to someone with whom they have a highly trusting relationship, regardless of whether other people already knew about their self-injury. Given the complexity of NSSI disclosure, understanding what individuals consider to be important to the decision to disclose NSSI and eliciting what is relevant when disclosing to different people could be helpful in guiding individuals with lived experience of NSSI through the decision-making process, potentially leading to better outcomes of disclosure.

Given the formal nature of therapeutic relationships, it is perhaps unsurprising that the importance of factors when disclosing to health professionals tended to differ the most as compared to the other relationship types. Specifically, factors of most importance to disclosing to

health professionals reflected tangible help, including provision of medical care and changes in NSSI (e.g., desire to stop self-injuring). It may be that individuals expect that as "professionals", these disclosure recipients should be able to help without stigma or judgement (although this has previously been identified as a barrier to formal disclosures, e.g., Long, 2018), particularly given that the expectation of negative views from others was least important when considering disclosing to health professionals versus other groups. Certainly, previous research has indicated that tangible support can be considered a positive outcome of NSSI disclosure (e.g., Ammerman & McCloskey, 2020; Park et al., 2020).

Interpersonal factors concerned with reactions of the disclosure recipient, the existing quality of the relationship with them, and the potential impact the disclosure could have on the relationship were perceived to be most important when considering disclosure within personal relationships, as compared to disclosing to health professionals. Indeed, individuals may be less inclined to anticipate relational implications in the latter, perhaps due to having less of a personal and more of a formal connection with professionals. In contrast, it is understandable that potential reactions and impacts on one's relationships were considered more important when considering disclosure to a recipient known personally to an individual. Such disclosures could potentially lead to day-to-day disruptions in the person's life and their relationships (Simone & Hamza, 2020).

There were also some differences amongst the three personal relationship types. For example, though there was a similar pattern of findings for both friends and significant others, factors concerned with help-seeking and the importance of the recipient knowing about the individual's self-injury were considered to be more important when disclosing to the latter. Arguably this may be expected if one assumes that a relationship with one's significant other is of a romantic nature and thus more intimate than that of a friend. Therefore, a significant other

learning about their partner's NSSI could hold deeper implications for their relationship than those of a platonic relationship (e.g., Simone & Hamza, 2020). This finding further highlights that not all NSSI disclosures should be approached in the same way, reflecting recent person-centred perspectives concerning self-injury experiences (e.g., Lewis & Hasking 2021).

**Implications**

The current findings offer insights into how correlates of NSSI disclosure may be prioritised when deciding whether to share one's experience of self-injury. This potentially indicates that cognitive processes are involved in disclosure decision-making as suggested by disclosure theorists (Chaudoir & Fisher, 2010; Greene, 2009). Given that key elements of these theories (e.g., interpersonal factors) appear relevant to disclosure of NSSI, the application of such models to understanding NSSI disclosure could be further explored in future research.

Additionally, it is possible that disclosing to different people could serve differing functions given the variability in importance of factors across groups. For example, a health professional may be preferentially sought for tangible aid whilst a friend may be disclosed to for social support. As such, aligning the response to a NSSI disclosure given one's relationship with the individual and the reason for them sharing this information is important in order to meet their needs and to not discourage further disclosure (Simone & Hamza, 2020). That is to say that the findings are indicative of taking a person-centered approach to NSSI disclosure. In other words, the person sharing their lived experience is placed as the expert of this experience and that when in doubt of the reason for a NSSI disclosure and/or how to respond, recipients should enquire respectfully (Lewis & Hasking, 2021).

Following the above, our findings may provide a first step toward informing the development of resources (e.g., guides, infographics) and other means of support that can be tailored to navigating disclosures to different recipients. In particular, the findings highlight the

pragmatic role clinicians could play in supporting clients with lived-experience of self-injury. For example, the way that clinicians should respond to NSSI disclosures (i.e., non-judgmental, providing requested tangible aid), in addition to collaboratively mentoring their client in navigating disclosures to others, is in line with person-centered practice recommendations (e.g., Lewis & Hasking, 2019).

**Limitations and Future Research**

There are some limitations to bear in mind when considering the findings of this research. For instance, this study used exclusively self-report cross-sectional ratings from a non-clinical sample in which participants were asked to rate the importance of the factors in a hypothetical decision to disclose to different parties in a face-to-face setting. It is plausible that the relative importance of factors may differ between actual face-to-face and other disclosure contexts, such as disclosing to someone online (Frost et al., 2016). Disclosure considerations could also differ across the demographics of those disclosing; the current sample was largely homogenous (e.g., predominantly young, Caucasian, female) and as such could not capture other potential factors that may be important to more diverse samples. Future research is needed to extend current understandings to different samples and explore the extent to which, and how decisions to disclose NSSI may vary (e.g., across cultures, age-groups, in clinical samples). Whilst this study provides preliminary considerations for disclosing NSSI to different people, future research could explore motivations for disclosure across contexts (e.g., in emergency rooms). Similarly, as even infrequent NSSI has been associated with increased risk for adverse outcomes such as suicidality (Whitlock et al., 2013a), future research should explore how people's NSSI history (e.g., frequency, medical severity) affects disclosure decisions. Furthermore, we present the average relative importance of factors, which may not reflect how and what considerations might be prioritised in the decision to disclose for a particular individual, in a given situation. Finally, we

recognise that factors other than those we examined may play a role in the decision to disclose NSSI; hence, there may be merit in asking people with lived experience of NSSI what they view as important to disclosure via more open-ended (e.g., interview) approaches (Lewis & Hasking, 2021).

**Conclusion**

The present study offers initial insight into the importance of a range of factors to the decision of whether to disclose NSSI in informal (e.g., friends) and formal (e.g., health professionals) settings. Notably, there may be unique considerations in particular disclosure contexts. In this way, the present findings set the stage for several theoretical and empirical implications for how NSSI disclosure manifests, which, in turn, can inform efforts to work toward appropriate and effective responding to individuals with lived experience.

**Chapter 7: Exploring Voluntary Disclosure of NSSI: A Thematic Analysis**

**Introduction to Chapter 7**

From the preceding studies of this thesis, a sense of the experience of disclosing NSSI in research, factors associated with NSSI disclosure broadly, and the relative importance of a breadth of considerations to the decision to disclose NSSI have been identified. Moving beyond the mere decision of whether to disclose NSSI, in the following study we sought lived-experience perspectives into the *process* of NSSI disclosure decision-making. The aim of this study was to complement the evidence and theoretically informed findings of the preceding chapters, with an inductive, lived-experience driven approach.

A Revise and Resubmit for this study has recently been submitted to a peer-reviewed journal. The supplementary materials of this paper and a copy of the ethical approval for the data used in this study, a copy of the interview guide used in this study, and excerpts from the audit trail are provided in Appendices K, L, and M.

**Authorship**

All signed authors acknowledge that the below table is an accurate representation of each person's contribution to this research output.

| Author | Contribution | Acknowledgement |
|--------|-------------|-----------------|
| Sylvanna Mirichlis | Development of research question, data collection, data management, data analysis, interpretation of findings and discussion, | |

| | manuscript preparation, reviewing and editing of drafts. | |
|---|---|---|
| Stephen P. Lewis | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Mark Boyes | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Penelope Hasking | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |

**Abstract**

**Background.** Voluntary disclosure of NSSI refers to instances when an individual chooses to share with another person that they have self-injured. **Aim.** The aim of this qualitative study was to explore lived experience perspectives of the decision to voluntarily disclose NSSI. **Method.** Fifteen semi-structured interviews were conducted with university students who were aged between 18 and 25 ($M = 20.33$, $SD = 1.88$), with 11 identifying as female. All participants had previously disclosed their NSSI to at least one other person. The interview transcripts were analysed using reflexive thematic analysis. **Findings.** Several themes were identified including: The Value of Trust in Disclosure, Context Matters- The Where, Me, and Who of NSSI disclosure, Why Disclose?, Overcoming Barriers, Selective Sharing, and Perceptions of Disclosure. **Conclusion.** The findings of this study highlight the multifaceted and ongoing nature of voluntary NSSI disclosure decision-making.

*Keywords*: disclosure, self-injury, thematic analysis, qualitative analysis, NSSI

**Introduction**

Non-suicidal self-injury (NSSI) or the deliberate damage to one's own body without the intent of ending one's own life encompasses a range of behaviours that are not socially sanctioned (International Society for the Study of Self-Injury, 2022), including but not limited to, cutting, burning, and scratching the skin (Swannell, et al., 2014). The onset of self-injury typically occurs during adolescence, with a second peak onset period identified in young adulthood coinciding with the age of many university students (Gandhi et al., 2018; Plener et al., 2015). Lifetime prevalence of NSSI is estimated to be 5.5% amongst adults, 13.4% amongst young adults (up to 25 years of age), and 17.2% amongst adolescents; Swannell et al., 2014). Emotion regulation is a key function of NSSI, with the behaviour being associated with a host of mental health difficulties including anxiety and depression; furthermore, NSSI is associated with later suicidal thoughts and behaviours (Fox et al., 2015; Kiekens et al., 2016; Klonsky et al., 2014; Taylor et al., 2018). Given these negative experiences associated with NSSI, an individual may disclose their history of self-injury as a means of seeking support (Simone & Hamza, 2020).

Disclosure of one's self-injury can take various forms, including instances when individuals voluntarily choose to disclose to a given recipient, as well as involuntary discovery (e.g., observing an individual's self-injury scarring; Simone & Hamza, 2020). In exploring the decision to voluntarily disclose one's NSSI experiences, the potential benefits of a disclosure can be considered. For example, NSSI disclosure in a therapeutic context could prompt intervention and support where necessary, potentially addressing the negative outcomes associated with NSSI (Turner et al., 2014). Beyond the clinical utility of disclosing NSSI, feeling comfortable to be open about one's NSSI experiences rather than concealing and self-shaming their experience could foster feelings of authenticity and empowerment for an individual (Burke et al., 2019).

Additionally, NSSI disclosure may help initiate support provision in social contexts such as from friends and romantic partners (Simone & Hamza, 2020).

Despite the potential benefits of disclosing NSSI, negative expectancies and experiences have been reported (Simone & Hamza, 2020). Poor responses to NSSI disclosures (e.g., rejection) can inform experiences of shame and anticipation of further negative outcomes for many people with lived experience of NSSI. Such stigma may contribute to an ambivalence towards, if not outright reluctance to disclose self-injury (Simone & Hamza, 2020). Evaluating both the potential impacts and benefits of disclosing one's NSSI presents decisional cross-roads for individuals with lived experience of NSSI; such a dilemma is reflected in broader frameworks of disclosure decision-making for personal information (e.g., Greene, 2009; Chaudoir & Fisher, 2010). In frameworks such as Greene's (2009) and Chaudoir & Fisher's (2010) processes by which individuals may decide to disclose stigmatised information are proposed. The disclosure of stigmatised experiences has been extensively investigated in the literature, including that of disclosing one's sexuality and gender identity (Sahoo et al., 2023). Further, the stigmatisation and disclosure of mental health difficulties has been long considered (e.g., Goffman, 1963), informing a recent framework of NSSI stigma (Staniland et al., 2020).

Whilst Simone et al. (2022) have discussed contextual factors, previous experiences, and support seeking informing the decision to disclose NSSI specifically, still relatively little is understood about antecedents to NSSI disclosures, including motivations for sharing one's NSSI experience and the decision-making process involved therein (Mirichlis et al., 2022; Simone & Hamza, 2020). In this qualitative study we have sought to deconstruct the ambivalence towards disclosing NSSI by aiming to explore lived experience perspectives of the decision to voluntarily disclose their NSSI.

**Method**

**Participants**

The sample comprised 15 participants who had lived experience of NSSI and of voluntarily disclosing this experience to at least one person. Of these, nine were recruited via the university's research participation pool and were reimbursed with course credits. The remaining six were contacted via email as they had previously indicated interest in participating in research studies after initially being recruited from the university pool; these participants received a gift-card to thank them for their time. The sample was 73.33% female ($n = 11$; male $n = 4$) and were aged between 18 and 25 years ($M = 20.33$, $SD = 1.88$). All participants were Australian university students.

**Procedure**

After gaining ethical approval, individuals who expressed interest in participating in the study were sent an information sheet. Interviews were conducted either in a quiet room on the university campus ($n = 12$) or online, according to mutual convenience and Coronavirus government restrictions at the time of the study. The interviews ranged from 30 minutes to up to an hour long. Participants read the information sheet and had the procedure verbally summarised for them, before providing informed consent. The semi-structured interview involved participants reflecting on their expectations in anticipation of previously disclosing their NSSI experiences, including how outcomes of earlier disclosures informed their approach to later disclosures (see Table 3 for a summary of questions asked).

**Table 3**

*Core Interview Questions and Probes*

| | |
|---|---|
| **Prior to disclosure** | 1. Were they the first person you talked to about your self-injury?<br>    A. As far as you know does this mean they were also the first person to know about it?<br>    B. If not, was other people knowing a contributing factor to you telling this person?<br>2. Could you tell me a bit about what your relationship with this person was like prior to them learning about your experience with self-injury?<br>3. What prompted your decision to disclose your self-injury?<br>    A. Were there any specific reasons why you wanted to talk to this person in particular about it, rather than talking to somebody else?<br>4. Was there anything that made you hesitant at first to disclose your self-injury to this person?<br>    A. How did you overcome this/what changed your mind?<br>5. What were you expecting to happen when you told this person?<br>    A. What other thoughts or feelings did you have right when you were about to tell this person?<br>    B. What were you hoping would happen?<br>    C. Why do you think this is? |
| **During disclosure** | 6. Can you briefly describe the situation to me?<br>    A. What was going through your mind? |
| **After disclosure** | 7. Now thinking about any potential outcomes of this disclosure experience, how did you feel after this interaction?<br>    A. Have you talked to other people about your self-injury since this disclosure experience?<br>        a. Do you think this experience impacted your decision of whether to talk to other people about it? Why/not? |

*Note.* Given the semi-structured nature of interviews, specific questions and order of these questions may vary. Questions may have been repeated in the context of different disclosure experiences.

At the close of the interview participants were provided with debriefing information including contacts for emotional support and information about NSSI. All interview recordings were later transcribed verbatim, with the de-identified transcripts being stored securely, and audio recordings destroyed.

**Analysis, Rigour, and Positionality**

The authors of this paper are based in Australia and Canada, with their collective 55 years of experience in the field of NSSI research. We adopt a person-centred and strengths-based approach to understanding NSSI and engage with those who have lived experience throughout our research practice.

We adopted a critical-realist epistemology when engaging in an inductive reflexive thematic analysis (Braun & Clarke, 2006; Braun & Clarke, 2022; Clarke et al., 2015). In adopting this position, we assumed that knowledge is socially constructed (e.g., by way of evolving interpretations of events by participants and by us as researchers) and that this knowledge can be logically and empirically investigated (Sullivan, 2010). Thus, this positioning also reflected our overall aim to contribute to an evidence base of understanding voluntary NSSI disclosure from the view of people with lived experience. In terms of informing our analytical process, we have taken participants' individual accounts as true, whilst we make interpretations across cases.

Thematic analysis was engaged in inductively by the first author to explore participants' decision to disclose NSSI following existing guidelines, outlined below (Braun & Clarke, 2006; 2022; Clarke et al., 2015). Processes of rigour were informed by Levitt et al. (2018) and included: seeking and incorporating feedback from members of the authors' research group iteratively throughout the project; engaging with Braun and Clarkes' (e.g., 2022) recommendations for thematic analysis; member-checking from participants of their individual transcripts; reflexive practice including the use of journaling; and maintaining an audit trail (see Appendix M). As

recommended by Berger (2015), a reflexive journal was used to detail the first author's positioning relative to the research topic, including reflection on their assumptions and reactions to what participants shared throughout their interviewing and analytical process. Given the iterative nature of this research, the audit trail maintained by the first author acted as a record of the key decisions made throughout the study. For example, the trail includes records of the organisational process when generating themes, and drafts of the interview guide questions. Reference back to the audit trail supported the analytical process as the first author was able to reflect back on earlier notes and decisions that informed emergent findings.

### *Engagement with Braun and Clarke's Recommendation for Reflexive Thematic Analysis*

**Phase 1: Familiarisation.** To familiarise themself with the data, the first author transcribed, and carefully read and re-read the transcripts, engaging in reflexive journalling and note-taking throughout. Notes were made of observations within and across transcripts.

**Phase 2: Coding and Generating Initial Themes.** Having already generated initial ideas, the first author commenced paper-based open-coding. Coding in thematic analysis refers to the practice of identifying data that is of interest to the research question (Braun & Clarke, 2022). Thematic analysis coding can be conducted a multitude of ways such as using digital software (e.g., NVivo), via spreadsheets, or with pen and paper. Paper-based coding was utilised in this study due to the first author's familiarity with this approach and the closeness it can afford with the data (Mattimoe et al., 2021). Codes were defined as the smallest units of meaning related to the research question, for example the code "Shared Understanding" refers to how having a mutual understanding of NSSI/mental wellbeing was a factor in why some participants disclosed their self-injury to that person. Throughout this process the first author noted preliminary descriptions of each code and recorded observations as to which codes were similar and

contrasting. The coding process was continuously reflected on with the co-authors, peers engaging in their own thematic analyses projects, and by way of journaling.

These codes were then organised into initial superordinate themes such that, themes, for example, "Context Matters- The Where, Me, and Who of NSSI Disclosure" are the product of thematic analysis which revolve around a central idea that contributes to addressing the research question. In doing so, notes were reviewed to gain a better sense of how the codes might fit together thematically. Taken together, this process generated the initial thematic map whilst working to condense the data in a meaningful way and facilitating iterative practice.

**Phase 3: Reviewing, Naming, and Defining Themes, and Writing-up.** The thematic map was drafted with proposed themes and subthemes informed by preliminary descriptions of each. This iteration of the thematic map and preliminary descriptions of each component were reviewed and discussed amongst all co-authors and revised as needed to enhance cohesion. In consideration of Clarke et al.'s (2015) discussion of reporting thematic analysis findings as part of the analytical process, we have integrated examples of how our findings are situated in the existing literature. Similar approaches presenting thematic analysis findings have been used in prior NSSI research (e.g., Rosenrot & Lewis, 2020). Similarly, we have focused on exploring which aspects of disclosure decision-making were discussed by people with lived experience of NSSI, rather than attempting to quantify the findings, as the latter approach would not align with the aim of thematic analysis (Braun & Clarke, 2006).

## Findings and Discussion

### Preliminary Findings: Nature of Disclosure Experiences

Participants recounted diverse disclosure experiences. Rather than NSSI disclosure being a single occurrence, participants' descriptions reflected a dynamic process whereby multiple disclosures unfolded over-time and to multiple people, as well as some reciprocal disclosures.

Whilst some disclosures were verbalised either as initiated by the individual or in response to being asked whether they had self-injured or about their well-being generally, others were non-verbal (e.g., being prompted due to visible scarring). Such instances reflect the dissensus in defining "voluntary", as compared to "non-voluntary" disclosure, as though it could be argued that being prompted to disclose one's self-injury may undermine one's agency over when and how to share such information, ultimately such a disclosure can still be made willingly (i.e., being prompted to disclose though without coercion). Indeed, such semantics have been the topic of debate in the field of NSSI disclosure research (Simone & Hamza, 2020). In terms of the discourse of the participants' disclosure experiences, at times specific details of their self-injurious behaviour, such as their primary method or reason for self-injuring were discussed, whilst at other times conversations transitioned to situational stressors and mental health more broadly. Six themes were identified regarding addressing the decision-making process leading to such disclosure experiences. Whilst the themes (and associated sub-themes) can each be distinguished from one another, they are, to some extent, inextricably linked. The themes are depicted in the thematic map of Figure 3, with the majority of the themes informing the central theme of "Perceptions of Disclosure". Taken together, these findings illustrate the complexity inherent in NSSI disclosure. The themes and subthemes have been summarised below in Table 4.

**Table 4**

*Summary of Themes and Subthemes*

| Theme name | Theme/subtheme description |
|---|---|
| *Theme 1: The Value of Trust in Disclosure* | This theme captures the value of trust and how this can inform NSSI disclosure decision-making. |
| *Theme 2: Context Matters- The Where, Me, and Who of NSSI Disclosure* | This theme captures considerations regarding the context of an NSSI disclosure, and how this may inform disclosure decision-making. |
| Subtheme: Immediate Setting | In this subtheme participants' regards for the setting within which a disclosure was to occur are discussed in relation to NSSI disclosure decision-making. |
| Subtheme: Individual Considerations | In this subtheme considerations relevant to the individual disclosing and their experiences of self-injury are discussed in relation to NSSI disclosure decision-making. |
| Subtheme: Relational Factors | In this subtheme considerations regarding the person being disclosed to and their relationship with the person who has lived experience of NSSI are discussed. |
| *Theme 3: Why Disclose?* | This theme captures the reasons prompting NSSI disclosures and the expectancies that those with lived experience have of disclosing their NSSI. |
| Subtheme: Seeking Support and Marking Distress | In this sub-theme the concept of disclosing NSSI to seek support and/or to indicate distress is explored. |
| Subtheme: Sharing Authentically | In this subtheme the prospect of being open about one's NSSI and the authenticity this offers is discussed. |
| Subtheme: Helping Out | In this subtheme, the notion of disclosing one's NSSI in order to help other people is explored. |
| *Theme 4: Overcoming Barriers* | This theme captures the barriers that may be overcome in order to disclose NSSI. |
| Subtheme: Facing Fears | In this subtheme the fear and/or anxiety that may precipitate a NSSI disclosure is discussed. |
| Subtheme: This Time It's Personal | In this subtheme, the personal nature of NSSI and the challenge this presents to disclosure is explored. |
| Subtheme: It's Hard to Say | In this subtheme the notion of disclosure self-efficacy, or lack thereof is explored. |
| *Theme 5: Selective Sharing* | In this theme the ongoing nature of NSSI disclosure is discussed, such that previous disclosures may inform future disclosure decisions. |

| | |
|---|---|
| Subtheme: The Past Facilitating the Future | This subtheme captures instances wherein helpful disclosure experiences may encourage future NSSI disclosures. |
| Subtheme: A Learning Curve | In this subtheme, the apprehension towards disclosing NSSI again in the future after a poor experience is discussed. |
| *Theme 6: Perceptions of Disclosure* | In this theme, the way in which the aforementioned considerations inform ideas about NSSI disclosure is explored. |
| Subtheme: Degree of Pre-Planning | In this subtheme, the extent to which individuals may pre-plan their voluntary disclosure of NSSI is examined. |
| Subtheme: Normalcy of Disclosure | In this subtheme, the degree to which individuals consider NSSI disclosure to be the norm and the way in which this interpretation informs their approach to disclosure is discussed. |
| Subtheme: Degree of Separation | In this subtheme, preferences for closeness and connection as opposed to disclosures being distinct from individuals' personal lives are contrasted. |

*Theme 1: The Value of Trust in Disclosure*

As one might expect for any behaviour, the value systems of participants partially informed how individuals approached disclosing their self-injury (Ponizovskiy et al., 2019). Specifically, participants' value of trust permeated their disclosure decision-making. In some instances, this reflected a general trust in the disclosure recipient: *"you have to find someone that you trust, as I said trust is very important" –P2*. This valuing of trust reflects findings from Simone et al.'s (2022) study in which interpersonal trust, and similar values, were also discussed as facilitators of NSSI disclosure. This value for trust also manifested in trust that others would facilitate individual with lived experience's own agency and autonomy:

> *I was worried about what he would do in the future, like is he going to force me to go to like some sort of like counselling or whatever, because at the time I was really reluctant to get help. I didn't want to speak to anyone about it. I didn't want to go see someone or anything like that... -P15*

Furthermore, the importance of tailoring responses to the individual whilst respecting their autonomy echoes considerations leading up to NSSI disclosures in prior research (Park, et al., 2020; Rosenrot & Lewis, 2020; Simone et al., 2022). For example, one participant expressed:

> *No, I think it's very different for each thing. Some people like being comforted and having someone to be like, "it's okay" but I hate that - I hate people feeling sorry for me, it's so weird I just laugh and so I think it just depends on the person. I have friends who really like, like I sit there and say "it's okay" and comfort them and tell them it's going to be fine and that it sucks right now but I don't want to hear that. -P6*

As such, an individual may feel more inclined to disclose their self-injury if they anticipate that their trust is upheld. Consideration of the context surrounding a potential disclosure may inform this appraisal.

