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Nonsuicidal Self-Injury and Real-Life Self-Disclosure Among Internet Users

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NONSUICIDAL SELF-INJURY AND REAL-LIFE SELF-DISCLOSURE AMONG INTERNET USERS

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ABSTRACT

NONSUICIDAL SELF-INJURY AND REAL-LIFE SELF-DISCLOSURE AMONG INTERNET USERS

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The purpose of this study was to explore several unknown issues regarding disclosure of nonsuicidal self-injury (NSSI) among users of social media. NSSI is a category of behaviors that cause intentional harm to the body without the intent to commit suicide. However, individuals who self-injure may unintentionally risk serious and even life-threatening harm. Moreover, the stigma and resultant shame associated with NSSI discourage reporting and thus complicate research into the behavior. This study examined the factors involved in individuals' decisions to disclose NSSI. The current study uses primarily descriptive statistics from an internet-based survey to explore the following questions: (a) Are there demographic differences between those who choose to disclose in real life (IRL) and those who do not? (b) Are IRL self-disclosers more likely than IRL nondisclosers to endorse pro-social and help-seeking motivations for disclosure over provocative motivations? (c) Do individuals who self-disclose IRL self-injure more frequently compared to IRL nondisclosers? (d) To whom are self-disclosers most likely to disclose? and (e) Are participants more likely to report SD-OL than SD-IRL? Disclosers and nondisclosers were demographically similar. Disclosers most frequently endorsed help-seeking motivations for self-disclosure. Disclosers were no more likely than nondisclosers to endorse high incidence of NSSI. Sixty-two percent of respondents disclosed IRL, and 57.3% of the sample disclosed online. Recommendations for clinical practice based on these results are

discussed. This dissertation is available in open access at AURA (https://aura.antioch.edu/) and Ohio Link ETD Center (https://etd.ohiolink.edu/etd).

Keywords: nonsuicidal self-injury, self-harm, disclosure, stigma, affect regulation

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Table of Contents

List of Tables

List of Figures

CHAPTER I: INTRODUCTION

The purpose of this study was to explore several issues regarding disclosure of nonsuicidal self-injury (NSSI) among users of social media. NSSI has been defined as purposeful damage inflicted on one's own body without the intent to commit suicide (Andover et al., 2010; Nock, 2010). The first issue the study explored was how frequently self-injurers who use social media disclose their NSSI to others they know in person (i.e., offline). The second issue was the intent of self-injurers when they disclose NSSI to others. Secondary to these issues, the study examined the relationships between self-injurers and the individuals to whom they disclose their NSSI. Third, the study examined the motivations behind self-injurers' decisions to disclose NSSI to people they know offline.

For self-injurers, NSSI often produces problematic outcomes. The most apparent adverse outcome is the risk of serious physical injury or death as a result of harm inflicted on the self. While physical signs of self-injury are more outwardly conspicuous, NSSI also has undesirable social and intrapsychic consequences. As discussed in more detail below, NSSI is a category of behaviors that are often stigmatized (Burke et al., 2019; Staniland et al., 2021). As the physical markings from NSSI may persist long after the individual has ceased self-injuring, so may the stigma the individual experiences (Poole, 2021). Moreover, the shame experienced by self-injurers may be heightened by negative social attitudes toward self-injury and interpersonal conflicts resulting from NSSI (Martinson, 1998; Staniland et al., 2021). Thus, self-injurers experience harm not only from the physical act of self-injury, but also from their own and others' reactions to the behavior.

NSSI is a recent construct that distinguishes superficial self-injury without the intent to die from suicidal behavior and from severe self-injury causing permanent damage to the body,

such as amputation. Since the 2000s, interest in NSSI as a distinct clinical problem and a topic of research has grown. The American Psychiatric Association (2013) included NSSI in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) as a condition for further study. Notably, previous editions of the DSM only recognized self-injury as a symptom of borderline personality disorder. Inclusion in DSM-5 has helped legitimize the construct and has encouraged new research into NSSI. However, the diagnostic definition of nonsuicidal self-injury disorder (NSSI-D) is even more circumscribed than the self-harming behaviors defined in prior literature; accurate diagnostic criteria have been a source of dispute for some researchers (Ma et al., 2021; Muehlenkamp & Brausch, 2016).

Historically, researchers have defined self-injury in overly broad, nonspecific, and stigmatizing terms. Some of the terminology categorizing NSSI includes, for example, self-harm, self-injurious behavior, deliberate self-injury, self-inflicted violence, parasuicide, and self-mutilation (Emelianchik-Key & La Guardia, 2020). Even more recent literature defines NSSI as existing on a spectrum of parasuicide (e.g., Muehlenkamp et al., 2013; Nock, 2010), a construct that obscures the nonsuicidal intent of NSSI—even as it seeks to distinguish it from suicidal behavior. These varying constructs make it difficult to compare studies of prevalence rates because some studies fail to distinguish suicide attempts and suicidal gestures from self-injury without suicidal intent (Muehlenkamp et al., 2012). Such disagreement about what constitutes NSSI complicates any integration of historical literature and recent research. Moreover, self-reports of NSSI may be less accurate when researchers use stigmatizing terms such as *self-mutilation* or suggest suicidal intent where none is present.