*Theme 2: Context Matters- The Where, Me, and Who of NSSI Disclosure*

Participants shared that the context in which they disclosed their NSSI played a role in their decision to share their experiences. Three key contextual factors were identified: the setting of the disclosure, factors specific to the individual disclosing and the nature of their self-injury, and the factors of their relationship that were perceived as relevant to the decision to disclose.

**Immediate Setting.** Various settings for NSSI disclosures were mentioned by participants, both in terms of physical locations (e.g., schoolgrounds) and other contextual considerations (e.g., group-based settings, cultural spaces). The consideration of such factors in personal information disclosure have not typically been examined either theoretically (Chaudoir & Fisher, 2010; Greene, 2009) nor empirically (Simone & Hamza, 2020), hence these findings provide insight into what settings may be conducive to disclosing NSSI. Of note, aside from disclosures to health professionals, much of the disclosure settings were relatively public despite confidentiality being of importance (Theme 1). One participant reflected on this paradox:

> *Even though the psychologist room is a safe space, what you're telling her probably isn't going to go anywhere, it's funny because it's like why did I feel more comfortable telling my best friend under a staircase than I did telling my psychologist in a closed sealed room?- P5*

**Individual Considerations.** There were also considerations specific to the individual and their experience of NSSI which were of relevance to disclosure experiences. Notably, though all participants were tertiary students at the time of being interviewed most disclosures were recounted from their adolescence. Some participants offered reflections of the unique complexities of disclosing NSSI at that time, including requiring adult assistance to gain access to support services, in turn raising the additional dilemma of whether to disclose to parents and other key adult figures in their life. For example, some participants reflected on the

inaccessibility of professional help without adult assistance, as the Australian healthcare system requires a referral from a general practitioner to access a psychologist, incurring costs and transportation barriers (National Mental Health Commission, 2021). Although, disclosure to a similar-aged peer may initially circumvent these barriers, participants were mindful that disclosure to peers could eventuate in forward disclosures to recruit further support as their peers may have felt ill-equipped to independently provide support:

> [*Disclosures are] a lot more constructive now I think because we're older it's easier to have access and be more open about things you can do to help yourself compared to when you're a teenager - everything is so much weirder and harder so when I was actually self-[injuring] that was really tough feeling like you could tell this one person who's your partner and they're 15 as well, they could tell other people as well and it's like "great nothing good is coming out of this, you're stressed, I'm upset. -P7*

Individual experiences of self-injury informing decisions to disclose were sometimes discussed. Indeed, factors such as the severity and main form of one's NSSI have previously been associated with NSSI disclosure (Ammerman et al., 2020; Mirichlis et al., 2022). Findings identified in this study provide insight into what may underly these correlations. For example, instances of increased frequency at times prompted disclosure, perhaps as a means to help-seeking or harm-reduction as was the case for this participant, *"that's when I properly started telling my friends about what was going on when I was becoming a bit more regular [with NSSI]."-P9*. Similarly, disclosure occasionally occurred soon after self-injury. Conversely, those who had not self-injured for an extended period of time reflected being unlikely to disclose spontaneously unless they felt there were a particular reason to do so, indicating that they perhaps felt that their self-injury was a less relevant aspect of their life at that time.

**Relational Factors.** Participants' relationships with people to whom they disclosed were pertinent in disclosure decision-making. As indicated by one participant, the sense of security offered by relational closeness seemed to facilitate disclosure confidence, *"we were just like best mates. We did everything together and yeah she was definitely a person that I would confide in about things for sure."-P5*. The inverse was true for others, for example when reflecting on why they opted to disclose to a school counsellor rather than a trusted teacher, another participant explained:

> *because I had to see that teacher every day for a year and even after that because we had very specialised teachers so once you were in class you had to go to that class again and again, and I just felt a little bit weird y'know and if I told this person and you know it would just create an awkwardness from my end, not necessarily them so it was just better if I had like a third party and was the counsellor. -P4*

Relatedly, the type of relationship was also taken into consideration, as noted by one individual, who said, *"because they're my parents it's different because they are responsible for me whereas my friend, she is just my friend and it's not like she will do anything about it" -P2*.

The expectation that the disclosure recipient would have an understanding of self-injury or mental health more broadly tended to permeate decisions to disclose NSSI. In formal settings this understanding reflected clinical expertise: *"Knowing that she was a professional, that she dealt with these kind of things before, she was experienced"-P4*. In social relationships this understanding could manifest as mutual lived experience or at least a shared understanding of mental health difficulties:

> *I think one of the things that made it a lot easier to talk to this person about the issues was that I knew that she had some things going on as well, so I guess she was able to*

*empathise more than some other people that I knew were not experiencing the same*

*issues that I had with like family stuff and mental health. -P9.*

This importance of mutual experience and understanding when disclosing in a personal

relationship resembles previous findings (e.g., Hasking et al., 2015; Mirichlis et al., 2023a) and

may reflect an expectation that such a disclosure recipient would not stigmatise NSSI (Simone et

al., 2022).

*Theme 3: Why Disclose?*

In addition to the above, participants drew attention to their pre-disclosure experiences,

including their reasons for and/or expectancies of disclosing their NSSI, though these were not

necessarily mutually exclusive. These findings shed light on what has been an under-researched

aspect of NSSI disclosure research, such that disclosure goals or expectancies may be a point of

consideration for those with lived experience and their support persons when navigating

appropriate approaches and responses to NSSI disclosure (Simone & Hamza, 2020). These

reasons for disclosure are captured in the sub-themes: "Seeking Support and Marking Distress",

"Sharing Authentically", and "Helping Out". In some cases, participants were not always able to

articulate particular reasons for disclosing their NSSI, possibly reflecting a more exploratory

approach to disclosure in which the recipient could play a more instrumental role in directing the

course of conversation and subsequent actions.

**Seeking Support and Marking Distress.** Participants reflected on disclosure offering a

means to communicate their distress to others, with some disclosing their self-injury to seek

support. This support ranged from more generally, *"hoping for understanding and acceptance" -*

*P1*, to tangible means of harm reduction:

*It [NSSI] had been happening for a little while and I knew I had to find a different way to*

*handle these emotions and I had to look to someone who would have given me the correct*

*guidance, could give me advice on what to do, what not to do, would have given me the*

*right course of action. -P4.*

For some, these desired outcomes were contrasted against their values for agency and to not be treated differently, and the reality that no specific disclosure outcome was guaranteed, though they overcame this ambivalence and disclosed their NSSI regardless. One participant gave insight into why they decided to disclose their NSSI despite this ambivalence:

*I just realised that if honestly if I didn't tell someone it would've gotten a lot worse and*

*she was one of my good friends and she will still be my friend after, because we already*

*had a bond it's not like it was a newly built thing, we had been good friends for a while…*

Whilst such ambivalence in NSSI disclosure has previously been noted with regards to the lived experience of NSSI generally (Gray et al., 2023), little further consideration in the context of NSSI disclosure ambivalence had been given prior to the current study.

**Sharing Authentically.** For some the prospect of disclosing their self-injury provided an opportunity to share their experience in a way driven by their own narrative rather than in the words of others. One participant reflected on this authenticity with their self-injury experience being: *"just like what I've experienced in my own personal life experience that I've gone through and that's just a part of who I am and that makes me who I am today".* Such notions of being one's authentic self and self-acceptance seem to reflect strengths-based approaches to self-injury recovery (e.g., Lewis & Hasking, 2021) and lived experience conceptualisations of recovery (Lewis & Hasking, 2021; Meheli et al., 2021), with the current findings providing novel insight into how this authenticity may specifically manifest for those with lived experience of NSSI. This aim of authenticity often intersected with the relevance of the self-injury to the disclosure recipient, particularly within intimate relationships, with hopes to improve such relationships:

*Well, I feel like because I live with him [partner]. I feel like he should know everything about me. There's like nothing I should hide and plus I just feel like I should be able to tell him anything - P14.*

Although the potential of benefitting existing relationships had previously been reported to be somewhat important to disclosure decisions, it was not necessarily a salient consideration as is suggested here (Mirichlis et al., 2023a). In contrast, others were more outspoken in their expression, as illustrated by the participant, *"I didn't hide it when I was at home, it was more of a like in your face attitude like "yeah I self-[injured] what are you going to do about it"." -P8.*

**Helping Out.** Whilst disclosure is often considered in terms of seeking support for oneself (Simone & Hamza, 2020), at times the needs of others outweighed participants' concerns for themselves, with the prospect of helping others prompting some participants to disclose their self-injury. Akin to the self-injury being relevant to the disclosure recipient, some participants expected that sharing their experience could benefit the other party:

*I think almost half of me was like I need to share this load but half of me was like hey if I share this with her she's going to feel less alone and I did know that telling her would build a kind of mateship there of like I knew she would also feel less judged and less awful about herself once I told her" -P5*

One participant expressed hope that sharing their experience could increase the disclosure recipient's awareness of NSSI, hence potentially leading to better outcomes for other people who may disclose to them in the future:

*Everyone [sic] will understand it [NSSI] better…In the benefit for others, they can easily disclose this [NSSI] to them [participant's recipient] and … I am relatively happy that it [supportive disclosure response] actually happened to them instead of me, at least they had a different experience -P1*

Similar hopes were expressed in relation to sharing one's experiences in NSSI research, *"I've had friends who have self-injured and I've had people who I've known who've taken their lives, so I feel like it's important to disclose for further research." -P15*. This sentiment also resonates with individuals who have not disclosed their NSSI outside of research settings indicating the pertinence of altruistic motives for disclosing self-injury despite potential barriers (Mirichlis et al, 2023b).

***Theme 4: Overcoming Barriers***

Often participants tousled with facilitating factors whilst experiencing apprehension towards disclosing due to barriers, reflecting those previously identified in the literature (e.g., Rosenrot & Lewis, 2020; Simone et al., 2022). One participant illustrates this ambivalence, *"it's sort of weighing up 'Do I want to be helped and be vulnerable to someone I don't know?' or 'do I not want to be helped and not have to deal with that vulnerability?'."*. The factors identified in the other themes of this study, reflect those which may contribute to the overcoming of barriers discussed by participants as captured in the below sub-themes of: "Facing Fears", "This Time it's Personal", and "It's Hard to Say".

**Facing Fears.** NSSI stigma is a key barrier to disclosure (Simone & Hamza, 2021). Here participants recounted instances of overcoming general fear or anticipation of particular negative outcomes when disclosing their NSSI. Such apprehension was sometimes informed by anticipated NSSI stigma as was explicitly stated by this participant:

> *it's not really acceptable for you to display that kind of weakness and the majority of cases back in my country… yeah so um exhibiting those kind of traits would represent weakness which have been engrained into the culture -P1.*

Others disclosed despite their own internalisation of stigma, *"when I was engaging in it, I feel like there was a lot of guilt and shame around it" -P12*. Guilt such as this sometimes

manifested as the prospect of disclosing self-injury approximating a confession, *"I didn't want to admit to someone else, it would admit to me fully I already knew that I failed" -P1.*

These accounts of anticipated and internalised stigma reflect those conceptualised in the NSSI Stigma Framework (Staniland et al., 2020). Relatedly, when reflecting on their considerations prior to disclosing their NSSI some participants expressed concerns for specific outcomes including the recipient making assumptions or passing judgement on the individual, them disclosing the information onto another party, and unsolicited intervention:

> *So I was so scared I thought that she was going to tell my parents, I thought that she was going to call the police on me, institutionalise me and I didn't want her to think that I was engaging in these behaviours because I wanted to die because obviously psychologists have to break confidentiality if they think you're at risk to yourself right so I was worried she was going to do that but I didn't want to die, I just wanted to self-[injure] because I felt that I needed to -P5*

Such concerns illustrate the importance of person-centred and collaborative responses to disclosures (Lewis & Hasking, 2021). Additionally, an apprehension towards negatively impacting the disclosure recipient or the individual's relationship with them contrasts the potential motive of benefitting a participant by sharing that they self-injure:

> *didn't want to share that burden with her because you tell someone maybe they will feel responsible … I think telling her I was really worried that I was going to worsen her mental health -P5.*

**This Time it's Personal.** Perhaps in wanting to avoid stigma or as a product of individual agency, some participants reflected on their self-injury experience being too personal to share: *"being able to have some of that control about how you tell them because it is really personal thing, it's really sensitive" -P10.* Although this selectivity contrasts notions of authentic sharing,

it aligns with the discourse surrounding the importance of trust in a disclosure described by participants. That is to say, whilst sharing one's NSSI experience can be highly personal, trust in the person being disclosed, as well as motives for disclosure (e.g., helping others), may compensate for this. Such a narrative reflects insights shared by individuals who had not previously disclosed their self-injury, as to why they felt comfortable sharing in a given context (i.e., in research; Mirichlis et al., 2023b).

**It's Hard to Say.** Alternatively, some participants expressed that articulating their disclosure was challenging; in some instances this reflected the anxiety of disclosing, whereas in others the challenge was more logistical, as mentioned by the following individual, "*I think I brought it up over text or Facebook but I don't think in person because I couldn't find the words" -P7*. This consideration of one's self-efficacy when deciding whether to disclose NSSI is consistent with Greene's (2009) suggestion of such an evaluation forming part of the disclosure decision-making process. As illustrated by one participant, use of non-face to face methods of communication were sometimes used to facilitate disclosure. Such forms of communication also mitigated other logistical barriers: *"Usually if I'm talking about this stuff over text I would be at home where I wouldn't be as comfortable on a phone call because there could be other people at home listening,"-P9.* The experiences shared offer context into how alternative forms of NSSI disclosure may be utilised by those with lived experience, with investigations into such disclosures (e.g., in online settings) being relatively scarce, and often confounded with posting or searching for information about NSSI online (e.g., Frost et al., 2016; Kim & Yu, 2022).

Participants reflected that apprehension could be present even when considering disclosure to a trusted individual, again highlighting the experience of ambivalence. Participants also noted that often, their worries about what would happen when they disclosed their NSSI did not necessarily reflect what they would generally expect from the individuals they disclosed to.

For example, concerns about being judged despite not perceiving the disclosure participant to be a judgemental person. Such contradictions further indicate the ambivalence leading up to NSSI disclosure.

### *Theme 5: Selective Sharing*

There is a growing body of evidence that previous NSSI disclosure outcomes can impact future disclosure decisions (i.e., whether and how to disclose; Park et al., 2020; Simone et al., 2022). These findings align with what our participants discussed in that they pointed to the cyclical and often complex nature of NSSI disclosure. When describing the outcomes of their disclosure experiences, participants reflected on whether these were helpful or not, in terms of whether a disclosure response met their needs. Some outcomes did not explicitly address or hinder ones' needs, we have considered these to be "ambiguous" outcomes. Helpful outcomes recounted by participants included receiving support, improvements to their relationship with the disclosure recipient, and personal growth and/or fostering NSSI recovery. Conversely, unhelpful outcomes included unmet needs or directly harmful experiences, as well as relationship disruptions, with ambiguous outcomes involving emotional or vague reactions to the disclosure.

**The Past Facilitating the Future.** Several disclosure outcomes were identified to be generally helpful, and as such encouraged future disclosures. Consistent with previous literature (e.g., Gayfer et al., 2020; Park et al., 2020; Rosenrot & Lewis, 2020; Simone et al., 2022) disclosures were said to facilitate support for participants, which ranged from an initial response that was perceived to be supportive to opening up networks of support or development of safe-spaces and catalysing help-seeking. In line with this, one participant shared that *"it just becomes easier to tell other people… once you tell that first person it's easier to go and tell another friend or something it's not something like, you don't have to keep it a secret anymore I guess."*- P2. Similarly, strengthening bonds as a result of sharing something "*that is like a big deal to share*

*with someone"-P5* was described to foster increased openness within that relationship: *"wow this person is going to be my friend for life and showed me that I can share further things with her which I thought were uncomfortable to share" -P5*. These insights provide further indication that NSSI is cyclical in nature, such that previous experiences can inform future disclosure decisions. More specifically, this subtheme captures instances wherein past positive experiences regarding the likes of relational quality and support seeking can contribute to the approaching of future disclosures.

Some participants expressed that disclosure experiences, "*can be really important for someone to a recovery journey" – P10*, including instances in which disclosures influenced how participants viewed NSSI and themselves. Such notions are consistent with Lewis and Hasking's (2021) Person-Centred Framework for NSSI recovery, in which disclosure is proposed to be an aspect of NSSI recovery, while intrapersonal growth amongst people who have disclosed their self-injury has been previously identified in research (i.e., Simone et al., 2022). This growth was noted to be particularly helpful if the disclosure was made to the "right" person, further highlighting the selectivity sometimes involved in NSSI disclosure. Relatedly, participants shared that: *"Talking to someone about it was very liberating" -P15*, that they were made to feel more safe and secure in the moment and in being more open in the future: "*I've been able to talk more freely about it" -P3*.

**A Learning Curve.** Participants noted that unhelpful disclosure experiences included when their needs were not met, the response given was harmful (e.g., discrimination), or when their relationship with the disclosure recipient was adversely impacted; impeded future disclosures. At times these experiences resulted in further selectivity in whom to disclose to: *"I knew who I could talk to and who I couldn't" -P6*, or an overall reluctance to disclose again:

*they didn't know what to do, it just caught them by surprise because I'm not very*

*vulnerable very often so when I was in a weak spot and I told them, it was very*

*uncharacteristic of me because I don't usually say that sort of stuff so yeah. That just sort*

*of prevented me from telling anyone else -P4*

This decision-making was not always straightforward, as illustrated by this participant's experiences:

*more secretive because I knew if it came up I would have to talk about it and I didn't*

*really want to, like I knew I wasn't actual danger to myself so I didn't want to talk about*

*it but then if it would come up then I would want to talk about it kind of. This is so*

*confusing but I almost didn't want it to come up but if it did I was a bit glad about it -P7*

This individual experienced a deliberation of various considerations. Whilst they did not proactively initiate the disclosure, they would still engage in discussion if it were to come up, though were mindful of how their self-injury might be perceived by others (e.g., dangerous). Whilst NSSI disclosure outcomes have typically been considered as either positive or negative (Simone & Hamza, 2020), the current findings highlight that individuals can experience a mix of helpful, unhelpful, and ambiguous outcomes across disclosures to different participants and in disclosing to the same participant multiple times, and as such influence their selectivity in deciding to disclose differently.

### Theme 6: Perceptions of Disclosure

The final theme captures how mixed expectations and experiences culminate when an individual decides to disclose their NSSI despite potential barriers. Specifically, in this theme we consider: the degree to which voluntary disclosure of NSSI is planned, as well as the perceived normalcy of disclosing self-injury, and some of the interpersonal dynamics of disclosure.

**Degree of Pre-Planning.** Mental evaluation (i.e., cost-benefit ratios) in deciding to disclose NSSI has previously been flagged (e.g., Mirichlis et al., 2022; 2023). Across participant experiences, perspectives varied in the degree of pre-planning leading up to their NSSI disclosures. Whilst some recounted active deliberation and consideration of factors such as those discussed in the previous themes, others expressed that: *"It wasn't pre-planned at all" -P1*. As such it may be more realistic to conceptualise NSSI disclosure as involving some degree of pre-cognition without individuals necessarily being aware of it at the time, similar to the experience of this participant:

> *it had been something that I had been engaging in for a while before I decided to tell anyone about it and I guess it was both something that I had been thinking about for a while and also something that just kind of came up – P10*

It appears that aspects of the decision to disclose NSSI experiences vary both temporally (i.e., time spent considering whether to disclose) and in the extent of deliberation leading to the disclosure (i.e., how thorough the thinking process was, volume of considerations made).
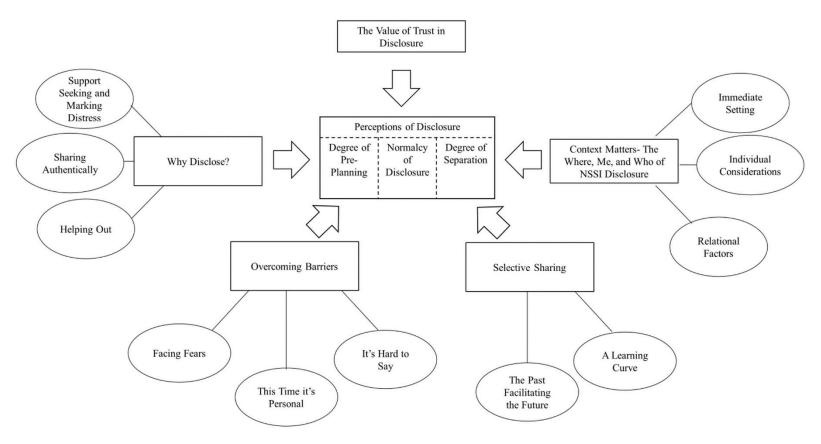
**Normalcy of Disclosure.** Perceptions of disclosing one's NSSI also varied in terms of the degree to which disclosure was considered to be the norm. Some individuals felt comfortable to disclose because it, "*was kind of like a normal everyday occurrence" -P8*, whereas for others disclosing their NSSI was a laborious experience: *"being vulnerable in front of someone was a bit difficult for me, yeah, definitely." -P14*. In navigating their decision to disclose their NSSI, an individual such as participant eight may experience less apprehension, compared to participant 14 as the prospect of disclosure may require greater deliberation due to its perceived difficulty. This is reflected in their anticipations to disclosing their NSSI: "it *was quite common to be open about it*"- P8, as compared to: "*it seemed a lot more serious, and yeah, I was just worried about being stigmatized or judged*" –P14. Such notions of normalcy, or lack thereof may reflect an

individual's self-efficacy to disclose their self-injury, indeed disclosure self-efficacy has been considered as a means of potentially fostering disclosures more generally (e.g., Greene, 2009).

      **Degree of Separation.** There were also conflicting views of what circumstances would be desirable for disclosure, such as the preferred degree of separation of NSSI disclosures from day-to-day life. Whilst some participants expressed relational closeness as being important (e.g., in the context of a friendship), others shared that the confined nature of disclosures in clinical settings offered a different sense of safety. For example, whilst this participant stated: *"She's like one of my best friends and I tell her everything," –P2*, another explained, *"because I feel like with my psychologist I can just tell everything and it doesn't matter 'cause in the end it wouldn't affect my any relationship with anyone else within like a friendship circle or anything." –P11*. Though similar considerations were discussed in the sub-theme, "Relational Factors", in this theme we wish to highlight the diverging perspectives of what degree of separation are ideal for the decision to disclose NSSI. Such perspectives again highlight the individual nature of NSSI disclosure and the importance of context such that individuals may perceive a "see-saw of risk", with anticipated outcomes being weighted differentially depending on the perceived likelihood of a given outcome (e.g., risk to relationships). Additionally, this theme could provide some insight into the discrepancy in rates of disclosure in social, as compared to formal settings (Simone & Hamza, 2020).

**Figure 3**

*Thematic Map*



The Value of Trust in Disclosure

Support Seeking and Marking Distress

Sharing Authentically

Helping Out

Why Disclose?

Perceptions of Disclosure

Degree of Pre-Planning | Normalcy of Disclosure | Degree of Separation

Immediate Setting

Individual Considerations

Context Matters- The Where, Me, and Who of NSSI Disclosure

Relational Factors

Overcoming Barriers

Facing Fears

This Time it's Personal

It's Hard to Say

Selective Sharing

The Past Facilitating the Future

A Learning Curve

*Note.* Boxes indicate superordinate themes, with ovals representing sub-themes.

**Conclusions**

In aiming to explore the decision to voluntarily disclose NSSI, we identified themes relevant to how one's personal values and contextual factors may "set the scene" for a disclosure; and how expectations, motives, and outcomes of disclosures can vary intrapersonally and between people. Taken together these findings provide insight into the various considerations and processes that may inform a NSSI disclosure.

*Voluntary NSSI Disclosure is…Individual and Multifaceted*

Participants reflected on a range of cognitive (e.g., disclosure expectancies), emotional (e.g., anxiety versus hope in anticipation of disclosure), and behavioural (e.g., selectivity in sharing) factors involved in the lead up to their NSSI disclosure. Such factors can be proximal to the individual and the situation (e.g., consideration of their own NSSI experiences) but also distal. For example, NSSI stigma may be experienced not just at an interpersonal level but may permeate at a cultural level, and as such may contribute to ambivalence towards disclosure (Staniland et al., 2022). Extending upon previous findings as to the relative importance of considerations to NSSI disclosure (Mirichlis et al., 2023a); the preferred setting, recipient of, and response to a NSSI disclosure was variable not just between different people but also depending on an individual's needs at a given time. In this way NSSI disclosure can evolve, in that an individual's needs and goals can change with time, reflection, and experience. Furthermore, NSSI disclosure can be cyclical in that previous disclosure experiences can inform if and/or how a person approaches future disclosures. Though outcomes of disclosure have been investigated, how these might inform future disclosures or indeed the ongoing perspective of NSSI disclosure generally, has been largely overlooked in previous literature until now (Simone et al., 2022).

*Voluntary NSSI Disclosure Redefined*

The conceptualisation of NSSI disclosure, particularly that of a voluntary nature has been a topic of much contestation, likely as a reflection of the complexity of NSSI and the various ways in which someone could learn of another's self-injury (e.g., Simone & Hamza, 2020). Whilst we operationalised "voluntary" as having chosen to share that oneself has self-injured, participants' accounts raise additional considerations such as the distinction between a conscious deliberation or simply being open to disclosing NSSI. Furthermore, the findings reflect varying degrees of deliberation prior to different disclosure experiences. As such, voluntary disclosure of NSSI may be conceptualised as a continuum along which individuals willingly share their NSSI with another person, though with varying degrees of deliberation. Such conceptualisation of voluntary NSSI disclosure extends upon those which do not explicitly reference the cognitions underpinning NSSI disclosure decision-making (e.g., Simone & Hamza, 2020). This extension of previous NSSI disclosure conceptualisations highlights that individuals may benefit from guidance to varying degrees, when making informed disclosure decisions.

### *Limitations and Future Research*

Whilst there were indications of the ongoing nature of NSSI disclosure, given that this study was cross-sectional and retrospective, longitudinal methods would be of greater utility for investigating this aspect of disclosure decision-making in the future as a means of capturing the evolving experience of disclosure from the point of contemplation to the examination of the outcomes of disclosure, and exploring potential distinctions between initial and subsequent disclosure experiences (Simone & Hamza, 2021). Similarly, diary studies could help to address the issue of recall bias to capture perceptions of disclosure experiences, with a follow-up to probe for any changes in these perceptions over time. As the frequency of disclosures may have

impacted participants' perspectives on NSSI disclosure, this warrants investigation in future research.

We also note that had additional details of participants' NSSI experiences and help-seeking been collected, this would have further improved our understanding of their disclosure experiences given that some participants' disclosures were informed by such experiences. Similar to the work of Simone et al. (2022), further research should investigate the role of disclosure recipients at the time of and following disclosures, particularly in terms of whether they too have lived experience of NSSI or mental health difficulties, given the consideration given to "who" to disclose to by our participants, with shared understandings of such experiences appearing particularly relevant. Finally, there is scope to explore processes of disclosure decision-making amongst more diverse samples.

### *Conceptual and Theoretical Implications*

Despite these limitations, the insights gained from participants hold implications for the way that NSSI disclosure is understood. Conceptually, our findings have provided insights into how voluntary NSSI disclosure may be operationalised, with the acknowledgement of it being an ongoing and dynamic phenomenon involving cognitive, emotional, and behavioural processes. In terms of how NSSI disclosure may be theoretically modelled, parts of participants' experiences were distinct from broader frameworks of disclosing personal information (e.g., Greene, 2009) suggesting that there could be utility in specific NSSI disclosure models. It should be highlighted that at times, the disclosures described by participants were part of larger conversations about other sensitive matters such as mental health difficulties. As such whilst there are considerations specific to self-injury disclosure researchers and clinicians should be mindful that other forms of disclosure (e.g., of trauma, diagnoses) may impact, follow, or prompt NSSI disclosures.

*Practical Implications*

As discussed below, the findings highlight some important considerations for those supporting people with lived experience of NSSI, including clinicians. Amongst others, these considerations include the value of trust, the context within which a disclosure is to occur, the goals and barriers of disclosures. The findings complement the growing discourse that NSSI disclosure is a nuanced phenomenon, highlighting the imperative of person-centred approaches to responding to such disclosures (e.g., Mirichlis et al., 2023; Lewis & Hasking, 2021). Additional considerations when responding to NSSI disclosures indicated by participants include: the potential need to improve self-awareness around an individual's needs so that they can make informed decisions about whether they would like to seek help and what that help might look like, being mindful that disclosure of NSSI may be part of a bigger conversation and that their self-injury may not be the focus for the individual, and accounting for cultural diversity (e.g., in views of talking about self-injury and mental health) when exploring disclosures. Here the intersectionality between NSSI experiences and other stigmatised experiences such as mental health difficulties is of particular importance (Link et al., 2004).

In conclusion, whilst voluntary NSSI disclosure is complex, this study presents lived experience perspectives of the factors and processes that inform NSSI disclosure decision making. Our findings indicate the multifaceted and ongoing nature of NSSI disclosure, with a consideration on what it means to share such information "voluntarily".

**Chapter 8: Does the Decision to Disclose Non-Suicidal Self-Injury Align with Decision-Making Frameworks of Personal Information Disclosure? A Directed Content Analysis**

**Introduction to Chapter 8**

In this chapter lived experience and theoretical approaches are integrated to better understand the NSSI disclosure decision-making process. This extends on Study four by explicitly examining the degree to which the lived experiences of disclosing NSSI as explored in the interviews, aligns with conceptual frameworks of personal information disclosure: The Disclosure Decision-Making (Greene, 2009) and Disclosure Processes (Chaudoir & Fisher, 2010) models. The findings of this study provide the foundations for a novel conceptual framework of NSSI disclosure.

A Revise and Resubmit for this study has recently been submitted to a peer-reviewed journal. The supplementary materials of this paper and a copy of the ethical approval for the data used in this study, and a copy of the interview guide used in this study are provided in Appendices K and L.

**Authorship**

All signed authors acknowledge that the below table is an accurate representation of each person's contribution to this research output.

| Author | Contribution | Acknowledgement |
|---|---|---|
| Sylvanna Mirichlis | Development of research question, data collection, data management, data analysis, interpretation of results and discussion, | |

| | manuscript preparation, reviewing and editing of drafts. | |
|---|---|---|
| Penelope Hasking | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Mark Boyes | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Stephen P. Lewis | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |
| Kassandra Hon | Assisted with development of research question, interpretation, and reviewing and editing of drafts. | |

**Abstract**

Non-suicidal self-injury (NSSI) is the deliberate damage caused to one's own body tissue, without the intent to die. Voluntary disclosure of one's NSSI can catalyse help-seeking and provision of support, though what informs the decision to disclose NSSI is not yet well understood. There is currently no existing framework specific to the process of NSSI disclosure and the aim of this study was to assess the fit between factors involved in the decision to disclose NSSI and two broader frameworks of disclosure, namely: the Disclosure Decision-Making and Disclosure Processes models. A directed content analysis was used to code interview transcripts from 15 participants, all of whom were university students aged between 18 and 25 ($M = 20.33$, $SD = 1.88$), with 11 identifying as female. All participants had lived experience of NSSI which they had previously disclosed to at least one other person. All codes within the coding matrix, which were informed by the disclosure models, were identified as being present in the data. Of the 229 units of data, 95.63% were captured in the existing frameworks with only 10 instances being unique to NSSI disclosure. In conclusion, though factors that inform the decision to disclose NSSI largely align with the aforementioned models of disclosure, there are aspects of disclosure decision-making that may be specific to NSSI.

*Keywords***:** NSSI disclosure, Disclosure decision-making, personal information disclosure

**Introduction**

Non-suicidal self-injury (NSSI) is the intentional damage to an individual's own body tissue, in the absence of suicidal intent (International Society for the Study of Self-Injury, 2022). Although NSSI can be diverse in form, skin cutting, burning, and self-battery are amongst the most frequently reported methods (Swannell et al., 2014). Similarly, there are a range of functions that NSSI may serve, with emotion regulation being most commonly reported (Taylor et al., 2018). A relatively common behaviour, approximately 17.2% of adolescents, 13.4% of young adults, and 5.5% of adults report a life-time history of NSSI (Swannell et al., 2014). More recently, rates of NSSI amongst adolescents and adults respectively have been reported at 32.4% and 15.7% (Deng et al., 2023). Negative outcomes such as later suicidal thoughts and behaviour and mental health difficulties (e.g., anxiety and depression) are associated with this lived experience of NSSI, presenting a potential need for supports (Fox et al., 2015; Kiekens et al., 2018). Although disclosure is not always pursued nor desired, NSSI disclosure can act as a catalyst for seeking and/or accessing support (Simone & Hamza, 2020; Mirichlis et al., 2023a). However, factors that inform the decision to disclose NSSI are largely unknown. If we wish to appropriately respond to and support people who self-injure, enquiry into factors that facilitate disclosure is needed.

It is estimated that on average, 50-60% of individuals who have self-injured will disclose this to another person (Simone & Hamza, 2020). Previous findings suggest that disclosing NSSI to seek tangible aid may be of greater relevance when disclosing to health professionals, though the majority of NSSI disclosures are made to one's friends, significant others, and/or families (Mirichlis et al., 2023a; Simone & Hamza, 2020). Interpersonal factors, such as the quality of the relationship, may be more important in the decision to disclose to family or friends (Mirichlis et

al., 2022). Additionally, NSSI disclosures may facilitate benefits other than support provision, such as opportunities for self-advocacy and to explore NSSI recovery. Such self-advocacy may reflect challenging the stigma towards NSSI, with disclosure offering opportunities for NSSI to be better understood from lived experience perspectives (Mirichlis et al., 2023). Further, disclosing one's NSSI can open dialogues to consider what recovery may look like for an individual and how this could be fostered (Hasking et al., 2023).

Although the potential to challenge NSSI stigma may empower some individuals to disclose their NSSI, the anticipation and internalisation of others' negative perceptions about NSSI can still pose considerable barriers to such disclosure (Mirichlis et al., 2023a; Simone & Hamza, 2020). Anticipated NSSI stigma refers to the expectation of a negative reaction from others, such as being judged or rejected due to their NSSI even in the absence of no prior stigmatising experience (Staniland et al., 2022). Conversely, an individual may internalise stigmatising views about NSSI and thus feel ashamed to disclose their NSSI (Simone & Hamza, 2020). Indeed, there is evidence of discrimination (e.g., being judged) and disruptions to relationships (e.g., introducing tension in friendships) following NSSI disclosures (Park et al., 2020; Staniland et al., 2022). Whilst the identification of these barriers provides some insight into what might inform the decision to not disclose NSSI, a more comprehensive approach to understanding and navigating NSSI disclosures could be instrumental in providing more appropriate support for individuals with lived experience of NSSI (Simone & Hamza, 2020). Having a theoretically informed understanding of NSSI disclosure decision-making would offer a process and set of factors to take into consideration when navigating disclosures and could potentially improve outcomes following disclosures (Stratton et al., 2019). Currently, no such framework exists for NSSI disclosure, though insight may be gleaned from broader frameworks

pertaining to the disclosure of personal information, such as the Disclosure-Decision Making-Model (Greene, 2009) and the Disclosure Processes Model (Chaudoir & Fisher, 2010).

**Frameworks of Personal Information Disclosure**

Although not conceptualised specifically for NSSI, the Disclosure-Decision Making (Greene, 2009) and Disclosure Processes (Chaudoir & Fisher, 2010) models each present a range of considerations people undertake when deciding to disclose personal and often stigmatised information. In the Disclosure-Decision Making-Model, the 'what?' and the 'who?' of disclosures are considered, with reference to stigmatised health conditions such as HIV. Adopting a medical approach to disclosure decisions, Greene (2009) posits that individuals may consider whether the condition/experience is stigmatised, the prognosis of the condition (or in the case of NSSI, the course of the behaviour such as the frequency, recency, or self-defined "recovery"), symptomatology (or visibility, e.g., NSSI scarring), and the relevance of this information to others (i.e., are other people somehow impacted by this experience?). Greene (2009) also proposes that when deciding whether to disclose personal information, individuals may evaluate confidants in terms of the quality of their relationship with them, and how they might be expected to respond to the disclosure. Further to this, Greene (2009) discusses an individual's self-efficacy to disclose, taking into consideration such factors as ability to articulate their message. These considerations appear applicable to NSSI disclosure stigma being an established barrier to its disclosure (e.g., Rosenrot & Lewis, 2020), and NSSI disclosure being associated with more impactful NSSI (i.e., causing distress to and/or interference with important aspects of the individual's life such as in their interpersonal relationship), the presence of NSSI scarring, and reports of people adopting different approaches to disclosure depending on the recipient (Mirichlis et al., 2022; 2023a; Simone & Hamza, 2020).

Complementing this focus on what to disclose and to whom, Chaudoir and Fisher (2010) consider the 'when?' and the 'why?' in their Disclosure Processes Model. Specifically, the 'when and why' are operationalised as "Approach-Focused Goals" (i.e., those which aim for movement towards positive outcomes) and "Avoidance-Focused Goals" (i.e., those which aim to move away from negative outcomes). The motivations for NSSI disclosure are not yet well understood, although reports of disclosing NSSI online to seek validation from others may offer an example of approach-focused goals. In contrast, disclosing NSSI online as a means of resisting urges to self-injure could exemplify goals which are avoidance-focused (Lewis et al., 2012; Lewis & Seko, 2016). Additionally, Chaudoir and Fisher (2010) outline considerations of the disclosure event itself such as the depth, breadth, and duration of a disclosure, with the framework being applied to a range of stigmatised groups such as individuals who have experienced mental illness and users of alcohol and other drugs (Barth & Wessel, 2022; Earnshaw et al., 2019).

Together, the Disclosure-Decision Making and Disclosure Processes models may provide a framework for understanding the 'what, who, when, why' of NSSI disclosure decision-making, offering a tool to better synthesise understandings of NSSI disclosure and to support NSSI disclosure efforts. Using content analysis, drawing from existing data (see Method) the aim of the current study was to assess the fit between factors that informed the decision to disclose NSSI and the Disclosure Decision-Making and Disclosure Processes Models. As such the research question was: to what degree do factors that inform the decision to disclose NSSI align with existing disclosure frameworks? Fitting with the deductive approach of this study, it was hypothesised that NSSI disclosure decision-making would align with the superordinate considerations collectively outlined in the Disclosure Decision-Making and Disclosure Processes

models (related to the information being disclosed, who to disclose to, one's confidence in their ability to disclose, and disclosure being goal-driven).

## Materials and Methods

### Participants

The sample comprised 15 participants with lived experience of NSSI who had voluntarily disclosed this to at least one other person. All participants were Australian university students, with nine being recruited from the university's research participation pool in which studies are advertised to psychology students who receive course credits for their participation. These participants could sign-up for a study slot, at which point they were contacted by the first author to arrange an interview booking. The remaining participants, were recruited from an existing pool of individuals interested in NSSI research, these participants were contacted via email to confirm their interest in participating in this study. Participants recruited the latter way received a gift-card as reimbursement for their time. The sample comprised 11 females and 4 males, aged 18 to 25 years ($M = 20.33$, $SD = 1.88$).

### Procedure

Upon receiving ethical approval, individuals who expressed interest in the study were emailed the information sheet and a mutually convenient interview time was arranged with each participant. To maintain confidentiality, participants provided informed consent in an audio recording separate from that of the recorded interview. The semi-structured interviews ran between 30 to 60 minutes. Participants were asked to describe NSSI in their own words before the interviewer asked them about their experiences of voluntarily disclosing their NSSI (see Table 5 for a summary of the interview questions relevant to this study). Once the interview concluded and the recording was stopped, participants were provided with debriefing information

including contacts for emotional support services and information about NSSI. All interview recordings were later transcribed verbatim. De-identified transcripts were stored securely, and audio recordings were destroyed. As these interviews were part of a broader study these transcripts featured participants' disclosure experiences as a whole, inclusive of participants' considerations leading to their disclosures.

**Analysis and Rigour**

A directed content analysis was used to assess the fit between frameworks of personal information disclosure and the decision to disclose NSSI (Elo & Kyngas, 2008; Hsieh & Shannon, 2005). Directed content analysis is a useful qualitative tool for examining existing conceptual frameworks, by way of deductively coding data against codes prescribed by said theory (Hsieh & Shannon, 2005). In order to address our research aim, the Disclosure Decision-Making Model (Greene, 2009) and the Disclosure Processes Model (Chaudoir & Fisher, 2010) were used to develop a theoretically informed coding matrix in Microsoft Excel. Elements of both models were combined in a single coding matrix. As seen in Table 6, higher-order categories reflecting the broad components of these frameworks (e.g., about the information being disclosed, interpersonal characteristics, etc), were further organised into subordinate codes reflecting more specific aspects of the frameworks (e.g., stigma). In accordance with the aim of this study, to understand the decision to disclose the stigmatised behaviour of NSSI, the labels of some of these categories and codes have been adapted from the original models to more appropriately denote NSSI experiences in a way that does not pathologise the behaviour. For example, rather than referring to "prognosis" and "symptomatology", as Greene (2009) does, the coding matrix features "course" and "visibility" of NSSI, in line with the NSSI stigma framework developed by Staniland et al. (2021).

Interview transcripts were exported into Microsoft Excel and segmented into codable data units to be mapped to the conceptual matrix. The transcripts were segmented so that each data unit represented a shift in meaning or topic (Campbell et al., 2013). Each data unit ($n = 277$) was labelled with a code that represented its analytically relevant content. A single data unit could be coded multiple times. An example is the data unit: "He's my partner, and because the first encounter was quite positive (relational quality) that kind of led me to have a bit more reassurance in that I'll be able to tell him again (self-efficacy)". This data unit captured the disclosure experiences relevant to both relational quality and self-efficacy.

In addition to considering how data was to be segmented, the coding team consulted methodological literature to inform what data was coded. With reference to Elo and Kyngas (2008) a mixture of manifest and latent codes were used. The additional context offered by the richness of interview data supported the feasibility of taking this combined approach. Although the focus of this study is on existing disclosure frameworks, data that did not fit within the existing coding matrix was assigned the code of "other" as per Hsieh and Shannon's (2005) recommendations. Data coded as "other" offers insight into factors that inform NSSI disclosure which have not been accounted for in the existing frameworks.

With the aim of maximising rigour, a second coder independently coded 10% of the data. This subsample was randomly selected to enable representation from the full dataset. Interrater reliability was obtained by comparing the same data units, coded by the primary and secondary coder. Intercoder reliability was calculated with Gwet's AC1 coefficients, and ranged between < -0.00 and 1 ($M = .66$, $SD = .30$) indicating good intercoder reliability on average (Gwet, 2014). The coders discussed the coding discrepancies (O'Connor & Joffe, 2020) and proceeded to a second round of independent coding, a further 10% of randomly selected data. Following this

second round of intercoder reliability, Gwet's AC1 ranged from .69 to .96 ($M = .90$, $SD = .09$), indicating an excellent level of agreement (Gwet, 2014). The remaining discrepancies were again discussed until resolved (O'Connor & Joffe, 2020). The final dataset, after coding was finalised, consisted of 229 data units. In addition to secondary coding, both coders engaged in reflective journaling and maintained an audit trail throughout the research process (O'Connor & Joffe, 2020). To ensure the validity of the data, interview transcripts underwent member checking, wherein full transcripts were provided to participants to check for accuracy.

**Table 5**

*Core Interview Questions and Probes*

| | |
|---|---|
| **Prior to disclosure** | 1. Were they the first person you talked to about your self-injury? |
| | A. As far as you know does this mean they were also the first person to know about it? |
| | B. If not, was other people knowing a contributing factor to you telling this person? |
| | 2. Could you tell me a bit about what your relationship with this person was like prior to them learning about your experience with self-injury? |
| | 3. What prompted your decision to disclose your self-injury? |
| | A. Were there any specific reasons why you wanted to talk to this person in particular about it, rather than talking to somebody else? |
| | 4. Was there anything that made you hesitant at first to disclose your self-injury to this person? |
| | A. How did you overcome this/what changed your mind? |
| | 5. What were you expecting to happen when you told this person? |
| | A. What other thoughts or feelings did you have right when you were about to tell this person? |
| | B. What were you hoping would happen? |
| | C. Why do you think this is? |

*Note.* The contents of this table has been adapted from Mirichlis et al.[under review]. Given the semi-structured nature of interviews, specific questions and order of these questions may vary. Questions may have been repeated in the context of different disclosure experiences.

**Table 6**

*Description of Categories and Codes*

| Categories | Category description | Codes | Code description |
|---|---|---|---|
| **NSSI characteristics** | The specific characteristics or features of NSSI that may alter one's decision to disclose their NSSI. | *Stigma* | Negative perceptions of NSSI that alter one's decision to disclose their NSSI. |
| | | *Course* | The occurrence or progression of NSSI that may alter the decision to disclose about NSSI. |
| | | *Visibility* | Notable features (e.g., scarring) of NSSI that may affect the trajectory of disclosure. |
| **Interpersonal Characteristics** | Consideration for disclosing NSSI in relation to the potential disclosure recipient. | *Relevance* | Consideration of the direct or indirect impacts that the disclosed information may have on the recipient. |
| | | *Relational Quality* | The relational dynamics and context with the disclosure recipient (e.g., level of trust). |
| | | *Anticipated Reactions* | The expected response from the disclosure recipient. |

| Categories | Category description | Codes | Code description |
|---|---|---|---|
| **Disclosure self-efficacy** | The perceived ability to disclose NSSI experiences. | | |
| **Disclosure Goals** | Underlying motives for disclosing self-injury. | *Approach/Positive Focus* | Perceptions that disclosure may facilitate positive outcomes such as increased understanding or acceptance from the disclosure recipient. |
| | | *Avoidance/Negative Focus* | Perceptions that disclosure may protect against negative outcomes such as preventing conflict and experiences of negative affect. |

*Note*. Matrix adapted from the Disclosure Decision-Making Model and the Disclosure Processes Model (Chaudoir & Fisher, 2010; Greene, 2009).

**Results**

Factors involved in the decision to disclose NSSI aligned with broader existing

frameworks of disclosure decision-making, with 95.63% of data units (i.e., individual excerpts)

being captured by aspects of the two disclosure frameworks examined. There were 10 data units

(4.37%) that discussed considerations of NSSI disclosure decision-making that were not at all

captured by the existing disclosure frameworks. A further 54 (23.58%) instances of data were

also coded as "other" such that some parts of the excerpt were relevant to elements of the

frameworks and other portions were not. The findings relevant to the existing disclosure

frameworks are summarised in Table 7.

**NSSI Characteristics**

Characteristics specific to the participant's NSSI were referenced in 25.76% of the data

units ($n = 59$). The code of NSSI Stigma was present in 23 of the data units (10.04%),

highlighting instances where this key barrier to disclosure was overcome in pursuit of disclosing

NSSI. For example, one participant reflected that although they confided their NSSI to a

particular friend, they were mindful that, "it's not really acceptable for you to display that kind of

weakness". Further, this participant reflected that, "I was nervous because of the stigma because I

know before then I had been accidentally found out and it hadn't gone well and I think and just

like with general in the media and stuff and hearing how friends' parents had reacted to stuff like

that". Akin to Greene's (2009) notion of considering the prognosis of a health condition to be

disclosed, the course of one's NSSI was referenced in 21 data units (9.17%). These references

reflected aspects of the behaviour such as the frequency, recency, and perceived controllability or

severity of one's NSSI. In some instances, the course of the NSSI at the time of the disclosure

may have also linked to the perceived relevance (as coded below) of disclosing to a particular

person as highlighted by this participant: "the first time I had to go to hospital was when it was the worst, but before that it was just more mild, in which I didn't need any attention so I didn't tell anyone about it". Other participants reflected on how the extended time that had elapsed since engaging in NSSI contributes to contemporary disclosure, for example: *"I feel more open about it now actually, since not engaging it I have told more people about it whereas when I was [still engaging] there was that concern of what if someone [sic]- I wasn't ready for that".* Relatedly, the visibility of one's NSSI as a proxy to Greene's (2009) reference to "symptoms" was coded in 15 data units (6.55%). This included references to scarring, lack of concealment/area of the body, and openness about NSSI in peer groups. One participant noted that, *"it's pretty clear like I have scars all over me you can tell but I don't think I've ever told many of my friends".* Another participant's reflection is illustrative other ways NSSI can be visible: "if you have a bandage on your wrist people are like going to ask about it, if you have it open people are going to ask about it".

**Interpersonal Characteristics**

The most commonly coded category was adapted from Greene's (2009) reference to assessing the recipient of a potential disclosure. Interpersonal characteristics were coded in 88.21% of data units ($n = 202$). Relevance of disclosing one's NSSI to a particular recipient was coded in 62 data units (27.07%), often coinciding with the code of Relationship Quality ($n = 81$; 35.37%). The latter code reflects the type of, and closeness of, the relationship with the disclosure recipient, with participants sometimes noting that these factors informed their assessment of the relevance of their NSSI disclosure. For example, one participant stated, "part of me felt like I owed it to him to be honest with him because of the relationship*"* when recounting their experience of disclosing their NSSI to their partner. Other participants reflected

on the "mateship" within their relationships with disclosure recipients noting that they were "very close friends" and a "trusted ally" for example. A further consideration in who to disclose information to adapted from both the Disclosure Decision-Making and Disclosure Processes Models (Chaudoir & Fisher, 2010; Greene, 2009) was the code of Anticipated Reactions. This code was present in 59 data units (25.76%) with participants citing both anticipated reactions that encouraged their disclosure and those which were potential barriers that they had overcome. For example, this participant reflects, "how will they react? What will they think? What are we going to do from here?". Conversely, this participant reflects on the positive expectations they had when considering disclosing their NSSI: "I knew that she would understand where I was coming from and wouldn't judge me".

**Disclosure Self-Efficacy**

Confidence in the ability to disclose NSSI was coded 48 times (20.96%). Considerations raised by participants included a general lack of confidence (or general anxiety) about how to approach disclosure, with some citing a preference for being prepared for what to expect of the disclosure experience: "I think when you go into a situation knowing what the consequences are and what the results will be, it just feels a lot better", though for others "even with the heads up, it was still difficult to talk about it.". Relatedly, some mentioned that with experience, disclosures became easier, and others noted how the means of disclosure (i.e., via message rather than face-to-face or having a casual rather than formal conversation) may facilitate disclosure. For example, one participant noted that, "I honestly think that everything is easier online, I'm not that kind of person to do that sort thing online anymore though but it's a lot easier to talk to a screen than it is to actually to be faced with someone who has emotions and reactions and their own thoughts".

**Disclosure Goals**

In considering the decision-making process of disclosure, Chaudoir and Fisher (2010)
describe both approach-focused and avoidance-focused goals reflecting the functional nature of
disclosing information. Overall, these goals were coded 73 times (31.88%) in the data units.
Approach-focused goals, that is those which seek out positive outcomes were the most
commonly coded ($n = 48$, 20.96%). Some goals cited by participants included seeking tangible
and/or emotional support, as well as more broadly seeking acceptance and understanding. For
example, this participant reflects on seeking "support maybe, knowing that they're always going
to be there when I need them, when I need them to be relied upon. Understanding, no judgement,
no pity, maybe empathy would be good". In contrast, the prevention of negative outcomes via
avoidance-focused goals were coded 25 times (10.92%). These avoidant goals included, "stop
social outcasting me in the social norm", reducing negative emotions and/or experiences such as,
"in case I got into a dark space where I was struggling to come out of it" and "once that pattern
started I knew I had to sort of stop it or get help for it and that's when I told her.".

**Considerations Not Captured in Existing Frameworks**

In addition to being interested in what aspects of NSSI disclosure decision-making align
with existing disclosure frameworks, we were interested in those not captured in these
frameworks. Of the 64 instances coded as "other", the following codes were generated
suggesting considerations specific to deciding to disclose NSSI. Some of these new codes did
align with the broader categories informed by the existing disclosure frameworks but not their
sub-categories. Within the category of "Interpersonal Characteristics" five additional codes were
identified. The most common of these pertained to "having an existing mutual understanding
with the recipient" (i.e., rather than seeking understanding, $n = 6$). For example, "It was more just

like we both kind of know what we're going through". Secondly, a sense of confidence and/or security in the recipient and their ability to respond appropriately to the disclosure was coded five times. Although potentially similar to the "Anticipated Reactions" code, rather than capturing specific reactions anticipated from a disclosure recipient, this code reflected an assumption of competency on the behalf of the recipient. For example, "she dealt with these kind of things before, she was experienced…she was qualified". Additionally, a code was identified to capture the potential impact of the disclosure itself on the recipient ($n = 3$). Such consideration is reflected here: "I imagine it's not good for people listening either like it's a hard process for them". Codes of the recipient previously knowing of their NSSI via other means ($n = 1$), and the disclosure being mutual ($n = 1$) were also identified, albeit rarely.

Within the category of "Disclosure Self-efficacy" four additional codes were identified. In terms of what may be involved in one's self-efficacy to disclose their NSSI, a lack of preparation/processing preceding the disclosure was coded four times, with appropriate timing ($n = 3$) and the setting in which the disclosure takes place ($n = 3$) also being coded here. For example, one participant reflected that their disclosure occurred when their school was, "looking at mental health awareness, it was r u ok day [a suicide prevention initiative]". Disclosure ambivalence was coded four times across the dataset, for example, this participant reflected that they, "didn't want it [self-injury] to come up but if it did I felt relieved", reflecting a sense of both wanting to and not wanting to disclose their NSSI simultaneously. Such conflict is of interest as it may challenge one's confidence in whether to disclose their NSSI (Gray et al., 2023).

With relation to the category of "Disclosure Goals", two further codes were identified. There were eleven instances of the code of "Selectivity/agency and Self-preservation" ($n = 11$),

capturing desires to exert control and protect oneself in future disclosures, as captured by this participant: "The rest of my voluntary disclosures were seen through a lens of "what's the risk to me?, I have to be more careful about this, who's going to find out?*"*. Secondly, there were three instances of the code "Ambiguous Expectations", such as this participant's expression: "I don't know what I was expecting [by disclosing NSSI]".

Two additional categories are proposed based on the identification of further codes which did not fit within the existing disclosure frameworks. Firstly, "Individual Characteristics" pertains to the person considering disclosing their NSSI. Within this category the codes of "difficult emotional experience/period" ($n = 3$) and "age at time of disclosure" ($n = 7$) were identified. That is to say that some participants referenced that their age at the time of disclosure and going through a difficult experience when disclosing their NSSI informed their disclosure decisions. This participant reflects on how being an adolescent informed their past disclosure decision-making: "I wouldn't of wanted to talk to them about it, I was young, adults are so unrelatable when you're a kid or a teenager you just think they don't know anything they're talking about and now being an adult". Further, this participant reflects on how their personal experience prompted their disclosure, "I was just having a rough day so we were kind of talking about it and then I think that's how it [NSSI] came up". Finally, the category of "Disclosure Course" captures instances when participants specifically referenced the trajectory of NSSI disclosure. The most common code of this category is the ongoing nature of disclosure ($n = 32$), here participants highlight that disclosure is not necessarily a single discrete event. For example this participant recounted the various people they had disclosed their NSSI to, "I went to my GP first because of other things and that [NSSI] came up because we were trying to figure out what was going on and that came up and then I went, I was like referred to a psychiatrist and

psychologist and stuff and then I was telling my friend about [my self-injury*]*". Although participants had disclosed their NSSI voluntarily, some noted that the conversation had been prompted by recipients, for example by being asked whether they had self-injured or from broader wellbeing check-ins ($n = 14$). Further, whether this would be an individual's first time disclosing their NSSI may warrant consideration, with one participant explicitly stating that the disclosure experience they were reflecting upon was the first (but not only) time they had told another person about their NSSI.

**Table 7**

*Frequency of Categories and Codes, and Code Examples*

| Categories | Codes | *n* | % | Code examples |
|---|---|---|---|---|
| **NSSI characteristics** (*n* = 59, 25.76%) | Stigma | 23 | 10.04 | "It's [NSSI] still a stigmatised issue a lot of the time, so it could still be something that people could react really negative to. There is that worry of the stigma that you might receive for talking about it." |
| | Course | 21 | 9.17 | "I told one of my friends about it because I was starting to worry that it wasn't just a one-time thing" |
| | Visibility | 15 | 6.55 | "No one else had known that I'd done it either because mine [self-injury] were like hidden" |
| **Interpersonal Characteristics** (*n* = 202, 88.21%) | Relevance | 62 | 27.07 | "She is one of my best friends and she's been there for me through everything so she should know" |
| | Relational Quality | 81 | 35.37 | "she created this really safe space where I could tell her what was happening" |
| | Anticipated Reactions | 59 | 25.76 | "I was scared to tell someone because I didn't want them to think of me as some like depressed child" |

| Categories | Codes | *n* | % | Code examples |
|---|---|---|---|---|
| **Disclosure self-efficacy** (*n* = 48, 20.96%) | | - | - | "I think after you tell one person it just becomes easier to tell other people" |
| **Disclosure Goals** (*n* = 73, 31.88%) | Approach/Positive Focus | 48 | 20.96 | "I would disclose to them … because on one hand they may be more understanding about the situation and … they might be more accepting to the next person who discloses to them." |
| | Avoidance/Negative Focus | 25 | 10.92 | "I was a bit nervous to sort of disclose that information to a complete stranger, but I felt that it was probably important too I guess. So they could help me stop doing that." |

*Note.* *n* = number of times the code was used; % = the percentages out of the 229 data unit

## Discussion

Despite a growing body of literature which has explored decision-making regarding NSSI disclosure (e.g., Fox et al., 2022; Mirichlis et al., 2022; Simone & Hamza, 2020), there is currently no conceptual framework specific to NSSI to guide this research. Two well-established frameworks of personal information disclosure, the Disclosure Decision-Making Model (Greene, 2009) and the Disclosure Processes Model (Chaudoir & Fisher, 2010) feature dynamic processes by which individuals evaluate information when deciding whether to disclose personal information. Namely, these theorists stipulate that characteristics of the information itself and of the disclosure recipient, the individual's self-efficacy to disclose the information, and the goals of the disclosure are considered in disclosure decisions. We aimed to investigate whether factors that inform the decision to disclose NSSI align with these frameworks following Hsieh and Shannon's (2005) process of directed content analysis. The current findings indicate that considerations of NSSI disclosure decision-making were largely captured in the combination of two existing frameworks. At the same time, several additional considerations suggest that these extant frameworks alone are not sufficient in conceptualising NSSI disclosure decisions.

Consistent with our hypothesis, the majority of NSSI disclosure considerations mentioned by participants were captured in the existing frameworks, although the specific ways these were expressed differed from the broader models. Of the considerations from the existing disclosure frameworks, the most commonly coded category was, "Interpersonal Considerations" which featured the most frequently used code: Relational Quality. This aligns with previous research in which individuals with lived experience of NSSI rated interpersonal considerations of greatest importance to the decision to disclose NSSI, with quality of the relationship with a disclosure recipient being rated the second most important (Mirichlis et al., 2023a). Of note for the current

study, data coded into "relational quality", were often also coded into "Relevance". It is plausible

that this coincident of the "Relational Quality" and "Relevance" codes reflects the sensitive

nature of NSSI disclosure such that one's NSSI may only be deemed relevant to a chosen

disclosure recipient if their relationship with the person disclosing necessitates such sharing.

There appears to be merit in also considering the relevance of the information itself, with the

"Course" code also co-occurring with "Relevance". This may reflect the relationship between

frequency and/or severity of NSSI and NSSI disclosures whereby more severe NSSI is more

likely to be disclosed (Simone & Hamza, 2020). Further, some individuals may find disclosure

less relevant if they have not recently engaged in NSSI (Mirichlis et al., 2022).

The least frequently coded category in the current study was that of "Disclosure Self-

Efficacy". One's confidence in their ability to disclose NSSI has received little empirical

attention. Nevertheless, it may have relevance among people with lived experience. In a previous

study in which individuals with lived experience rated the importance of various factors to the

decision to disclose their NSSI, their confidence to talk about their NSSI was rated as the third

most important factor (Mirichlis et al., 2023a). It is plausible that some factors that contribute to

one's self-efficacy to disclose their NSSI were instead captured in the other categories. For

example, an individual may feel more confident in their ability to disclose their NSSI to someone

that they have a close relationship with and that may have been coded under "Relationship

Quality". As such, further research is warranted into the factors underlying one's self-efficacy to

disclose NSSI. The least commonly reported code in this content analysis was the visibility of

one's NSSI potentially reflecting the focus on voluntary disclosure in this study rather than

involuntary disclosure/discoveries due to one's NSSI being visible (e.g., by way of scarring;

Pugh et al., 2023). Further, it may be the case that many of our participants did not perceive their

NSSI to be visible, and as such this was not a common consideration when they decided to disclose their experience.

**Considering the 'What Else?'**
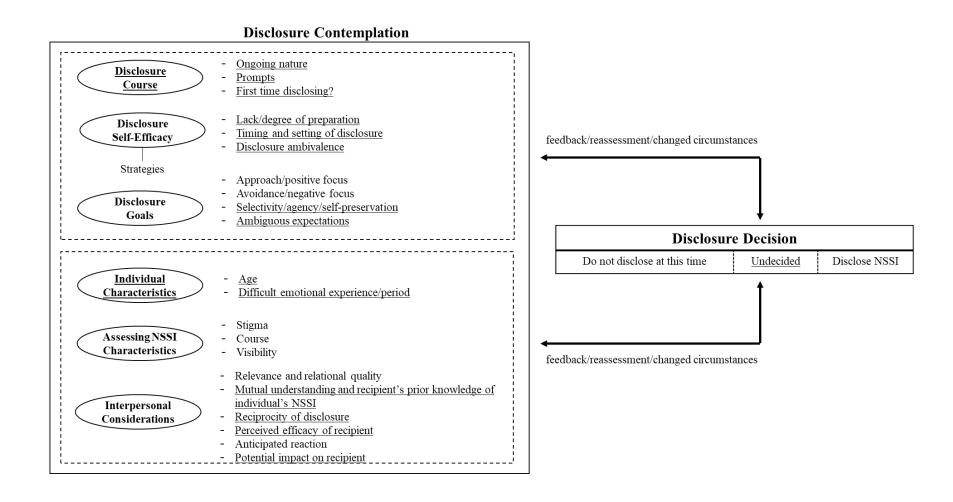
The identification of codes and categories beyond those captured in the existing disclosure frameworks suggest the potential merit of extending upon current theoretical approaches when considering disclosure of NSSI. Of note, the "Individual Characteristics" category, suggests the importance of considering an individual's own characteristics when navigating a disclosure. This fits intuitively with a person-centred approach, characterised by prioritising a person's individual lived experience as opposed to taking a universal approach to understanding NSSI (Lewis & Hasking, 2023). Given the experiential nature of disclosing information and emerging findings that previous disclosure experiences can inform, and indeed predict future NSSI disclosures (Mirichlis et al., 2023a; Simone & Hamza, 2021), the identification of the "Disclosure Course" category appears of relevance when navigating and researching disclosure as an ongoing and dynamic process. Additional research could provide greater insights into these emerging considerations for NSSI disclosure decision-making.

**A NSSI-Specific Framework.** While our findings offer support for the Disclosure Decision-Making and Disclosure Processes models, evidently there are additional considerations when conceptualising NSSI disclosure decision-making. We therefore propose a more comprehensive framework, in the form of the NSSI Disclosure-Decisions Framework. In this framework depicted in Figure 4 we aim to merge and extend upon the factors of the Disclosure Decision-Making and Disclosure Processes models that were diagrammed in Figure 1, to present a framework specific to NSSI disclosure. Additions to the existing models have been underlined in Figure 4. The considerations involved in the decision to disclose NSSI are outlined in the

"Disclosure Contemplation" box and are arranged according to the categories discussed in the findings of this study (e.g., Disclosure Course, Assessing NSSI Characteristics, etc). These categories have been further organised to reflect those broaching the process of disclosure itself (i.e., course of and self-efficacy to disclose, and the goals of disclosure) as compared to those pertaining to more contextual factors relevant to the individual in the lower dashed-box (i.e., individual and NSSI characteristics, and interpersonal considerations). It should be noted that the process by which an individual may consider the factors presented is not necessarily linear. Various factors may be considered in different combinations such that not all factors presented may inform a single disclosure decision at a given time. That is to say that whilst such frameworks can be helpful in understanding disclosure decision-making they cannot be universally applied. Rather than being an itemised checklist, the figure may serve as a suggestive guide of what may inform the decision to disclose NSSI. Also of note are the dual-headed arrows linking the contemplation and "Disclosure Decision" boxes. These arrows denote that in addition to the contemplation factors informing disclosure decisions, feedback and other changes at the point of deciding whether to disclose NSSI may inform future decision-making. Taken together, this framework is illustrative of a disclosure process which varies both contextually (e.g., between different disclosure recipients and settings) and temporally (e.g., subsequent disclosures to the same recipient over time).

**Figure 4**

*NSSI Disclosure-Decisions Framework*

**Disclosure Contemplation**

**Disclosure Course**
- Ongoing nature
- Prompts
- First time disclosing?

**Disclosure Self-Efficacy**
- Lack/degree of preparation
- Timing and setting of disclosure
- Disclosure ambivalence

Strategies

**Disclosure Goals**
- Approach/positive focus
- Avoidance/negative focus
- Selectivity/agency/self-preservation
- Ambiguous expectations

**Individual Characteristics**
- Age
- Difficult emotional experience/period

**Assessing NSSI Characteristics**
- Stigma
- Course
- Visibility

**Interpersonal Considerations**
- Relevance and relational quality
- Mutual understanding and recipient's prior knowledge of individual's NSSI
- Reciprocity of disclosure
- Perceived efficacy of recipient
- Anticipated reaction
- Potential impact on recipient

feedback/reassessment/changed circumstances

**Disclosure Decision**

| Do not disclose at this time | Undecided | Disclose NSSI |
| --- | --- | --- |

feedback/reassessment/changed circumstances

**Limitations, Future Research, and Implications**

When interpreting the implications of this research there are some key limitations to bear in mind. As the direct content analysis was applied to existing transcripts from a previous study, we were limited to the demographic and NSSI history data already collected. Given the reference to "NSSI Characteristics" in the analytical process, further information regarding participants' experiences of NSSI such as what form of self-injury they had engaged in and how recently, as well as the presence/nature of any NSSI scarring, should be collected when researching NSSI disclosure. Similarly, the emerging support for considering individual characteristics in decisions to disclose NSSI further warrants investigation amongst more diverse samples, including across varied developmental periods, cross-cultural perspectives, and minority groups with elevated rates of NSSI (e.g., LGBTIQ+ individuals; Liu et al., 2019).

Our findings could have the following implications. Theoretically, the nature and frequency of the considerations that aligned with the existing frameworks are suggestive of the utility of these frameworks when investigating NSSI disclosure. The findings indicate that when conceptualising NSSI disclosure decision-making, considerations about the information being disclosed, the recipient to disclose to, self-efficacy to disclose NSSI, and goals of disclosure should be taken into account. Additionally, novel areas for future research and theoretical expansion have been presented in the identification of new codes and categories captured in the newly proposed NSSI Disclosure-Decisions Framework. As such future research should investigate these factors, as well as further lived experience perspectives on NSSI disclosure decision-making.

The findings present a series of factors for clinicians and support persons to consider with their client/loved one, particularly if the individual with lived experience is uncertain about making such a disclosure. These factors span characteristics of the individual themself and their

NSSI experience, the disclosure recipient and the individual's self-efficacy to disclose to this person, as well as the goals and course of disclosing NSSI. Any disclosure process should be guided by the individual's lived experience and goals, such that the decision-making frameworks should be seen as no more than a flexible guide rather than a prescriptive tool for how to disclose NSSI. For example, the framework offers factors to be mindful of such as their relationship with a prospective disclosure recipient, and the extent of the relevance of their NSSI to them, though ultimately, it is an individual's own agency which makes a disclosure voluntary.

**Conclusions**

In deductively coding NSSI disclosure decision-making factors within existing disclosure frameworks, we have found that such factors tend to align with the key considerations posited in these frameworks. Several additional considerations were identified within the data, which may be specific to disclosing NSSI. These frameworks could offer tangible theoretical groundings to future NSSI disclosure research and practice, with scope to inform a NSSI-specific disclosure framework. Access to a comprehensive disclosure navigation tool could facilitate support-seeking efforts for individuals with lived experience of NSSI, mitigating negative outcomes associated with the behaviour.

**Chapter 9: General Discussion**

**Discussion Outline**

In this chapter I summarise the research aims and key findings of this program of research. Drawing on these findings I will expand on the description of a newly proposed conceptual framework of voluntary disclosure of NSSI which was introduced in the discussion of Study 5. I will then go on to discuss the limitations and implications of the research. A final conclusion to the thesis is offered at the close of this chapter.

**Project Aims**

Despite growing interest in NSSI disclosure, and its potential to facilitate supports for individuals with lived experience of NSSI, the decision to voluntarily share such experience had been under-researched (Simone & Hamza, 2020). As such, the overarching theme of this program of research was to develop an understanding of the decision-making involved in the voluntary disclosure of NSSI. This aim was addressed across five studies. The first aimed to seek out why individuals who had not previously disclosed their NSSI felt comfortable doing so in a research context (Chapter 4). Having established that individuals who have not previously disclosed their NSSI are willing to share their experiences in research, and gaining insight as to why, in Chapter 5, the objective was to identify correlates of voluntary NSSI disclosure. Along with factors from existing NSSI disclosure literature, the correlates from Chapter 5 were incorporated into Chapter 6, in which the aim was to ascertain the relative importance of various factors to the decision to disclose NSSI, overall, and between different recipients. From here, I sought further lived experience perspectives on the NSSI disclosure decision-making process in Chapter 7, before assessing the fit of these perspectives to previously established frameworks of personal information disclosure (Chapter 8). Key findings gained from these objectives are synthesised further below.

**Key Findings**

Findings from this thesis pertain both to the way in which voluntary disclosure of NSSI is conceptualised and the processes involved in deciding whether to disclose NSSI.

*Defining Voluntary Disclosure of NSSI*

Within pre-existing literature, conceptualisation of NSSI disclosure, let alone the disclosure of personal information broadly, are varied (Simone & Hamza, 2020). In some work any instance of others learning of one's NSSI is captured in the operationalisation of disclosure, whether that be by way of involuntary discovery (see Pugh et al., 2023), or with voluntary intent regardless of whether they reflect help-seeking efforts. For the purposes of this program of research, disclosure has been operationalised as instances in which individuals have voluntarily sought to disclose their NSSI, though not necessarily with the intention to seek help. Participants' accounts soon highlighted the ambiguity of what is meant by "voluntarily", providing novel insights into how NSSI disclosure might best be conceptualised.

One such consideration is what qualifies as a disclosure. The majority of the NSSI disclosure literature and the current research program focuses on face-to-face disclosures in social or clinical settings (Simone & Hamza, 2020). In Chapter 4 however the concept of disclosure in research was explored. This is an important area to examine given the proportion of individuals with lived experience of NSSI who report having disclosed their experience in research but not elsewhere (Simone & Hamza, 2020). The similarity in participants' approaches to sharing their experiences in NSSI research to that of NSSI disclosure generally, suggests at some of the considerations relevant in other disclosure settings may also be relevant in research. For example, the safe space provided by research contributed to participants' comfort in discussing their NSSI in research, reflecting notions such as trust that have been highlighted throughout this thesis to being relevant to the decision to disclose NSSI broadly.

In contrast, other insights provided by participants in Chapter 4 indicate that sharing NSSI experiences in research may be distinct from other forms of disclosure. Of note is the salience for some of research participation involving engagement with a stranger in a setting distinct from their day-to-day life, for the purposes of contributing to empirical evidence, as opposed to a dyadic conversation with a known relation (e.g., friend). There appear to be some parallels to other disclosure settings. Namely, if disclosing one's NSSI experiences in research may be comparable to disclosures to formal sources such as health professionals (Simone & Hamza, 2020; Mirichlis et al., 2023a). Indeed, distinctions in rates of and approaches to NSSI disclosures to formal and informal (e.g., friends, significant others, family) sources have been reported in the literature (Simone & Hamza, 2020). Generally, disclosures to formal sources are less common than those in personal relationships, with this trend reflected in the disclosure experiences reported by participants in this program of research (Chapters 5 and 6).

Two key considerations may differentiate how NSSI disclosures made to informal, as compared to formal sources are approached. Generally, participants who disclosed to formal sources sought tangible aid, for example therapeutic interventions, and a value for privacy manifested as a preference for the therapeutic relationship distant from their personal life (see Chapters 6 and 7). These preferences in part reflect the practical goals and views of researchers as an entity distinct from one's personal life when discussing lived experiences of NSSI in research (Chapter 4). In contrast, disclosures to informal sources tend to be more in search of socio-emotional support, with trust and closeness in one's relationship with their disclosure recipient viewed as a privacy safeguard (Chapters 5-7). These competing similarities and contrasts between discussing one's NSSI in research and disclosures across settings, highlight some of the complexity in defining voluntary disclosure of NSSI, necessitating further investigation into the role and experience of discussing lived experiences in research.

Aside from what may qualify as disclosure, participants also raised considerations into how the voluntary aspect of NSSI disclosure may be conceptualised. As opposed to the dichotomy presented in the literature that NSSI disclosure is either voluntary or not, findings from the current program of research indicate that disclosure exists on a spectrum, with varying degrees of being voluntary. Specifically, participants' accounts reflected competing wants and barriers to disclosure resulting in disclosure ambivalence (Gray et al., 2021), varying degrees of pre-meditation and deliberation as opposed to spontaneity in their disclosures, and mixed views on the acceptability of forward disclosures of their experiences. Further, some participants noted that their disclosures were prompted by others, for example in response to wellbeing check-ins, noting that whilst they may or may not have otherwise disclosed, they were ultimately willing to do so following such a prompt.
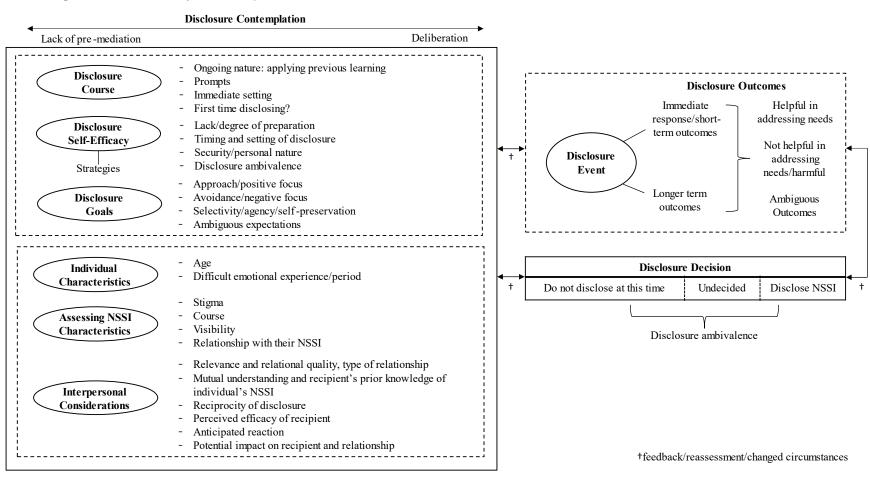
Underlying these perspectives of voluntary NSSI disclosure are two broad approaches to defining voluntary action, one being the degree of control, desire, and intent discussed in philosophical literature (e.g., Wall, 2001), and the other reflecting the processes of conscious thought, decision-making, and planning of a neuropsychological perspective (e.g., Colautti et al., 2022). Disclosure decision-making models blend these approaches, presenting processes by which individuals may think about disclosing personal information, that they intend on sharing with others. Adopting the spectrum perspective of voluntary disclosure from my participants when engaging with disclosure decision-making models offers a lived-experience and theoretically informed definition of voluntary disclosure of NSSI. As such, voluntary disclosure of NSSI may be considered on a spectrum, involving a degree of intent and planning to share one's NSSI with another person or group, face-to-face or via other means of direct communication.

### Processes of Voluntary NSSI Disclosure Decision-Making

Beyond defining voluntary disclosure, this program of research sought to better understand the decision-making processes informing NSSI disclosures. The Disclosure Decision-Making (Greene, 2009) and Disclosure Processes models (Chaudoir & Fisher, 2010) provide a theoretical foundation for examining such processes for the disclosure of personal information more generally. In these models, individuals are suggested to consider a range of factors when evaluating whether it is worthwhile to disclose personal and often stigmatised information such as HIV status and mental health difficulties. These considerations largely pertain to the nature of the information being shared (e.g., its visibility), to whom the individual would disclose this to, the individual's capacity to make such a disclosure, and the goals of the disclosure (Greene, 2009; Chaudoir & Fisher, 2010). In Chapter 8, the degree of fit between lived experience perspectives of NSSI disclosure decision-making and these existing frameworks was discussed. While many of the factors that informed the decision to disclose NSSI were captured in Greene's (2009), and Chaudoir and Fisher's (2010) models, there were particular considerations unique to NSSI disclosure. As such, a novel conceptual framework of NSSI disclosure was proposed. Introduced in Chapter 8, this framework has been expanded below (see Figure 5) to incorporate factors identified throughout this thesis and the broader NSSI disclosure literature.

**Figure 5**

*Conceptual Framework of Voluntary NSSI Disclosure*



**Disclosure Contemplation**

Lack of pre-mediation → Deliberation

**Disclosure Course**
- Ongoing nature: applying previous learning
- Prompts
- Immediate setting
- First time disclosing?

**Disclosure Self-Efficacy**
- Lack/degree of preparation
- Timing and setting of disclosure
- Security/personal nature
- Disclosure ambivalence

Strategies

**Disclosure Goals**
- Approach/positive focus
- Avoidance/negative focus
- Selectivity/agency/self-preservation
- Ambiguous expectations

**Individual Characteristics**
- Age
- Difficult emotional experience/period

**Assessing NSSI Characteristics**
- Stigma
- Course
- Visibility
- Relationship with their NSSI

**Interpersonal Considerations**
- Relevance and relational quality, type of relationship
- Mutual understanding and recipient's prior knowledge of individual's NSSI
- Reciprocity of disclosure
- Perceived efficacy of recipient
- Anticipated reaction
- Potential impact on recipient and relationship

**Disclosure Outcomes**

**Disclosure Event**
- Immediate response/short-term outcomes
- Longer term outcomes

- Helpful in addressing needs
- Not helpful in addressing needs/harmful
- Ambiguous Outcomes

**Disclosure Decision**

| Do not disclose at this time | Undecided | Disclose NSSI |

Disclosure ambivalence

†feedback/reassessment/changed circumstances

*Note.* Adapted from Mirichlis et al. (under review)

The framework consists of three broad sections moving from pre- to post-disclosure. Firstly, on the left-hand side is "Disclosure Contemplation" in which factors pertaining to the decision of whether to disclose one's NSSI are outlined. The degree to which an individual may engage in active deliberation prior to disclosing their NSSI is indicated by the double-headed arrow across the top of the box. The contemplation factors have been segregated with those relevant to the disclosure process itself captured in the top-half of the box (i.e., Disclosure Course, Disclosure Self-Efficacy, and Disclosure Goals), whereas contextual factors about the individual disclosing, their NSSI experiences, and interpersonal considerations are noted in the bottom-half of the box. Disclosure contemplation factors presented in this framework capture both facilitators for and barriers to NSSI disclosure. At this point of the disclosure process, an individual considering NSSI disclosure could establish that their goal is to seek social support from a friend (Approach-focused goal) as they have recently had an emotionally difficult period (Individual Characteristics), and though they are mindful that NSSI is stigmatised (NSSI Characteristics), this friend has been supportive before during difficult experiences (interpersonal considerations). Three particular findings of interest from this portion of the framework are the roles of disclosure goals, one's self-efficacy to disclose, and interpersonal trust.

The driving goals of NSSI disclosures have not been well understood, though participants in this program of research have provided key insights into why they disclosed their NSSI (Simone & Hamza, 2020). Of note, similar approaches may underly multiple disclosures but result in varied outcomes. Further, reasons for disclosures can vary across instances, with intersections between disclosure goals and interpersonal considerations appearing particularly relevant. For example, disclosures in formal settings tend to reflect more tangible support seeking efforts than those to personal relationships. Although Chaudoir and Fisher (2010)

suggest both positively and negatively focused disclosure goals, the current findings highlight that one's expectations of disclosing their NSSI can also be more ambiguous, and at times undefined. Consistent with previous research (e.g., Simone et al., 2022), trust within the relationship that a disclosure occurs was of great importance to our participants. Such trust was often described as a protective factor against barriers of disclosure such as stigma (Rosenrot & Lewis, 2020). The way in which trust manifests with regards to NSSI disclosure may differ. Participants' accounts of trust in personal relationships tended to reflect a closeness and confidence in the disclosure recipient maintaining confidentiality. Though the latter was also present in participants' descriptions of trust in formal relationships, here a sense of professionalism and efficacy of the recipient to respond appropriately were also pertinent. Self-efficacy to disclose one's NSSI had been an under-researched component of NSSI disclosure, though the current research highlights some factors that may inform one's disclosure self-efficacy (e.g., trust in relationship, expectations of stigma; Simone & Hamza, 2020). The conceptualisation of disclosure self-efficacy and its facets warrants further research.

Decisions regarding disclosure are captured in the bottom-right box of the framework. Of note, ambivalence about whether to disclose NSSI is depicted. The dual-headed arrows with obelisk connecting this box with that of "Disclosure Contemplation" denotes the reciprocal exchange of information informing an individual's disclosure decision-making. For example, an individual may believe that it is relevant for them to disclose their NSSI to a loved one, but feel unprepared to disclose at this time, these aspects of "Interpersonal Considerations" and "Disclosure Self-Efficacy" may contribute to a sense of ambivalence about whether they should disclose their self-injury, this resolve may in turn inform future contemplation about NSSI disclosure. Similarly, deciding to disclose one's NSSI eventuates into the "Disclosure Event"

itself and the subsequent outcomes of the disclosure as outlined in the third box of the framework. The obelisk-marked arrows connecting this box to those regarding disclosure contemplation and decisions, reflects how disclosure experiences can inform future disclosure decision-making.

Taken together, this conceptual framework is illustrative of a non-linear and dynamic process of NSSI disclosure. An individual's decision to disclose their NSSI may be informed by any unique combination of the factors listed in the "Disclosure Contemplation" box, which may vary according to context (i.e., across disclosure recipients, e.g., friends vs. health care professionals, and settings, e.g., at school vs. in one's home). Further, the NSSI disclosure process may vary when disclosing to the same recipient at different times for example an individual may approach their first disclosure to a friend lacking self-efficacy following an emotionally difficult period. Assuming the disclosure is helpful in addressing their needs an individual may disclose NSSI to this friend again in the future with specific expectations as to how this friend will react, and with greater confidence in their ability to disclose to them.

**Implications and Additional Future Research Directions**

The findings of this research are illustrative of the dynamic, individualised, and interpersonal nature of NSSI disclosure, as well as its distinction from other forms of personal information disclosure. Of note, this research has led to the development of a new conceptual framework of voluntary disclosure. This novel framework could offer utility in understanding not just what voluntary disclosure of NSSI entails but also hold practical usefulness in that it affords guidance for those considering disclosure and their support persons on how to navigate this. For example, clinicians could work with clients to establish reasonable expectations given the ongoing nature of disclosure outlined in the model, such that an individual may position

themselves to develop a support plan across a number of disclosures, rather than a single discussion. Such decision-making and planning could be facilitated via engagement with research-informed resources such as those created as an output of this research project (see Appendix N). Here, handout resources were curated for both those considering disclosing their NSSI and for those who might receive NSSI disclosures. These resources provide information about what NSSI and its disclosure is, they provide an outline of considerations when deciding whether to disclose NSSI/for how to respond to a disclosure, and provide links to further support and information. Plans for disseminating these resources to local education institutions and healthcare settings are currently underway. Relatedly, the findings of this thesis and the subsequent conceptual model could contribute to the development of disclosure decision-making tools, the utility of which could be assessed in future research. In terms of further implications for future research, the development of this framework presents opportunities for its evaluation and validation, including via the use of deductive thematic analysis, but also for the investigation for previously under-researched aspects of NSSI disclosure that emerged as salient in this line of inquiry (e.g., expectation, self-efficacy). Such future research should expand on the forms of voluntary NSSI disclosure so that disclosures to different recipients, by diverse individuals, and in different cultures are explored for greater comprehension of the framework.

Participants in this research program have highlighted the value of lived experience perspectives in understanding NSSI disclosure. The inclusion of individuals who had not previously disclosed their NSSI, along with those who have, allowed for unique insights into the barriers and ambivalence involved in NSSI disclosure decision-making. Additionally, the perspectives shared by our lived experience participants afforded the conceptual framework to be grounded in such perspectives. Inclusion of lived experience perspectives aligns with movements

encouraged not just in research, but in practice too (World Health Organisation, 2023). For example, at the time of writing this thesis, both the *Australian Journal of Psychology* and *Qualitative Research in Medicine and Healthcare* journal have calls for lived experience focused papers. In this research, the value of lived-experiences being captured is exemplified by the intricacies of the degree to which one may deliberate their decision to disclose NSSI. Such deliberation was previously taken for granted in the literature, with disclosures essentially being viewed as either voluntary or not, however our participants have indicated that it may not be this simple. The theoretical implication of this finding intersects with the conceptualisation of "Involuntary Disclosure Experiences", a relatively new field in NSSI disclosure literature. Lived-experience driven research differentiating voluntary and involuntary disclosure is therefore warranted. Relatedly, the need for person-centred approaches to NSSI disclosure was explicated by participants' diverse expectations of disclosures. This finding aligns with calls for such individually-grounded approaches in the NSSI field (e.g., Lewis & Hasking 2021). Looking to NSSI research broadly, the benefits of such research participation have been emphasised here as they have been done previously (e.g., Robinson et al., 2023; Whitlock et al., 2013b). Researchers have an ethical and scientific obligation to involve individuals with lived experience of NSSI appropriately in their research.

**Limitations of Thesis**

As outlined in the preceding chapters, the findings of this research are not without their caveats. One such limitation to bear in mind when interpreting the findings is that the studies predominantly focused on in-person dyadic disclosures. Although great insight into such disclosures have been gained here, there may be unique considerations of other forms of voluntary NSSI disclosures that have been overlooked. For example, people who disclose their

NSSI online, rather than face-to-face may be more likely to do so for help-seeking purposes (Tanner, 2023). Indeed, the unique potential to remain anonymous when disclosing NSSI online has been highlighted in the sparse literature into disclosures in this setting (Simone & Hamza. 2020). As such, the novel framework of NSSI disclosure should be investigated in the context of other forms of disclosures to appropriately inform how such disclosures are facilitated.

It should also be noted that while the retrospective, and at times hypothetical, lens used throughout this program of research offered insight into participants' perspectives on disclosure decision-making, we need to interpret the resultant findings within this context. Namely, when interviewing participants for chapters 7 and 8, the processing and reflection of their experiences retrospectively highlighted the cruciality of epistemology when making meaning of lived experiences. For example, an individual may have felt hesitant at the time to disclose their NSSI but ultimately decided to proceed. Upon reflection they might view this disclosure as being completely voluntary despite their hesitation, perhaps in part due to positive outcomes following that disclosure. Whether this reflection is interpreted as "valid", or "fact" would be informed by both the participant's and the researcher's epistemological positions (Brinkman & Kvale, 2019). Further, some insights into disclosure decision-making were based upon hypothetical situations (e.g., in Chapter 6), though it is established that intentions and actions do not necessarily align (Sniehotta et al., 2014). As such, what participants deem to be important to the decision to voluntarily disclose NSSI, and how any particular disclosure unfolds may vary. Capturing more proximal perspectives on disclosure decision-making by way of diary study research could be complementary to the findings identified in this thesis.

Finally, the samples of this research were largely homogenous being mostly composed of university students. Though exploration of NSSI disclosure experiences in this population is

invaluable given the unique challenges they face (e.g., Kiekens et al., 2016), a key point of discussion has been the importance of an individualised approach to NSSI disclosure. Given the preliminary insights gained into some cultural considerations when disclosing NSSI (e.g., values, stigma), investigating voluntary disclosure of NSSI across diverse cultures may provide more comprehensive insights into the decision-making process, to allow for more appropriate supports for more people with lived experience of NSSI (Simone & Hamza, 2020).

**Conclusions**

This program of research offers novel conceptual understandings of voluntary NSSI disclosure, only made possible due to the rich insights provided by its participants. Individually the studies of this thesis have contributed to the literature of NSSI research participation, correlates of disclosure, the relative importance of disclosure decision-making factor, and how they fit together to inform the decision to disclose NSSI. Collectively, the findings have informed the critique of the way in which voluntary disclosure of NSSI is conceptualised, and the development of a topic-specific framework of disclosure-decision making. In all, this thesis provides clinicians, researchers, and the broader community with opportunities to better understand and appropriately facilitate NSSI disclosure.

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**Appendices**

**Appendix A**

**Chapters 4 and 6 Ethics Approval**

**Curtin University**

22-Jul-2021

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

Dear Penelope Hasking

**RE: Ethics approval**
**Approval number: HRE2021-0429**

Thank you for submitting your application to the Human Research Ethics Office for the project **What is Important to the Decision to Disclose Non-Suicidal Self-Injury?**.

Your application was reviewed by the Curtin University Human Research Ethics Committee at their meeting on **06-Jul-2021**.

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 **22-Jul-2021** to **21-Jul-2022**. 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 |
| Mirichlis, Sylvanna | Student |
| 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
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 B

# Chapters 4 and 6 Information Sheet and Survey Items

**Default Question Block**

PARTICIPANT INFORMATION STATEMENT

| HREC Project Number: | HRE2021-0429 |
|---|---|
| Project Title: | *What is Important to the Decision to Disclose Non-Suicidal Self-Injury?* |
| Chief Investigator: | *Prof Penelope Hasking* |
| Associate Investigator(s): | *A/Prof Mark Boyes & Prof Stephen P Lewis (U of Guelph)* |
| Student researcher: | *Sylvanna Mirichlis* |
| Version Number: | *2* |
| Version Date: | *19/07/2021* |

**What is the Project About?**
Non-suicidal self-injury (NSSI) is the deliberate damage to one's body without trying to end one's life (e.g., cutting, burning). We are interested in learning about the factors people with lived experience of NSSI consider to be important when deciding whether to disclose this to friends, family, significant others, a health professional, and/or other people.

We would like to focus on what might be important if you were to voluntarily disclose your self-injury by your own choice, rather than thinking about other ways people might discover your self-injury.

We think it is important to learn about disclosure of self-injury from the point of view of people who have lived experience so we can better guide future research and practice in the area. We aim to recruit students with lived experience of self-injury complete our survey, regardless of whether they have previously told another person about their self-injury.

**Who is doing the Research?**
PhD candidate Sylvanna Mirichlis, Professor Penelope Hasking, Associate Professor Mark Boyes, and Professor Stephen P Lewis will be conducting this research.
This project will be used, in part to help obtain a Doctorate of Philosophy in Psychology at Curtin University and is funded by the university.

**What will I have to do?**
If you are willing to participate in this research, you will be asked to complete an online survey. The first part of the survey asks you demographic questions and about your NSSI, and whether you have disclosed your NSSI to anyone. You will then be asked who you have disclosed to (friend, family, significant other, health professional, other) and to rate the importance of a range of factors to the decision of whether to disclose NSSI to each of the relationship types.

If you have not disclosed your NSSI to somebody before you will be asked some follow up questions about participating in research like this.

The survey is estimated to 30-40 minutes to complete.

**What are the risks and benefits of participating?**
We understand that talking about your self-injury experiences may be upsetting. You are welcome to take breaks as needed, and you can choose to withdraw participation at any point before we de-identify responses (as after that point we will not be able to trace back individual responses to the participant). You can withdraw from the survey by closing your internet browser. Any information entered prior to that will be used in analysis.

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 or to find more information visit: https://students.curtin.edu.au/personal-support/counselling-guidance/counselling/.

Taking part in this research is voluntary, it is up to you whether you take part or not. While there may be no direct benefits to you participating in this research, it will provide the opportunity for you to share your opinions in a safe way. Furthermore, knowledge gained from this research will contribute to the broader understanding of self-injury disclosure and could lead to the development of better resources for people who have self-injured and different types of disclosure recipients.
Only Curtin students recruited via SONA will receive 2 SONA points for participating.

If you choose to participate, resources (e.g., information about helplines and other support services, websites, and self-injury fact sheet) will be provided at the end of the survey (and after this information sheet).

**Who will have access to my information?**

If you are a Curtin student we will ask you your name, student email and ID so that we can allocate your SONA credit points. If you are interested in participating in our future research, we ask that you provide your email address at the end of the survey.
Once your grades have been finalised at the end of semester, identifying information such as this will be removed so that the data is anonymous. Please note however that your data will be used in the study even if these details are not provided.

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.

Collected data will be stored on Curtin's secured research server which is password protected. This information will be kept for at least 7 years after the research is published. De-identified data may be deposited in a public repository if this is a requirement for publication.

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. If you wish to have a copy of the final findings, please contact one of the researchers in 2022 (see below for contact details).

What happens next and who can I contact about the research?
If you have questions or concerns relating to this project, please contact Sylvanna Mirichlis at sylvanna.mirichlis@postgrad.curtin.edu.au or Prof Penelope Hasking on 9266 3437 or at penelope.hasking@curtin.edu.au

If you decide to take part in this research you can provide your consent to participate by selecting the yes option in the next question, this will take you the start of the survey. If you do not want to participate please select the no option. Consent will also be assumed if you simply press the arrow button.

Providing consent indicates that you agree to be in the research project and have your information used as described. Please take your time and ask any questions you have before you decide what to do.

Whether or not you choose to participate or withdraw will not affect your relationship with the university or its staff

Curtin University Human Research Ethics Committee (HREC) has approved this study (*XXXX 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.
If reading this raises any issues for you, you may like to view these: Resources

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Do you consent to participate in this research?

○ yes

○ no

---

Are you a Curtin University student participating for SONA credit points?

○ yes

○ no

Demographics

How old are you?

[_____]

What gender do you identify as?

○ Man

○ Woman

○ Another gender, please specify

[_____]

What country were you born in?

[_____]

**Do you identify as Aboriginal or Torres Strait Islander?**

○ Yes

○ No

**Have you ever been diagnosed with a mental illness?**

○ Yes

○ No

**Please specify which mental illness(es) you have been diagnosed with**

[                                                      ]

**Have you ever sought professional help for a mental illness?**

○ Yes

○ No

**Who did you seek help from? (tick all that apply)**

☐ GP

☐ Psychologist

☐ Psychiatrist

☐ School psychologist/counselor

☐ Counselor

☐ Phone help line (eg lifeline)

☐ Religious leader/chaplain

☐ Other (please specify)

[          ]

## ISAS

### Self-injury

In this next section we will ask you questions about your experience with self-injury. We will ask about your personal experience of self-injury.

If you become upset at any stage we suggest taking a break or completely stopping the questionnaire. Remember there are some resources you might find useful that are free to download at end of this questionnaire.

Self-injury refers to directly and intentionally hurting yourself without the intention of killing yourself.

**Have you ever engaged in self-injury?**

○ Yes

○ No

Thank you for your interest in this study. Unfortunately you are not eligible to participate, as a result if you signed up for this study via SONA you will not granted credit points.

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

○ None

○ Once

○ Twice
○ Three times

○ Four times

○ Five or more times

**What age did you start to self-injure?**

**What age did you most recently self-injure?**

**Please only endorse a behavior if you have done it intentionally (i.e., on purpose) and without suicidal intent (i.e., not for suicidal reasons). Please select all that apply**

- ☐ 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, please specify:

**If you feel that you have a main form of self-injury, please indicate from the list below the behavior that 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 wounds healing
- ☐ Rubbing skin against rough surface
- ☐ Sticking yourself with needles
- ☐ Swallowing dangerous substances
- ☐ Other

**Do you experience physical pain when you self-injure?**

- ○ Yes
- ○ No

**When you self-injure are you usually alone?**

○ Yes

○ No

**Typically how much time elapses 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

**Have you ever sought professional help specifically for self-injury?**

○ Yes

○ No

**Do you want to stop self-injuring?**

○ Yes

○ No

**This inventory was written to help us better understand the experience of non-suicidal self-injury. Below is a list of statements that may or may not be relevant to your experience of self-injury. Please identify the statements that are most relevant for you.**

**When I self-injure I am......**

|  | 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 | ○ | ○ | ○ |
|  | Not relevant | Somewhat relevant | Very relevant |
| 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 that 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 | ○ | ○ | ○ |
|  | Not relevant | Somewhat relevant | Very relevant |
| Creating a physical injury that 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 | ○ | ○ | ○ |
| Fitting in with others | ○ | ○ | ○ |

| | Not relevant | Somewhat relevant | Very relevant |
|---|:---:|:---:|:---:|
| Seeking care or help from others | ○ | ○ | ○ |
| Demonstrating I am tough or strong | ○ | ○ | ○ |
| Proving to myself that my emotional pain is real | ○ | ○ | ○ |
| | Not relevant | Somewhat relevant | Very relevant |
| 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 still alive when I don't feel real | ○ | ○ | ○ |
| Putting a stop to suicidal thoughts | ○ | ○ | ○ |
| | Not relevant | Somewhat relevant | Very relevant |
| 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 | ○ | ○ | ○ |

**Disclosure Status**

**Have you ever voluntarily disclosed your self-injury to another person, face-to face?**
By this we mean was it your choice to talk to this person(s) about your self-injury

○ Yes

○ No

**Who have you disclosed to?**
Please select all that apply:

☐ Friend

☐ Family

☐ Significant other

☐ Health Professional, if so what kind/s?
[          ]

☐ Other, please specify
[          ]

**2. Ratings**

Below you will be presented with a range of factors. Please use the scale to indicate how important you think each of the factors would be to the decision to disclose to each person. Even if you have not disclosed to these people before, we would like to know what you think.

A rating of 0 would indicate that it is not at all important to the decision to disclose self-injury, whereas a rating of 100 would indicate it is extremely important.

If something does not apply you can respond with 0.
There are no right or wrong answers, we are interested in *your* opinion.

Expecting others to have negative views (e.g., judgement) about your self-injury

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Feeling bad about yourself because you have self-injured (e.g., feeling ashamed)**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Negative views about self-injury from the general public**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Having previously experienced discrimination because of your self-injury**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**How recently you self-injured**

| | Not at all Important | | Slightly important | | Moderately important | | Very important | | Extremely important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Desire to continue self-injuring**

| | Not at all Important | | Slightly important | | Moderately important | | Very important | | Extremely important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Desire to stop self-injuring**

| | Not at all Important | | Slightly important | | Moderately important | | Very important | | Extremely important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Feeling by your own definition, recovered from self-injury**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Being seen engaging in self-injury**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Having wounds seen after injuring yourself**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Thinking that someone might find items used to self-injure**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Having physical scars from self-injury**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Having visible scars from self-injury**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Requiring medical care because of self-injury**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Wanting to keep your self-injury concealed/a secret**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Your confidence in being able to talk to this person about your self-injury**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Having the physical means to talk to this person about your self-injury (i.e., physically close or phone/internet to communicate)**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Confidence in your knowledge to be able to answer questions they might have had about it**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Impact on this person if you did not tell them**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Relevance of your self-injury to this person**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Quality of relationship with this person**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Amount of trust in the relationship**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

## How emotionally close you feel to this person

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

## Expecting a particular reaction to the disclosure from this person.

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

## What kind/s of reactions would you expect?

| | Provide your answers in the text boxes below (note that the boxes can fit more text than what is displayed, i.e. you will not be confined to the size of the box). |
|---|---|
| Friend | |
| Family Member | |
| Significant Other | |
| Health Professional | |
| Other | |

## wanting to disclose your self-injury to let the other person know you are/have been experiencing distress

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Thinking that the disclosure experience could be distressing**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Thinking that the disclosure experience could improve your wellbeing**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Thinking that this person could provide social support**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Thinking that you could lose social support from this person if you disclosed to them**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Expecting to feel less socially isolated if you disclosed to this person**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Expecting that disclosing your self-injury to this person would impact how you feel about yourself**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Expectation that your relationship with this person would be negatively impacted**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | |
| Family Member | | | | | | | | | | |
| Significant Other | | | | | | | | | | |
| Health Professional | | | | | | | | | | |
| Other | | | | | | | | | | |

**Expectation that your relationship with this person would be positively impacted**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | |
| Family Member | | | | | | | | | | |
| Significant Other | | | | | | | | | | |
| Health Professional | | | | | | | | | | |
| Other | | | | | | | | | | |

**Knowing whether this person has also self-injured**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | |
| Family Member | | | | | | | | | | |
| Significant Other | | | | | | | | | | |
| Health Professional | | | | | | | | | | |
| Other | | | | | | | | | | |

**Expecting that knowing that you have self-injured would impact this person in some way**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Wanting to seek professional help**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Other people already knew about your self-injury**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Wanting to tell them before they found out some other way**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | |
| Family Member | | | | | | | | | | |
| Significant Other | | | | | | | | | | |
| Health Professional | | | | | | | | | | |
| Other | | | | | | | | | | |

**Seeking acceptance**

**The physical and/or medical intensity of your self-injury**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | |
| Family Member | | | | | | | | | | |
| Significant Other | | | | | | | | | | |
| Health Professional | | | | | | | | | | |
| Other | | | | | | | | | | |

**You had previously disclosed your self-injury to somebody else**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**You had previously disclosed mental health difficulties**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**The impact self-injury has had on you (physically, emotionally, socially, or in some other way)**

| | Not at all Important | | Slightly Important | | Moderately Important | | Very Important | | Extremely Important | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Friend | | | | | | | | | | | |
| Family Member | | | | | | | | | | | |
| Significant Other | | | | | | | | | | | |
| Health Professional | | | | | | | | | | | |
| Other | | | | | | | | | | | |

**Not disclosed**

Since you indicated that you have not previously voluntarily disclosed your self-injury before, we are interested in why you felt comfortable in commenting on your experiences in this research.

In your words why did you feel comfortable in discussing your self-injury in this research?

**SONA details**

Thank you for taking the time to complete this questionnaire.

So we can award you credit in SONA please enter your full name and student ID.
Even if you are NOT participating in this study via SONA, please enter your email address if you are interested in participating in our future research.
Identifying information will be permanently removed from the data set as soon as grades are ratified at the end of semester.

You may find these Resources helpful if this questionnaire has raised any issues for you.

| | |
|---|---|
| Full name | |
| Student ID | |
| email | |

**Eligibility**

**Appendix C**

**Chapter 4 Journal Copyright**

**Appendix D**

**Chapter 5 Ethical Approvals**

**Longitudinal NSSI study**



**Curtin University**

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

11-Feb-2019

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

Dear Penelope Hasking

**RE: Ethics approval**
**Approval number: HRE2019-0050**

Thank you for submitting your application to the Human Research Ethics Office for the project **Longitudinal NSSI study**.

Your application was reviewed by the Curtin University Human Research Ethics Committee at their meeting on **05-Feb-2019**.

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 **11-Feb-2019** to **11-Feb-2020**. 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 |
| Howell, Joel | 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

**The experience of self-injury study**

**Curtin University**

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

**Understanding Recovery from NSSI Ethics**

**Curtin University**

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

19-Feb-2020

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

Dear Penelope Hasking

**RE: Ethics approval**
**Approval number: HRE2020-0078**

Thank you for submitting your application to the Human Research Ethics Office for the project Understanding recovery from NSSI.

Your application was reviewed by the Curtin University Human Research Ethics Committee at their meeting on 04-Feb-2020.

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 **19-Feb-2020** to **19-Feb-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 | CI |
| 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
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

## Appendix E

## Chapter 5 Information Sheets and Survey Items

### Longitudinal NSSI study

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**Default Question Block**

**Longitudinal NSSI Study**
**Participant Information Sheet**

| | |
|---|---|
| **HREC Project Number:** | **XXXX** |
| **Project Title:** | **Longitudinal NSSI Study** |
| **Principal Investigator:** | Associate Professor Penelope Hasking |
| **Co-Investigators:** | Dr Mark Boyes <br> Dr Joel Howell |
| **Version Number:** | v1.0 |
| **Version Date:** | November 2018 |

Up to one third of university students engage in NSSI (the deliberate damage to bodily tissue without intent to die), which is associated with a range of academic, social, emotional and psychological outcomes. Prior work has identified a number of social, cognitive, and psychological factors that contribute to, or maintain, NSSI. These include: how someone experiences and regulates their emotions, a history of psychological distress, their belief in their ability to tackle life's challenges, and their thoughts about emotion. The majority of these studies are cross-sectional, precluding any investigation of how these variables might change over time, and fluctuate with changes in NSSI (i.e. increasing/decreasing frequency; recovery from NSSI).

We invite all students, both with and without experience of self-injury, to take part in the current study to assess how these variables are related over time.
Please read this Information Sheet in full before making a decision. If you have any questions you would like to ask before participating please contact the Principal Investigator.

You can come back and finish the survey any time within one week. After one week your responses will be deleted and you will need to start again if you wish to participate in the study.

**Why were you chosen for this research?**
All undergraduate students enrolled in the Curtin University Psychology Undergraduate Participant Pool are eligible to participate. To answer our research questions we need both people who self-injure and people who do not self-injure to participate.

**What does the research involve?**
You are invited to complete a questionnaire online that can be completed whenever you like. If you agree to participate, you will be asked questions about any experiences you have had with self-injury, and your beliefs about what people might expect to happen when they self-injure. You will also be asked about how you experience, think about, and change emotions. Finally we will ask some questions about your emotional health and levels of distress.

The questionnaire will take approximately 45-60 minutes to complete.

We are interested in how these variables change over time. If you participate in this study we will invite you to do the same questionnaire again each semester (contributing SONA points toward that semester).

We may also ask you if you are interested in participating in an interview about your experiences with self-injury, or knowing someone with experience of self-injury.

**Possible benefits**
While you may not personally benefit from participating in this study the results will help us better understand the factors that initiative and maintain self-injury. Furthering our understanding of this complex behaviour will help us develop more effective prevention and early intervention initiatives to help those who want to stop self-injuring.

You will be awarded 4 credit points if you answer at least 80% of the questions in the survey.

**Possible risks**
It is unlikely that participating in this study will incur any risks beyond normal day-to-day living. However some of the questions asked could trigger upsetting thoughts and memories for some people. Being in this study is voluntary and you are under no obligation to consent to participate. If you do consent to participate but later change your mind, you may withdraw from further participation by simply closing your browser. Note that any responses you have already made will automatically be recorded.

If you do become upset at any stage while completing the questionnaire we suggest you take a break or stop the questionnaire. A list of useful resources is provided at the bottom of this information sheet, and at the end of the questionnaire.

We are also interested in how the variables we assess are related to academic performance. For this reason we would also like to seek your permission to access your Course Weighted Average (CWA). This information will only be used for this research project and will not be provided to any third party. You can still complete the questionnaire even if you do not consent for us to access this information.

Confidentiality
We will ask for your name and student ID number to allow us to match your responses to your record in SONA, allowing us to award you course credit. Your student ID will also be used to match responses to the questionnaires over different semesters. At completion of the study, all identifying information will be removed from the data and only anonymous data will be stored. No information that could identify any participant will ever be released to a third party or made public in any way. Some journals request that raw data be made available when articles are published. In this case we will only provide de-identified data that will not identify any individuals or their responses.

Storage of data
Data collected will be stored in accordance with Curtin University regulations, kept on University premises, in a password protected file for 7 years. A report of the study may be submitted for publication, and data may be used to support student research projects (e.g. theses), but individual participants will not be identifiable in any report or student thesis.

Results
If you would like to be informed of the aggregate research finding, please contact Penelope.Hasking@curtin.edu.au in December 2015.


Thank you!

A/Prof Penelope Hasking
Ph: 9266 3437
E: Penelope.Hasking@curtin.edu.au

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number 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.

Useful resources
Talking to students october 2018
Stress management

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| I have received information regarding this research and had an opportunity to ask questions. I believe I understand the purpose, extent and possible risks of my involvement in this project and I voluntarily consent to take part. |

○ I agree

○ I do not agree

# The Experience of Self-Injury Study

**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.

## Understanding NSSI Recovery Study

Info sheet

**Understanding NSSI Recovery**
**Professor Penelope Hasking (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 it is used to help cope with overwhelming feelings. While a lot of work has been done to better understand why people self-injure, less work has focused on what it is like for people who self-injure. In this study we are looking to hear from people who have a history of self-injury. We are particularly interested in what recovery from NSSI means to you, and your experiences of recovery associated with self-injury.

**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 self-injury. The survey should take approximately 45-60 minutes of your time. We will ask you about your thoughts about self-injury, the effect self-injury has had on you, and how you look after yourself.

**Are there any risks or benefits?**
We appreciate that thinking about 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). Any data you provide prior to stopping the survey may be used for analysis. If you wish to talk to anyone about any of the topics raised in this survey you can find local support here.

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

Students recruited through SONA (the School of Psychology online sign up system for research participation) will receive 4 SONA points for completing the survey. Participants recruited through other means will not be reimbursed for their time. However, people have told us that they value the opportunity to express their views, and to help others who might have a history of self-injury. 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 11 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. Anonymous data may be placed in an open access repository if requested by a journal. We may also use direct quotes from open ended responses in publications, but will use a pseudonym so you can never be identified.

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

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

**Can I see the results?**
If you are interested in seeing the aggregate research findings, please contact us in December 2020.

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

Penny Hasking & Stephen Lewis

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2020-0078). 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.

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

**What is this study about?**

○ Self-injury and experiences of recovery

○ Relationships with parents

○ Donald Trump's use of social media

**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

# Chapter 5 Survey Items

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

**What is your gender?**

○ Male

○ Female

○ Another gender (please specify)

**How old are you?**

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

○ Yes

○ No

## Self-injury

In this next section we will ask you questions about your experience with self-injury. We will ask about your personal experience of self-injure, and whether your friends self-injure.

If you become upset at any stage we suggest taking a break or completely stopping the questionnaire. Remember there are some resources you might find useful that are free to download at end of this questionnaire.

If you need to, you can also find local emergency services here

Self-injury refers to directly and intentionally hurting yourself (such as by cutting, burning, excessively scratching, etc.) *without* the intention of killing yourself.

**Have you ever engaged in self-injury?**

○ Yes

○ No

**How many times have you self-injured <u>in the last year</u>?**

○ None

○ Once

○ Twice

○ Three times

○ Four times

○ Five or more times

**What age did you start to self-injure?**

[                                                              ]

**If you feel that you have a *main* <u>form of self-injury</u>, please indicate from the list below the behavior that 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 wounds healing

○ Rubbing skin against rough surface

○ Sticking yourself with needles

○ Swallowing dangerous substances

○ Other

[              ]

**Do you experience physical pain when you self-injure?**

○ Yes

○ No

**Typically how much time elapses 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

This inventory was written to help us better understand the experience of non-suicidal self-injury. Below is a list of statements that may or may not be relevant to your experience of self-injury. Please identify the statements that are most relevant for you.

**When I self-injure I am......**

| | 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 | ○ | ○ | ○ |
| | Not relevant | Somewhat relevant | Very relevant |
| 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 that 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 | ○ | ○ | ○ |
| | Not relevant | Somewhat relevant | Very relevant |
| creating a physical injury that 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 | ○ | ○ | ○ |
| fitting in with others | ○ | ○ | ○ |
| seeking care or help from others | ○ | ○ | ○ |
| demonstrating I am tough or strong | ○ | ○ | ○ |
| | Not relevant | Somewhat relevant | Very relevant |
| proving to myself that my emotional pain is real | ○ | ○ | ○ |
| | Not relevant | Somewhat relevant | Very relevant |
| 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 still alive when I don't feel real | ○ | ○ | ○ |
| putting a stop to suicidal thoughts | ○ | ○ | ○ |
| | Not relevant | Somewhat relevant | Very relevant |
| 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 told anyone that you self-injure?**

○ Yes

○ No

**Who did you tell? Please tick all that apply.**

☐ Friend

☐ Parent

☐ Sibling

☐ Other relative

☐ Partner (ie boyfriend/girlfriend)

☐ Teacher

☐ Mental health worker (eg psychologist; counselor)

☐ Family doctor/GP

☐ Other (please specify)

[        ]

**To what extent do you agree with the following statements. "My self-injury....**

|  | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |
|---|---|---|---|---|---|
| causes me significant distress | ○ | ○ | ○ | ○ | ○ |
| causes other people significant distress | ○ | ○ | ○ | ○ | ○ |
| causes interference in my interpersonal life | ○ | ○ | ○ | ○ | ○ |
| causes interference in my academic life | ○ | ○ | ○ | ○ | ○ |
| causes interference in other important areas of my life | ○ | ○ | ○ | ○ | ○ |

**Do you have any physical scarring as a result of your self-injury?**

○ Yes

○ No

| | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |
|---|:---:|:---:|:---:|:---:|:---:|
| I feel out of place in the world because I have self-injured | ○ | ○ | ○ | ○ | ○ |
| People who self-injure tend to be violent | ○ | ○ | ○ | ○ | ○ |
| People discriminate against me because I have self-injured | ○ | ○ | ○ | ○ | ○ |
| I avoid getting close to people who don't self-injure to avoid rejection | ○ | ○ | ○ | ○ | ○ |
| I am embarrassed or ashamed that I self-injured | ○ | ○ | ○ | ○ | ○ |
| People who self-injure should not get married | ○ | ○ | ○ | ○ | ○ |
| People who self-injure make important contributions to society | ○ | ○ | ○ | ○ | ○ |
| I feel inferior to others who have not self-injured | ○ | ○ | ○ | ○ | ○ |
| I don't socialise as much as I used to because my self-injury might make me look or behave 'weird' | ○ | ○ | ○ | ○ | ○ |
| People who self-injure cannot live a good, rewarding life | ○ | ○ | ○ | ○ | ○ |
| I don't talk about myself much because I don't want to burden others with my self-injury | ○ | ○ | ○ | ● | ○ |
| Negative stereotypes about self-injury keep me isolated from the "normal" world | ○ | ○ | ○ | ○ | ○ |
| Being around people who do not self-injure makes me feel out of place or inadequate | ○ | ○ | ○ | ○ | ○ |
| I feel comfortable being seen in public with a person who obviously self-injures | ○ | ○ | ○ | ○ | ○ |
| People often patronise me, or treat me like a child, just because I self-injure | ○ | ○ | ○ | ○ | ○ |
| I am disappointed in myself for self-injuring | ○ | ○ | ○ | ○ | ○ |
| Self-injurying has spoiled my life | ○ | ○ | ○ | ○ | ○ |
| People can tell that I have self-injured by the way I look | ○ | ○ | ○ | ○ | ○ |
| Because I have self-injured I need others to make most decisions for me | ○ | ○ | ○ | ○ | ○ |
| I stay away from social situations in order to protect my family or friends from embarrassment | ○ | ○ | ○ | ○ | ○ |
| People who do not self-injure could not possibly understand me | ○ | ○ | ○ | ○ | ○ |
| People ignore me or take me less seriously just because I have self-injured | ○ | ○ | ○ | ○ | ○ |
| I can't contribute anything to society because I have self-injured | ○ | ○ | ○ | ○ | ○ |
| Living with self-injury has made me a tough survivor | ○ | ○ | ○ | ○ | ○ |
| Nobody would be interested in getting close to me because I have self-injured | ○ | ○ | ○ | ○ | ○ |
| In general, I am able to live my life the way I want to | ○ | ○ | ○ | ○ | ○ |
| I can have a good, fulfilling, life despite my self-injury | ○ | ○ | ○ | ○ | ○ |
| Others think that I can't achieve much in life because I have self-injured | ○ | ○ | ○ | ○ | ○ |
| Stereotypes about self-injury apply to me | ○ | ○ | ○ | ○ | ○ |

There are many attitudes about self-injury. We would like to know what you think most of the public as a whole (or most people) believe about these attitudes. Please answer the following items using the 9-point scale below.

**I think the public believes:**

| | Strongly disagree | 2 | 3 | 4 | Neither agree nor disagree | 6 | 7 | 8 | Strongly agree |
|---|---|---|---|---|---|---|---|---|---|
| 1. most people who self-injure cannot be trusted | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. most people who self-injure are disgusting | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. most people who self-injure are unable to get or keep a regular job | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. most people who self-injure are dirty and unkempt | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. most people who self-injure are to blame for their problem | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. most people who self-injure are below average in intelligence | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 7. most people who self-injure are unpredictable | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 8. most people who self-injure will not recover or get better | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 9. most people who self-injure are dangerous | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 10. most people who self-injure are unable to take care of themselves | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

We are interested in your thoughts about what might happen if someone engages in self-injury. If you personally have self-injured think about what you might expect the outcome to be when you self-injure. If you do not self-injure, think about what the outcome might be if you did.

**How likely is it that after self-injuring:**

| | Extremely likely | Somewhat likely | Somewhat unlikely | Extremely unlikely |
|---|---|---|---|---|
| 1. I would feel less frustrated with the world | ○ | ○ | ○ | ○ |
| 2. My friends would be disgusted | ○ | ○ | ○ | ○ |
| 3. I could make people do things for me | ○ | ○ | ○ | ○ |
| 4. I would feel physical pain | ○ | ○ | ○ | ○ |
| 5. I would feel like a failure | ○ | ○ | ○ | ○ |
| 6. I would feel better about myself | ○ | ○ | ○ | ○ |
| 7. My friends would not approve of me | ○ | ○ | ○ | ○ |
| 8. It would be easier to get what I want from others | ○ | ○ | ○ | ○ |

| | Extremely likely | Somewhat likely | Somewhat unlikely | Extremely unlikely |
|---|---|---|---|---|
| 9. It would hurt | ○ | ○ | ○ | ○ |
| 10. I would feel ashamed | ○ | ○ | ○ | ○ |
| 11. I would feel calm | ○ | ○ | ○ | ○ |
| 12. My family would be disgusted | ○ | ○ | ○ | ○ |
| 13. Other people would notice and offer sympathy | ○ | ○ | ○ | ○ |
| 14. I would not be aware of my physical pain | ○ | ○ | ○ | ○ |
| 15. I would feel numb | ○ | ○ | ○ | ○ |
| 16. The future would seem more optimistic | ○ | ○ | ○ | ○ |
| 17. My parents would be angry | ○ | ○ | ○ | ○ |
| 18. I would feel that it would be easier to open up and express my feelings | ○ | ○ | ○ | ○ |
| 19. I would not feel any pain | ○ | ○ | ○ | ○ |
| 20. I would feel emotionally drained | ○ | ○ | ○ | ○ |
| 21. I would feel relieved | ○ | ○ | ○ | ○ |
| 22. Other people would notice and think I was a freak | ○ | ○ | ○ | ○ |
| 23. I would get care from others | ○ | ○ | ○ | ○ |
| 24. The pain would be intense | ○ | ○ | ○ | ○ |
| 25. I would hate myself | ○ | ○ | ○ | ○ |

**Please read each of the statements below carefully and circle the number which best fits how certain you are about how you would act in each of the following situations.**

| | Very uncertain | | | | | Very certain |
|---|---|---|---|---|---|---|
| 1. How certain are you that you will not self-injure in the future? | ○ | ○ | ○ | ○ | ○ | ○ |
| 2. If at some point in the future you had self-injurious thoughts, how certain are you that you could resist self-injury? | ○ | ○ | ○ | ○ | ○ | ○ |
| 3. If at some point in the future you had self-injurious thoughts, how certain are you that you could resist self-injury if you were using alcohol or other drugs? | ○ | ○ | ○ | ○ | ○ | ○ |
| 4. How certain are you that you could control future thoughts of self-injury if you were experiencing physical pain? | ○ | ○ | ○ | ○ | ○ | ○ |
| 5. How certain are you that you could control future self-injurious thoughts if you lost an important relationship? | ○ | ○ | ○ | ○ | ○ | ○ |
| 6. How certain are you that you could control future self-injurious thoughts if you lost a job, could not find employment, or suffered a financial crisis? | ○ | ○ | ○ | ○ | ○ | ○ |

**In the last four weeks:**

| | None of the time | A little of the time | Some of the time | Most of the time | All of the Time |
|---|---|---|---|---|---|
| 1. About how often did you feel tired out for no reason? | ○ | ○ | ○ | ○ | ○ |
| 2. About how often did you feel nervous? | ○ | ○ | ○ | ○ | ○ |
| 3. About how often did you feel so nervous that nothing could calm you down? | ○ | ○ | ○ | ○ | ○ |
| 4. About how often did you feel hopeless? | ○ | ○ | ○ | ○ | ○ |
| 5. About how often did you feel restless or fidgety? | ○ | ○ | ○ | ○ | ○ |
| 6. About how often do you feel so restless you could not sit still? | ○ | ○ | ○ | ○ | ○ |
| 7. About how often did you feel depressed? | ○ | ○ | ○ | ○ | ○ |
| 8. About how often did you feel that everything was an effort? | ○ | ○ | ○ | ○ | ○ |
| 9. About how often did you feel so sad that nothing could cheer you up? | ○ | ○ | ○ | ○ | ○ |

**We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.**

| | Very Strongly Disagree | Strongly Disagree | Mildly Disagree | Neutral | Mildly Agree | Strongly Agree | Very Strongly Agree |
|---|---|---|---|---|---|---|---|
| There is a special person who is around when I am in need. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| There is a special person with whom I can share joys and sorrows. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| My family really tries to help me. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I get the emotional help and support I need from my family. | ● | ○ | ○ | ○ | ○ | ○ | ○ |
| I have a special person who is a real source of comfort to me. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| My friends really try to help me. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I can count on my friends when things go wrong. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I can talk about my problems with my family. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I have friends with whom I can share my joys and sorrows. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| There is a special person in my life who cares about my feelings. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| My family is willing to help me make decisions. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| I can talk about my problems with my friends. | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.**

| | Strongly agree | Agree | Disagree | Strongly disagree |
|---|---|---|---|---|
| On the whole I am satisfied with myself | ○ | ○ | ○ | ○ |
| At times I think I am no good at all | ○ | ○ | ○ | ○ |
| I feel that I have a number of good qualities | ○ | ○ | ○ | ○ |
| I am able to do things as well as most other people | ○ | ○ | ○ | ○ |
| I feel I do not have much to be proud of | ○ | ○ | ○ | ○ |
| I certainly feel useless at times | ○ | ○ | ○ | ○ |
| I feel that I'm a person of worth, at least on an equal plane with others | ○ | ○ | ○ | ○ |
| I wish I could have more respect for myself | ○ | ○ | ○ | ○ |
| All in all, I am inclined to feel that I am a failure | ○ | ○ | ○ | ○ |
| I take a positive attitude toward myself | ○ | ○ | ○ | ○ |

| | Strongly disagree | Disagree | Neutral | Agree | Strongly agree |
|---|---|---|---|---|---|
| I tend to bounce back quickly after hard times | ○ | ○ | ○ | ○ | ○ |
| I have a hard time making it through stressful events | ○ | ○ | ○ | ○ | ○ |
| It does not take me long to recover from a stressful event | ○ | ○ | ○ | ○ | ○ |
| It is hard for me to snap back when something bad happens | ○ | ○ | ○ | ○ | ○ |
| I usually come through difficult times with little trouble | ○ | ○ | ○ | ○ | ○ |
| I tend to take a long time to get over set-backs in my life | ○ | ○ | ○ | ○ | ○ |

**Appendix F**

**Chapter 5 Supplementary Materials**

**Supplementary Materials-Correlation Matrices**

Table II

Correlations of Socio-Demographic Factors

|  | 1 | 2 | 3 |
|---|---|---|---|
| 1. Gender | - | .06 | .10* |
| 2. Age |  | - | .15** |
| 3. Mental illness |  |  | - |

Note. * $p < .05$; **$p < .01$

Table III

Correlations of NSSI-Related Factors

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Intrapersonal functions | - | .41** | .17** | .28** | -.07 | .01 | -.22** | .38** | .03 | .29*' |
| 2. Interpersonal functions | - | - | <.00 | .05 | .02 | .15** | -.09* | .28** | .02 | .24*' |
| 3. Frequency | - | - | - | .18** | -.04 | -.02 | -.02 | .02 | .14 | .37 |
| 4. Scars | - | - | - | - | -.05 | -.06 | -.26** | .14** | .09 | -.02 |
| 5. Pain | - | - | - | - | - | -.05 | .05 | .01 | -.02 | .07 |
| 6. Time elapsed | - | - | - | - | - | - | .04 | .07 | -.09 | -.02 |
| 7. Main form | - | - | - | - | - | - | - | -.14** | .10 | -.01 |
| 8. Impact | - | - | - | - | - | - | - | - | .07 | .22*' |
| 9. Anticipated stigma | - | - | - | - | - | - | - | - | - | .28*' |
| 10. Internalised stigma | - | - | - | - | - | - | - | - | - | - |

Note. * p <.05; **p <.01

Table IV

Correlations of Socio-Cognitive Factors

| | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| NSSI Outcome Expectancies | | | | | | |
| 1. Affect regulation | - | .13** | .27** | -.19** | -.07 | -.02 |
| 2. Negative social | - | - | .13** | .06 | .38** | -.01 |
| 3. communication | - | - | - | -.48** | -.24** | .10* |
| 4. Pain | - | - | - | - | .33** | -.03 |
| 5. Negative-self | - | - | - | - | - | -.06 |
| 6. Self-efficacy to avoid NSSI | - | - | - | - | - | - |

Note. * p <.05; **p <.01
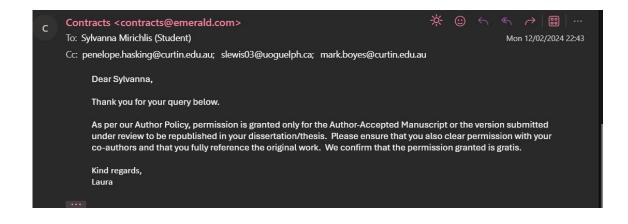
Table V

Correlations of Socio-Emotional Factors

| | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| 1. Distress | - | -.17** | -.14* | -.21** | -.40** | -.58** |
| Social Support | | | | | | |
|    2. Family | - | - | .38** | .37** | .09 | .25** |
|    3. Friend | - | - | - | .51** | .16* | .27** |
|    4. Significant other | - | - | - | - | .15* | .23** |
| 5. Resilience | - | - | - | - | - | .55** |
| 6. self-esteem | - | - | - | - | - | - |

Note. * p <.05; **p <.01
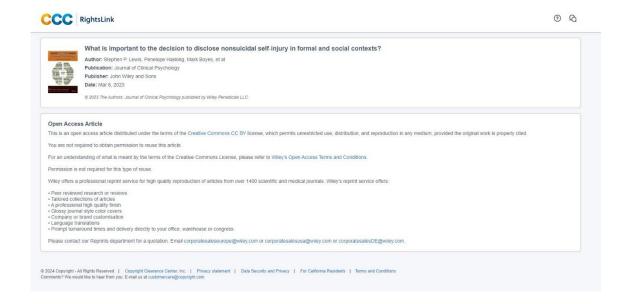
# Appendix G

## Chapter 5 Journal Copyright

**Contracts <contracts@emerald.com>**

To: Sylvanna Mirichlis (Student)                                                    Mon 12/02/2024 22:43

Cc: penelope.hasking@curtin.edu.au;  slewis03@uoguelph.ca;  mark.boyes@curtin.edu.au

Dear Sylvanna,

Thank you for your query below.

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Kind regards,
Laura

# Appendix H

# Chapter 6 Journal Copyright

# Appendix I

# Chapter 6 Group Comparisons Table

**Table 1.** Average Within and Between Group Importance of Factors.

| Factor | Total Mean (SD) | F | Between Group Means (SD) | Multiple Comparisons[a] |
|---|---|---|---|---|
| Amount of trust in the relationship | 78.59 (30.04) | 13.46*** | a. Friend: 82.79 (26.04) | a > d***; c > d*** |
| | | | b. Family: 77.20 (32.31) | |
| | | | c. S.O: 83.19 (27.99) | |
| | | | d. H.P: 71.17 (31.88) | |
| Quality of relationship with this person | 75.17 (31.61) | 57.78*** | a. Friend: 82.94 (24.98) | a > d**; b > d**; c > d** |
| | | | b. Family: 77.54 (30.75) | |
| | | | c. S.O: 82.39 (28.30) | |
| | | | d. H.P: 57.82 (34.86) | |
| Your confidence in being able to talk to this person about your self-injury | 71.57 (32.56) | 3.79* | a. Friend: 74.46 (29.79) | - |
| | | | b. Family: 67.72 (36.48) | |
| | | | c. S.O: 74.13 (31.03) | |
| | | | d. H.P: 69.98 (32.17) | |
| How emotionally close you feel to this person | 70.60 (33.95) | 106.63*** | a. Friend: 79.73 (26.98) | a > d**; b < c***; b > d**; c > d** |
| | | | b. Family: 72.97 (32.99) | |
| | | | c. S.O: 83.06 (28.09) | |
| | | | d. H.P: 46.63 (34.54) | |
| Thinking that the disclosure experience could be distressing | 68.87 (32.91) | 53.35*** | a. Friend: 71.37 (29.63) | a < b***; a > d**; b > c***; b > d**; c > d*** |
| | | | b. Family: 81.09 (27.41) | |
| | | | c. S.O: 70.39 (31.45) | |
| | | | d. H.P: 52.61 (36.04) | |
| Wanting to keep your self-injury concealed/a secret | 68.58 (34.33) | 24.16*** | a. Friend: 71.40 (32.06) | a > d***; b > c***; b > d**; c > d** |
| | | | b. Family: 78.47 (30.41) | |
| | | | c. S.O: 66.33 (34.12) | |
| | | | d. H.P: 58.13 (37.25) | |
| Expecting others to have negative views (e.g., judgement) about your self-injury | 63.79 (33.25) | 50.84*** | a. Friend: 64.57 (28.96) | a < b***; a > d***; b > c***; b > d**; c >d*** |
| | | | b. Family: 76.58 (31.66) | |
| | | | c. S.O: 65.84 (31.73) | |
| | | | d. H.P: 48.16 (34.18) | |
| Feeling bad about yourself because you have self-injured (e.g., feeling ashamed) | 63.66 (33.27) | 20.63*** | a. Friend: 64.65 (30.46) | a > d***; b >d***; c > d*** |
| | | | b. Family: 70.13 (34.25) | |
| | | | c. S.O: 67.25 (31.47) | |
| | | | d. H.P: 52.62 (34.16) | |
| Desire to stop self-injuring | 63.05 (33.91) | 6.16*** | a. Friend: 59.33 (33.51) | a < d**; b <d** |
| | | | b. Family: 59.51 (35.21) | |
| | | | c. S.O: 65.32 (33.31) | |
| | | | d. H.P: 68.06 (32.85) | |
| Being seen engaging in self-injury | 62.00 (37.49) | 2.01 | a. Friend: 62.01(37.04) | - |
| | | | b. Family: 64.09 (37.98) | |
| | | | c. S.O: 63.81 (37.06) | |
| | | | d. H.P: 58.10 (37.49) | |
| Having the physical means to talk to this person about your self-injury (i.e., physically close or phone/internet to communicate) | 61.81 (35.63) | 4.73** | a. Friend: 63.60 (33.92) | b < d** |
| | | | b. Family: 56.09 (37.82) | |
| | | | c. S.O: 62.27 (36.10) | |
| | | | d. H.P: 65.29 (34.01) | |
| Having wounds seen after injuring yourself | 61.75 (35.28) | 2.69* | a. Friend: 61.42 (33.64) | - |
| | | | b. Family: 62.70 (37.01) | |
| | | | c. S.O: 65.02 (34.81) | |
| | | | d. H.P: 57.84 (35.34) | |
| How recently you self-injured | 61.72 (33.71) | 5.01** | a. Friend: 60.50 (31.49) | b > d*** |
| | | | b. Family: 66.63 (33.97) | |
| | | | c. S.O: 62.46 (34.13) | |
| | | | d. H.P: 57.30 (34.62) | |
| Feeling by your own definition, recovered from self-injury | 61.29 (34.83) | 3.16* | a. Friend: 61.24 (33.65) | - |
| | | | b. Family: 62.41 (35.06) | |
| | | | c. S.O: 64.57 (33.64) | |
| | | | d. H.P: 56.95 (36.56) | |

| | | | | |
|---|---|---|---|---|
| Desire to continue self-injuring | 61.08 (34.74) | 4.03** | a. Friend: 56.19 (33.20) | a < d** |
| | | | b. Family: 60.53 (36.81) | |
| | | | c. S.O: 63.49 (34.16) | |
| | | | d. H.P: 64.09 (34.272) | |
| You had previously disclosed mental health difficulties | 60.75 (33.88) | 1.74 | a. Friend: 60.68 (31.53) | - |
| | | | b. Family: 57.71 (35.08) | |
| | | | c. S.O: 63.32 (33.57) | |
| | | | d. H.P: 61.31 (35.14) | |
| Requiring medical care because of self-injury | 60.54 (35.95) | 4.57** | a. Friend: 55.22 (35.28) | a < d** |
| | | | b. Family: 59.97 (36.31) | |
| | | | c. S.O: 62.62 (35.71) | |
| | | | d. H.P: 64.35 (35.96) | |
| Expecting that knowing that you have self-injured would impact this person in some way | 60.19 (35.90) | 115.19*** | a. Friend: 66.06 (31.50) | a > d**; b > d**; c > d** |
| | | | b. Family: 71.68 (32.59) | |
| | | | c. S.O: 69.65 (31.49) | |
| | | | d. H.P: 33.37 (33.78) | |
| Expecting a particular reaction to the disclosure from this person | 60.08 (34.03) | 21.78*** | a. Friend: 59.94 (31.23) | a > d***; b > d***; c > d*** |
| | | | b. Family: 67.08 (33.70) | |
| | | | c. S.O: 64.50 (34.06) | |
| | | | d. H.P: 48.80 (34.25) | |
| Expectation that your relationship with this person would be negatively impacted | 59.51 (36.45) | 124.10*** | a. Friend: 63.67 (33.07) | a < b***; a > d**; b > c**; b > d**; c > d** |
| | | | b. Family: 75.34 (30.90) | |
| | | | c. S.O: 66.81 (34.60) | |
| | | | d. H.P: 32.20 (31.76) | |
| Wanting to seek professional help | 59.46 (35.07) | 52.59*** | a. Friend: 49.35 (33.03) | a < c**; a < d**; b < d**; c < d** |
| | | | b. Family: 53.31 (36.57) | |
| | | | c. S.O: 57.55 (33.54) | |
| | | | | |
| Thinking that the disclosure experience could improve your wellbeing | 58.62 (33.83) | 38.12*** | a. Friend: 55.08 (32.59) | a > b**; a < d***; b < c***; b < d**; c < d*** |
| | | | b. Family: 47.33 (34.03) | |
| | | | c. S.O: 59.78 (33.93) | |
| | | | d. H.P: 72.28 (29.76) | |
| The impact self-injury has had on you (physically, emotionally, socially, or in some other way) | 57.56 (34.09) | 14.41*** | a. Friend: 55.29 (32.39) | a < d**; b < c***; b < d*** |
| | | | b. Family: 49.31 (35.88) | |
| | | | c. S.O: 61.59 (32.75) | |
| | | | d. H.P: 64.07 (33.40) | |
| Thinking that you could lose social support from this person if you disclosed to them | 56.34 (38.00) | 94.05*** | a. Friend: 64.20 (34.47) | a > d**; b > d**; c > d** |
| | | | b. Family: 68.73 (35.34) | |
| | | | c. S.O: 62.09 (36.50) | |
| | | | d. H.P: 30.34 (33.05) | |
| Expecting that disclosing your self-injury to this person would impact how you feel about yourself | 56.03 (34.48) | 11.46*** | a. Friend: 54.57 (32.93) | a < b**; b > d***; c > d*** |
| | | | b. Family: 62.45 (34.10) | |
| | | | c. S.O: 58.67 (34.30) | |
| | | | d. H.P: 48.44 (35.13) | |
| The physical and/or medical intensity of your self-injury | 55.69 (34.98) | 25.11*** | a. Friend: 47.42 (34.49) | a < c***; a < d**; b < d***; c < d*** |
| | | | b. Family: 50.49 (35.18) | |
| | | | c. S.O: 57.38 (34.29) | |
| | | | d. H.P: 67.46 (32.64) | |
| Thinking that this person could provide social support | 55.65 (34.20) | 36.03*** | a. Friend: 63.02 (30.60) | a > b**; a > d***; b < c**; b < d**; c > d*** |
| | | | b. Family: 43.13 (34.09) | |
| | | | c. S.O: 65.08 (31.74) | |
| | | | d. H.P: 51.38 (35.56) | |
| Confidence in your knowledge to be able to answer questions they | 54.78 (33.49) | .106 | a. Friend: 54.69 (32.21) | - |
| | | | b. Family: 55.22 (34.86) | |

| | | | | |
|---|---|---|---|---|
| might have had about it | | | c. S.O: 55.19 (32.85) | |
| | | | d. H.P: 54.01 (34.08) | |
| Wanting to disclose your self-injury to let the other person know you are/have been experiencing distress | 54.76 (34.70) | 22.46*** | a. Friend: 52.41 (33.95) | a > b**; a < d***; b < c***; b < d*** |
| | | | b. Family: 44.05 (35.09) | |
| | | | c. S.O: 59.90 (34.19) | |
| | | | d. H.P: 62.69 (32.62) | |
| Negative views about self-injury from the general public | 54.72 (35.37) | 25.40*** | a. Friend: 55.75 (33.95) | a > b***; a > d***; b > c***; c > d** |
| | | | b. Family: 66.04 (34.67) | |
| | | | c. S.O: 53.01 (34.61) | |
| | | | d. H.P: 44.10 (34.89) | |
| Relevance of your self-injury to this person | 54.44 (35.78) | 17.47*** | a. Friend: 52.95 (33.65) | a < c**; a > d**; b > d***; c > d*** |
| | | | b. Family: 58.85 (35.65) | |
| | | | c. S.O: 61.61 (35.05) | |
| | | | d. H.P: 44.35 (36.37) | |
| Having physical scars from self-injury | 54.35 (34.50) | 8.44*** | a. Friend: 52.73 (32.20) | b > d**; c > d*** |
| | | | b. Family: 57.22 (35.23) | |
| | | | c. S.O: 59.58 (34.93) | |
| | | | d. H.P: 47.88 (34.52) | |
| Having visible scars from self-injury | 53.85 (35.04) | 8.84*** | a. Friend: 52.94 (33.50) | b > d***; c > d*** |
| | | | b. Family: 56.67 (35.25) | |
| | | | c. S.O: 59.05 (35.44) | |
| | | | d. H.P: 46.74 (34.83) | |
| Having previously experienced discrimination because of your self-injury | 52.11 (36.79) | 10.78*** | a. Friend: 50.22 (35.83) | a < b***; b > c**; b > d*** |
| | | | b. Family: 61.09 (37.23) | |
| | | | c. S.O: 50.37 (35.42) | |
| | | | d. H.P: 46.78 (37.22) | |
| Wanting to tell them before they found out some other way | 51.94 (37.56) | 53.57*** | a. Friend: 51.12 (35.42) | a < c***; a > d***; b < c***; b > d**; c > d*** |
| | | | b. Family: 55.10 (37.58) | |
| | | | c. S.O: 67.19 (35.32) | |
| | | | d. H.P: 34.35 (34.46) | |
| Knowing whether this person has also self-injured | 50.03 (36.90) | 77.30*** | a. Friend: 66.30 (31.64) | a > b***; a > c***; a > d**; b < c**; b > d***; c > d** |
| | | | b. Family: 47.74 (36.84) | |
| | | | c. S.O: 56.64 (35.66) | |
| | | | d. H.P: 29.45 (32.97) | |
| Impact on this person if you did not tell them | 49.72 (36.33) | 53.61*** | a. Friend: 49.19 (35.02) | a < c***; a > d***; b < c***; b > d***; c > d** |
| | | | b. Family: 51.49 (37.07) | |
| | | | c. S.O: 65.12 (34.06) | |
| | | | d. H.P: 33.08 (31.81) | |
| Thinking that someone might find items used to self-injure | 49.39 (37.28) | 15.76*** | a. Friend: 47.43 (36.09) | a < b**; a > d**; b > d***; c > d*** |
| | | | b. Family: 55.90 (38.01) | |
| | | | c. S.O: 54.71 (36.95) | |
| | | | d. H.P: 39.51 (35.878) | |
| Expecting to feel less socially isolated if you disclosed to this person | 48.28 (35.40) | 28.06*** | a. Friend: 56.24 (33.60) | a > b***; a > d***; b < c***; c > d*** |
| | | | b. Family: 39.46 (34.10) | |
| | | | c. S.O: 56.70 (35.72) | |
| | | | d. H.P: 40.70 (34.43) | |
| Other people already knew about your self-injury | 47.66 (34.83) | 13.42*** | a. Friend: 51.85 (32.68) | a > d***; c > d*** |
| | | | b. Family: 45.96 (34.43) | |
| | | | c. S.O: 53.65 (35.24) | |
| | | | d. H.P: 39.18 (35.18) | |
| Seeking acceptance | 47.20 (37.11) | 11.51*** | a. Friend: 49.86 (35.65) | a > d**; b < c***; c > d*** |
| | | | b. Family: 42.83 (37.26) | |
| | | | c. S.O: 55.06 (37.19) | |
| | | | d. H.P: 41.06 (36.76) | |

| | | | | |
|---|---|---|---|---|
| Seeking validation | 43.43 (37.04) | 6.32*** | a. Friend: 44.78 (35.91) | b < c***; b < d** |
| | | | b. Family: 36.41 (35.93) | |
| | | | c. S.O: 47.30 (37.87) | |
| | | | d. H.P: 45.23 (37.04) | |
| You had previously disclosed your self-injury to somebody else | 43.33 (35.09) | 5.54*** | a. Friend: 45.70 (33.42) | b < c** |
| | | | b. Family: 39.29 (35.84) | |
| | | | c. S.O: 48.12 (35.51) | |
| | | | d. H.P: 40.21 (34.89) | |
| Expectation that your relationship with this person would be positively impacted | 40.70 (34.17) | 4.66** | a. Friend: 42.58 (33.28) | b < c** |
| | | | b. Family: 36.07 (33.68) | |
| | | | c. S.O: 44.81 (33.76) | |
| | | | d. H.P: 39.36 (35.43) | |

*Note.* *$p \leq .05$, **$p < .01$, *** $p < .001$, df = 3, 1480; S.O: significant other, H.P: health professional; [a]Only significant comparisons presented ($\alpha$ = .01). Presented from most to least important.

**Appendix J**

**Figure: Variability in Importance of Factors Across Relationship Types**



Note. 1=expecting negative views from others, 2=feeling ashamed due to NSSI, 3=negative views from the public, 4=previous NSSI discrimination, 5=NSSI recency, 6=desire to continue, 7=desire to stop, 8=feeling recovered, 9=being seen self-injuring, 10=having NSSI wounds seen, 11=thought of someone finding items used to self-injure, 12=having physical NSSI scars, 13=having visible scars, 14=requiring medical care, 15=wanting to conceal NSSI, 16=confidence to talk about own NSSI, 17=having the means to disclose, 18=confidence to answer questions, 19=impact on recipient if not disclose, 20=relevance to recipient, 21=relationship quality, 22=trust in relationship, 23=emotional closeness to recipient, 24=expecting a particular reaction, 25=disclose to mark distress, 26=expecting disclosure to be distressing, 27=expecting to improve wellbeing, 28=expecting social support, 29=expecting to lose social support, 30=expecting to feel less socially isolated,

# Appendix K

# Chapters 7 and 8 Ethical Approval

**Curtin University**

Research Office at Curtin

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Perth Western Australia 6845

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11-May-2021

Name:             Penelope Hasking
Department/School: Curtin University
Email:            Penelope.Hasking@curtin.edu.au

Dear Penelope Hasking

**RE: Ethics approval**
**Approval number: HRE2021-0241**

Thank you for submitting your application to the Human Research Ethics Office for the project **Exploring Voluntary NSSI Disclosure**.

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 **11-May-2021** to **10-May-2022**. 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 |
| Mirichlis, Sylvanna | 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
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**

**Chapters 7 and 8 Information Sheet and Interview Guide**

*Voluntary Self-Injury Disclosure*

**PARTICIPANT INFORMATION STATEMENT**

| | |
|---|---|
| **HREC Project Number:** | *HRE2021-0241* |
| **Project Title:** | *Exploring Voluntary Self-Injury Disclosure* |
| **Chief Investigator:** | *Prof Penelope Hasking* |
| **Associate Investigator(s):** | *A/Prof Mark Boyes & Prof Stephen P Lewis (U of Guelph)* |
| **Student researcher:** | *Sylvanna Mirichlis* |
| **Version Number:** | 2 |
| **Version Date:** | *22/04/21* |

**What is the Project About?**
Non-suicidal self-injury is the deliberate damage to one's body without trying to end one's life (e.g., cutting, burning). We would like to learn more about the experiences people have of talking to another person about their self-injury. We would like to focus on a time when people have talked about their own self-injury by their own choice and face-to-face, rather than because they were made to talk about it. We think it is important to learn about disclosure of self-injury from the point of view of people who have lived experience so we can better guide future research and practice in the area.

We aim to interview approximately 15 people who have previously disclosed their self-injury to another person.

**Who is doing the Research?**
Professor Penelope Hasking, Associate Professor Mark Boyes, Professor Stephen P Lewis and, PhD candidate Sylvanna Mirichlis will be conducting this research.

This project will be used, in part to help obtain a Doctorate of Philosophy in Psychology at Curtin University and is funded by the university.

**What will I have to do?**
If you are willing to participate in this research, we would like to interview you about your experiences of disclosing your self-injury to another person. We may ask questions about who you disclosed to, why you disclosed your self-injury to this person, the experience of talking to them about your self-injury, and the outcomes of the disclosure experience.

If applicable and if time permits you may be asked to comment on both a positive experience of telling somebody about your self-injury and a negative experience.

*Voluntary Self-Injury Disclosure*

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. If you wish to have a copy of the final findings, please contact one of the researchers after October 2022 (see below for contact details).

**What happens next and who can I contact about the research?**
If you have questions or concerns relating to this project, please contact Sylvanna Mirichlis at sylvanna.mirichlis@postgrad.curtin.edu.au or Prof Penelope Hasking on 9266 3437 or at penelope.hasking@curtin.edu.au

If you decide to take part in this research, you will be asked to provide audio consent in a separate recording to the interview. By providing your consent you are indicating to us that you understand what you have read and what has been discussed. Providing consent indicates that you agree to be in the research project and have your information used as described. Please take your time and ask any questions you have before you decide what to do. You will be given a copy of this information.

Curtin University Human Research Ethics Committee (HREC) has approved this study (*HRE2021-0241*). 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.

*Participant Information Form Version 2, 22/04/2021*
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CRICOS Provider Code 00301J

## Understanding NSSI Disclosure-Interview guide

**PREP:**

- ☐ Have spare information sheets handy
- ☐ Have phone on airplane mode and recorder
- ☐ Set up: chairs, recording device, way to keep track of time, tissues, water
- ☐ Have resources handy (and giftcard if not sona)
- ☐ Notebook and pen just in case

*ask directly about what was going through their head and what diff experiences meant for them

## GREETING PARTICIPANT:

Hi _____ thank you for coming in today, my name is ____. How did you go getting here today etc?

This interview is about experiences of talking to another person about your self-injury, but before we get started, I just need to check, have you read the information sheet? Do you have any questions? (*if have not read it or need reminding, provide the participant with a copy and give them time to read it*).

Just to re-cap, participating in this interview is completely voluntary~~—you do not have to if you do not want to. If you at this point you would like to proceed but then change your mind~~, you can stop the interview at any time. If you need to take a short break or do not want to answer particular questions, please let me know. If you look like you might be getting upset I may pause the interview and check in on how you are going. If you need me to repeat a question I can do so.

A reminder that when you consent to participating in the interview you are also consenting to being audio-recorded~~. The purpose of audio recording is two-fold~~, it allows me to pay full attention and listen properly without having to take notes and it means that later I can transcribe the audio to use for my analysis. I will be using two devices to record so that we have a back up. ~~A reminder that~~ once I have had a chance to transcribe your interview you will be sent a copy of your transcript so you can provide feedback before I formally begin my analysis. Once your interview is transcribed the audio file will be deleted. Does that sound okay? Do you have any questions?

If you would like to participate ~~and consent to being audio recorded~~, I will record you giving verbal consent in a separate audio-file now if you are ready. If you would like to continue please state your full name and that you understand the purpose, extent and possible risks of my involvement in this project and voluntarily consent to take part in this research project. *record consent*

**When you're ready I will start the main recording for the interview now on my 2 devices**-*new recording*.

Age and gender

Just to make sure we are on the same page, what comes to mind when you think about self-injury?

- If their definition differs, acknowledge that many people have different definitions of self-injury, for research purposes: we are interested in damage one's own body that is done intentionally but not to die, and is not sanctioned by their society/culture like drinking alcohol or having tattoos might be.

With that definition in mind…

Sometimes people learn about another person's self-injury inadvertently because they happen to notice it or someone else tells them about it, this might be thought of as discovery self-injury. Today I would like to focus on when you have voluntarily disclosed your self-injury to another person whether that be face-to-face, video or phone. In other words I would like to hear about a time or times where you chose talk to somebody about your self-injury by your own terms and in person, rather than anonymously/indirectly.

Can you think of a time when you intentionally told someone about your self-injury? For now we will focus on this particular experience, later we might discuss another experience.

    A. Were they the first person you talked to about your self-injury?
        i. As far as you know does this mean they were also the first person to know about it? If not, was other people knowing a contributing factor to you telling this person?
    b. Could you tell me a bit about what your relationship with them was like prior to them learning about your experience with self-injury?
    c. What prompted your decision to disclose your self-injury?
        i. Were there any specific reasons why you wanted to talk to this person in particular about it, rather than talking to somebody else?
    d. Was there anything that made you hesitant at first to disclose your self-injury to this person?
        i. How did you overcome this/what changed your mind?

2. What were you expecting to happen when you told them?
    a. What other thoughts or feelings did you have right when you were about to tell them?
    b. What were you hoping would happen?
    c. Why do you think this is?

3. *How did you go about telling this person about your self-injury?
    a. What sort of information did you disclose?
        i. PROMPT: e.g., that you self-injured? Nature of the self-injury? Reason you self-injured? Etc…
    b. Can you briefly describe the situation to me?
        i. Was there anybody else present?

4. *Once you did tell them about your self-injury, how did they react?
   a. PROMPT: emotional reaction? Did they ask questions? What sort of things did they say? Did they respond at all?
   b. Can you tell me a bit more about the following interaction between the two of you?
   c. How did you deal with their reaction? Was it different to what you expected?

5. Now thinking about any potential outcomes of this disclosure experience, how did feel after this interaction?
   a. Is there something you would have done differently? What?
      i. Why/not?
   b. Did things change for you personally/socially/professionally/wellbeing wise after this?
      i. How so?
      ii. Impact on how you view your NSSI?
   c. Have you talked to other people (personal/professional) about your self-injury since this disclosure experience?
      i. Do you think this experience impacted your decision of whether talk to other people about it? Why/not?

6. Considering who you told about your self-injury, do you think learning about your self-injury changed anything for them personally/socially/professionally/wellbeing wise?
   a. Is this something they have talked to you about (or just something you have noticed/thought about?)?

7. Since you talked to this person about your self-injury, do you feel like things between the two of you changed?
   a. If so, in what way?
   b. How do you feel about this?
   c. Have you talked about your self-injury with this person since?
      i. Why/not?
8. Overall how would you describe this experience? (would you say this was more of a positive or negative experience)? If you have talked to other people about your self-injury, have their responses tended to be positive or negative?
   a. Depending on how the participant is going and how much time is remaining - may ask about a different experience of disclosing their self-injury using the above prompts as a guide; if not appropriate or practical proceed to the next prompt.
   b. Different experience? might come up during course of interview anyway
   c. Anything else you would like to add?

9. We are getting towards the end of the interview now, but I am interested to know, if somebody was considering disclosing their self-injury to another person what is one piece of advice you would give them?

*Summarise, thank and conclude interview*

**After with participant:**

- Check email to send transcript to; if I don't hear back from you within a week I will assume you are happy with it
- If end up having q's: email address
- Resources: if this has raised anything for you

*do not take phone off airplane mode until after audio has been transferred and deleted from the phone*

# Appendix M

# Chapter 7 Reflexive Journal and Audit Trail Excerpts
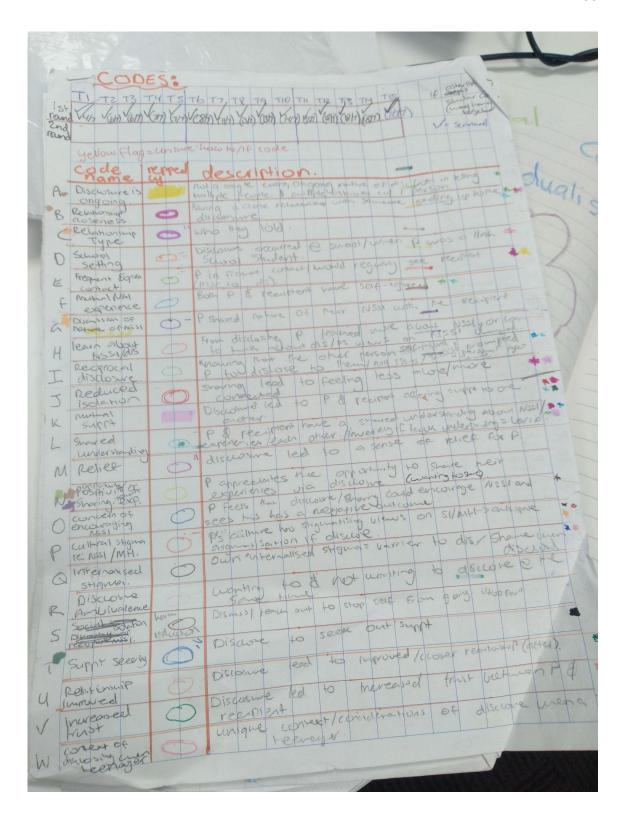
(Pg 8

24/5/21.

· was supposed to have 1st interview today but rescheduled to next week, which im glad about b/c I was feeling a bit stressed launching straight into my 1st one straight off of the weekend, particularly since I wasnt feeling well. Just wasnt in the headspace.
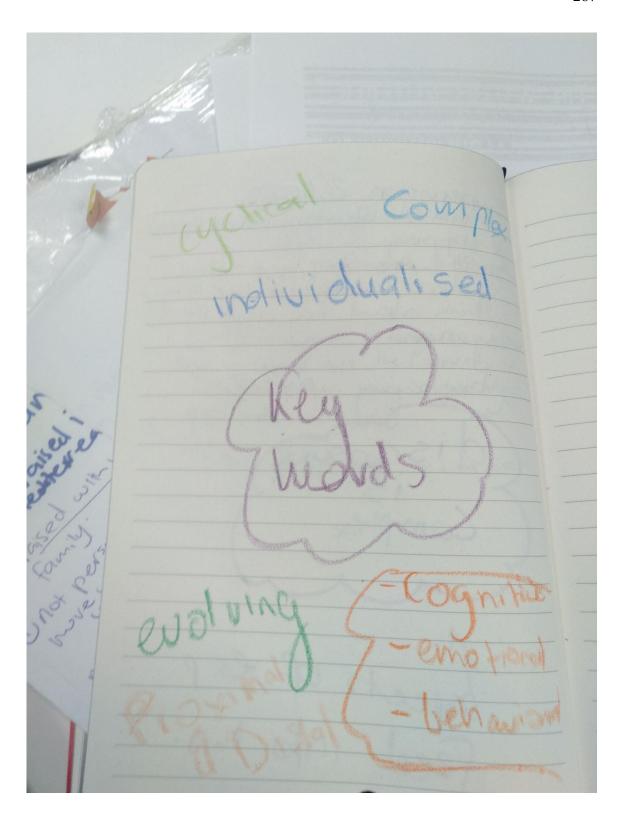
— I wanted to go back in time & speak up for this person, disclose I on I do not tell other people behind person & dont havethem say it infront of people.
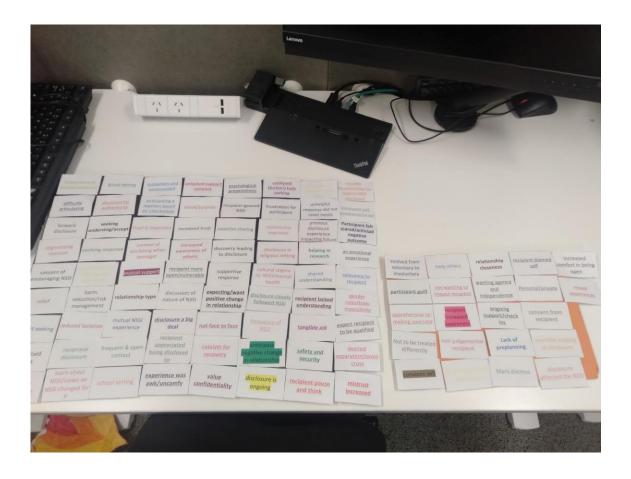
learning to balance empathy w/o crossing boundary of whenever man I don't agree w/ what people in their lives have done.

Pg1)

31/5/21. 10am interview:

p.4

- workplace settings. vs family setting.
- why not tell others if told someone else.
- If experience a shift (eg. shame → acceptance) why / what drove this change?
- I felt so happy re: her learning to ~~be~~ have pride
- I feel so lucky to have had the opportunity to hear this person's experience especially since they said they couldn't (just tell a stranger (which I essentially am) & that their own family don't know

2pm interview :) P.S feel so special that they opened up to me considering they describe themselves as "having walls up & not being vulnerable".

Q. Opinion on breaching confidentiality in professional setting because of regulation) duty of care vs morals.

↓ Things that are relatable like this will come up, this is partly why we do what we do & why we care.

— I do not know the full story & it is not my cross to bear, this is her experience not mine. She herself said that she has gotten help & worked through things & has support. I am not the therapist.

— eg. of how NSSI does not exist in a vacuum → dealing with real people with real experiences.

This is something to note when working through reading & analysing this transcript

# CODES:

| | T1 | T2 | T3 | T4 | T5 | T6 | T7 | T8 | T9 | T10 | T11 | T12 | T13 | T14 | T15 | | If asterisk, sample too (many have single quote) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1st round | ✓(4/7) | ✓(6/7) | ✓(6/7) | ✓(7/7) | ✓(7/7) | ✓(8/7) | ✓(11/7) | ✓(11/7) | (13/7) | ✓(14/7) | ✓ | ✓(9/7) | (8/7) | (8/7) | ✓(20/7) | | ✓= scanned |
| 2nd round | | | | | | | | | | | | | | | | | |

Yellow flag = unsure how to/if code.

| | code name | freq (y) | description |
|---|---|---|---|
| A | Disclosure is ongoing | | Not a single event, ongoing nature of disclosure in telling multiple people & multiple instances w/ 1 person |
| B | Relationship closeness | | Having a close relationship with someone leading up to the disclosure |
| C | Relationship Type | | who they told |
| D | School setting | | Disclosure occurred @ school / when P was a High School student. |
| E | Frequent & open contact | | P in frequent contact / would regularly see recipient (prior to dis) |
| F | Mutual NSSI experience | | Both P & recipient have self-injured |
| G | Discussion of nature of NSSI | | P shared nature of their NSSI with the recipient |
| H | learn about NSSI/dis | | From disclosing, P learned more about NSSI or learned to think about dis/its views on self-injured |
| I | Reciprocal disclosure | | Knowing that the other person self-injured prompted P/to disclose to them/MH issues |
| J | Reduced isolation | | Sharing lead to feeling less alone/more considered |
| K | Mutual supprt | | Disclosure led to P & recipient offering supprt to one another. |
| L | Shared understanding | | P & recipient have a shared understanding about NSSI/experiences/each other. Inversely if lack understanding = barrier |
| M | Relief | | disclosure led to a sense of relief for P |
| N | Positivity of sharing exp. | | disclosure the opportunity to share their experiences via disclosure (wanting to share) |
| O | Concern of encouraging NSSI | | P appreciates their NSSI and seeing this has a negative outcome |
| P | Cultural stigma rei NSSI/MH. | | P's culture how stigmatising views on SI/MH → anticipate stigmatisation if disclose. |
| Q | Internalised stigma. | | Own internalised stigma = barrier to dis/share when disclosed |
| R | Disclose Ambivalence | | Wanting to & not wanting to disclose @ the same time |
| S | Social Isolation Disclosed w/ recipient NSSI | | Dismiss/reach out to stop self from going further |
| T | Supprt seeking | | Disclose to seek out supprt. |
| U | Relationship improved | | Disclosure lead to improved/closer relationship (after). |
| V | Increased trust | | Disclosure led to increased trust between P & recipient |
| W | Context of disclosing as a teenager | | unique context/considerations of disclosure as a teenager. |

cyclical    Complex

individualised

Key
words

evolving    {
- Cognitive
- emotional
- behaviour

Proximal
& Distal

raised i
family.
not pers
move

**Left grouping:**

experience of NSSI disclosure · group setting · outspoken and unconcealed · unlocked support network · psychological preparedness · catalysed (further) help seeking · broader situation/disease lead to NSSI disclosure

difficulty articulating · disclosed for authenticity · anticipating a reaction based on interactions · shock/surprise · recipient ignored NSSI · Frustration for participant · unhelpful response did not meet needs · increased self-acceptance/pride

forward disclosure · seeking understng/accept · Trust is important · increased trust · selective sharing · relationship improved · previous disclosure experience impacting future · Participant felt scared/anticipd negative outcome

stigmatising reaction · evolving response · context of disclosing when teenager · increased awareness of others · discovery leading to disclosure · disclosure in religious setting · helping in research · an emotional experience

concern of encouraging NSSI · mutual support · recipient more open/vulnerable · supportive response · cultural stigma re: NSSI/mental health · shared understanding · relevance to recipient

relief · harm reduction/risk management · relationship type · discussion of nature of NSSI · expecting/want positive change in relationship · disclosure closely followed NSSI · recipient lacked understanding · gender roles/toxic masculinity

seeking · reduced isolation · mutual NSSI experience · disclosure a big deal · not face to face · frequency of NSSI · tangible aid · expect recipient to be qualified

reciprocal disclosure · frequent & open contact · recipient appreciated being disclosed to · catalyst for recovery · anticipate negative change in relationship · safety and security · desired separation/avoid cross

learn about NSSI/views on NSSI changed for p · school setting · experience was awk/uncomfy · value confidentiality · disclosure is ongoing · recipient pause and think · mistrust increased

**Right grouping:**

evolved from voluntary to involuntary · help others · relationship closeness · recipient blamed self · increased comfort in being open

participant guilt · not wanting to impact recipient · wanting agency and independence · Personal/private · mixed experiences

apprehensive re: making concrete · recipient increased awareness · ongoing support/check ins · concern from recipient

Not to be treated differently · non-judgemental recipient · Lack of preplanning · question leading to disclosure

convince self · Mark distress · disclosure affected the NSSI

Defining disclosure

Context matters (?? convers
-cept + topic

not F2F

does this
count

diff
setting

Motives

Values

17/10/22.

helpful outcomes

for P &
recipient

Overcoming

Ambivalence

mixed
resp

Selective
sharing

unhelpful outcomes

Barriers

Lived
Experience
Values

Defining
Disclosure

Considering
Disclosure

Context
Matters

**Pre-disclosure
Considerations**

**Post-disclosure
Outcomes**

DISCLOSURE
AMBIVALENCE

Motives +

Barriers -

Helpful ☺

Unhelpful ☹

Ambiguous ?

SELECTIVE
SHARING

# Appendix N

## Chapter 9 Research-informed Resources

A diverse range of people self-injure and for different reasons.

Non-suicidal self-injury (NSSI) includes times when someone has hurt themselves intentionally without trying to end their life.

Self-injury is different to risky behaviours such as risky drinking, as the damage caused to the body by risky behaviours can be indirect.

Self-injury does not include behaviours that are a part of a person's culture (e.g., tattoos, body modifications)

Although self-injury can be helpful in some ways in the short-term, it has been linked to challenges including mental health difficulties and later suicidal thoughts and actions.

**So what is there to think about before telling someone you've self-injured?**

Self-injury disclosure is when someone intentionally tells someone else that they have self-injured.

Let's think about disclosure the **"CHAT-R"** way

## Supports & Resources

https://www.itriples.org/supports

### References

Park, Y., Mahdy, J. C., Ammerman, B. A. (2020). How others respond to non-suicidal self-injury disclosure: A systematic review. *Journal of Community Applied Social Psychology*, 1–13. https://doi.org/10.1002/casp.2478

Mirichlis, S. (2024). Understanding voluntary disclosure of NSSI [thesis]

I'm thinking about telling someone I've self-injured

A research-informed resource by Sylvanna Mirichlis 2024

The **"CHAT-R"** way

**"Check-in"**
**"Hearer"**
**"Approach"**
**"Talk"**
**"Reflect"**

**"Check-in"**

Check-in & ask yourself:
- Do I have to disclose right now? Do I want to?
- Why do I want to/not?
- What do I expect will happen if I do/not?
- What do I hope this person will say/do?

**"Hearer"**

Who is going to hear you out?
- We might tell different people for different reasons
- Do we feel comfortable confiding in them?
- How might they respond?

**"Approach"**

How will you go about disclosing to this person?
- What do you want them to know?
- Will you tell them in-person or some other way?
- Where & when will you disclose?

**"Talk"**

- Sometimes when people disclose they do most of the talking, other times each person might take turns sharing.
- Disclosures can lead to ongoing check-ins, let your "hearer" know if this is something that you want or not.

**"Reflect"**

- What went well?
- What could have been done differently? By the person you told? By yourself?
- Did the disclosure event align with your expectations?

## What might happen when you disclose?

- Emotional support
- Help in connecting with other support (e.g., professional)
- understanding, concern
- questions about your experience

Unfortunately responses aren't always helpful:
- judgement or rejection
- overly-emotional
- dismissive or trivialising

See the resources & supports linked at the back of this pamphlet

It is important to remember that everyone's disclosure experiences are unique. This is not an exhaustive list.

# Someone told me they have self-injured. What next?

A research-informed resource by Sylvanna Mirichlis 2024

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Non-suicidal self-injury (NSSI) includes times when someone has hurt themselves intentionally without trying to end their life.

Self-injury is different to risky behaviours such as risky drinking, as the damage caused to the body by risky behaviours can be indirect.

Self-injury does not include behaviours that are a part of a person's culture (e.g., tattoos, body modifications)

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# Why do people self-injure?

There are many reasons why someone might self-injure. Some of the more common reasons are:

- to feel more of an emotion/experience
- to feel less of an emotion/experience
- to punish themselves
- to let others know they are distressed
- to communicate
- or for other, reasons

In other words, NSSI can often be a sign that something else is going on for this person.

Although self-injury can be helpful in the short-term, it has been linked to challenges including mental health difficulties and later suicidal thoughts and actions.

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# How do I support someone who has self-injured?

Self-injury disclosure is when someone intentionally tells someone else that they have self-injured.

There are a lot of reasons why someone may or not want disclose their self-injury.

If someone is not ready to share, you can check in on how they are going whilst still respecting their boundaries.

Avoid interrogating them or discussing their business with other people without their consent.

Your relationship with the person who has self-injured plays a big part in how to best support them.

If they are your friend, it is not your role to be their counsellor.

If you are their parent, you might be really concerned about your child and you could be feeling really strong emotions about this.

It is important to give yourself the time and space you need to process a disclosure, and it is okay to be upfront about that.

# Hear them out

If someone does share with you that they have self-injured, there are some things to keep in mind*

**Goal:**

For the person to feel comfortable to share

WHY:
- Feeling unsafe to disclose can make things more challenging for the person who has self-injured and your relationship with them.
- To keep the "door open" to for the person to reach out when needed.

**Goal:**

Understand what it is they are sharing

WHY:
- People use different language to describe self-injury.
- Self-injury can take many forms.
- It may be something quite recent or from a while ago.

**Goal:**

Understand why they are sharing this with you

WHY:
- They might not be seeking any action and just want to share their experience with someone.
- They might not know why they are sharing or what they want out of a disclosure.

*not a checklist to achieve, but a guide

**Do:**
Acknowledge that it can be difficult to talk about self-injury.

**Do:**
Be respectfully curious

**Do not:**
Bombard the person with questions and expect them to share more than they are comfortable with.

**Do:**
Hold space for the person and communicate your boundaries.

**Do:**
Separate the person from the behaviour.

**Do not:**
Make assumptions about why they have self-injured

**Do:**
Reflect the language they use to describe their experience.
**Do not:**
Try to correct them.

# Respond Appropriately

**Goal:**

Directed by the person who has self-injured at their own pace, with your support

WHY:
- People should have a say in matters that impact them.
- Different people will need different degrees of guidance here.

**Goal:**

Realistic expectations for what you can do

WHY:
- You should be just one part of other people's support networks.
- There is only so much we can each do, and we need to prioritise our wellbeing.

## Tips

- Validate/acknowledge their needs and concerns.
- Collaborate to identify next steps, this might mean exploring other supports or taking a breather.
- Be honest about what you can and cannot do.
- It's not always going to go as intended, apologise and be receptive to their feedback

# Looking after yourself:

Encourage the person to seek additional support (do not force this)

Set and maintain boundaries

Seek out your own personal or professional support

Supports & Resources

https://www.headtohealth.gov.au

https://www.selfinjury.bctr.cornell.edu/resources.html

### References

Mirichlis, S. (2024). Understanding voluntary disclosure of NSSI [thesis]

Park, Y., Mahdy, J. C., Ammerman, B. A. (2020). How others respond to non-suicidal self-injury disclosure: A systematic review. Journal of Community Applied Social Psychology, 1–13. https://doi.org/10.1002/casp.2478

Taylor, P. J., Jomar, K., Dhingra, K., Forrester, R., Shahmalak, U., & Dickson, J. M. (2018). A meta-analysis of the prevalence of different functions of non-suicidal self-injury. Journal of affective disorders, 227, 759–769. https://doi.org/10.1016/j.jad.2017.11.073