Prevalence

Given the range of definitions, it is perhaps not surprising that lifetime prevalence for NSSI ranges from 4.0–32.0% (Armiento et al., 2014; Klonsky, 2011). Estimates of rates of NSSI over a 12-month period span a range of 7.3–28.4% (Hilt et al., 2008; Muehlenkamp et al., 2012). These discrepant findings are likely also a function of differences in research design. Recent research often relies on multi-item assessments. Multi-item assessments of NSSI that query various self-injurious behaviors consistently find higher rates of NSSI than those that assess self-injury in a single yes-no question (Muehlenkamp et al., 2012). This change in methodology further complicates comparisons between recent estimates of NSSI's prevalence and the historical measures.

Rates of NSSI are highest among adolescents and young adults and drop by two-thirds after age 25. A metanalysis found that the 12-month prevalence of NSSI in the United States is 17.2% among adolescents age 10–17, 13.4% among adults 18–25, and 5.5% among adults over 25 years of age (Swannell et al., 2014). Interestingly, NSSI does not seem to be a culture-bound phenomenon. In a review of international research, Muehlenkamp et al. (2012) found that NSSI occurs in about 18% of adolescents worldwide, with no significant variation among nations. Individuals in an inpatient sample were two and a half times as likely to report a history of NSSI (Andover & Gibb, 2010), compared to rates among noninpatient samples (Muehlenkamp et al., 2012; Swannell et al., 2014). Andover and Gibb (2010) found that 45.3% of hospitalized psychiatric patients reported a history of self-injury.

Varying methodologies used in surveys make it difficult to determine the degree to which rates of NSSI might differ between genders, and research has yielded conflicting findings. However, NSSI is at least somewhat more common among females. Various studies have found

that 72–74.2% of individuals who have engaged in NSSI identify as female (Burke et al., 2019; Buser et al., 2019; Hankin & Abela, 2011; Nock & Prinstein, 2004). A meta-analysis by Swannell et al. (2014) found that total lifetime prevalence among females was 19.9% versus 14.7% for males, a significant but less stark difference than suggested by individual studies. The difference in these finding may well be related to a greater frequency of self-injury for females, though other factors, including definitions of what constitutes NSSI and differences in methodologies among studies, may also be at play. Further, there may be greater gender differences in rates of self-disclosure of self-injury than in rates of self-harm. For example, Andover et al. (2010) found that males with a history of NSSI were less likely to report self-injury over the past year compared to females. Prevalence of self-harm also appears to be higher among sexual minorities. Among adolescents who self-identified as gay, lesbian, bisexual, or queer, 46.4% report NSSI in the past 12 months (Reisner et al., 2014), and when transgender or gender-queer individuals are included, 62.8% report NSSI over their lifetime (Muehlenkamp et al., 2015). Some nonbinary individuals have described others' lack of understanding of their gender as contributing to their distress and NSSI (Jackman et al., 2018).

Key Concepts and Constructs

Nonsuicidal Self-Injury

For the purposes of this study, nonsuicidal self-injury was defined as behavior in which one purposefully causes superficial harm to one's own body without tacit or express intent to commit suicide. Researchers and clinicians studying NSSI broadly agree upon this definition of NSSI. For example, Nock and Favazza (2009) define NSSI as "direct and deliberate destruction of body tissue in the absence of any observable intent to die" (p. 9). Similarly, Andover et al. (2010) describe NSSI as "deliberate harm to the body without suicidal intent" (p. 79). Thus,

NSSI is distinct from attempts to commit suicide, which carry the specific intent to kill oneself, or suicidal gestures, which are committed with the intent to communicate a desire to kill oneself.

Because NSSI is deliberate, the definition excludes acts that have other primary motivations aside from harm to one's body. For instance, the act of smoking cigarettes would be excluded because, though harmful, smoking has clear motivations that supersede the intention to hurt oneself. Similar, socially sanctioned activities such as religious rituals, body piercing, and tattooing differ from NSSI in that the primary intent in each case is not to harm one's body.

NSSI is also distinct from less deliberate behaviors stemming from another psychopathology. Nock and Favazza (2009) distinguish between NSSI and stereotypic self-injury (e.g., repetitive tongue biting) of the sort seen among individuals with neuropsychiatric disorders or developmental disabilities. Acts against the self that are committed during episodes of psychosis or delirium are also excluded because they can be understood as resulting from other clear psychopathology in which the intent of the individual is difficult to determine. Nock and Favazza (2009) also make a useful distinction between NSSI, which is relatively superficial in nature, and major self-injury, such as eye enucleation, which may be seen among individuals experiencing psychosis and which results in severe and permanent bodily harm.

Differentiating Between NSSI and Related Constructs

While the scope of this study specifically examined NSSI, it is important to distinguish NSSI from other related constructs that differ in function or specificity. The majority of research on the constructs below concern behaviors broader or narrower than those that fall within the scope of this paper. Throughout this paper the terms *nonsuicidal self-injury* or *self-injury* will be used interchangeably and should be understood to refer to the definition of NSSI above. If I review a study with a different definition, I will discuss how it diverges. At times, however, it

will be useful to refer to literature regarding these other constructs, and at those times, the constructs being studied will be referred to by their name.

Attempted Suicide

The motivation behind a suicide attempt is to die or to communicate an intention to kill oneself. NSSI—in particular wrist-cutting—has sometimes been conflated with suicidal behaviors in the literature. The motivation for NSSI cannot, by definition, be to die.

Suicidal Gestures

Suicidal gestures include acts similar to attempted suicide but have a low likelihood of resulting in death. The purpose may be to prepare for suicide attempt or to communicate that one is motivated to kill oneself (Nock, 2010). As above, such behaviors are definitionally excluded from the scope of this research.

Parasuicide

The term *parasuicide* refers to a broad range of behaviors involving "deliberate self-harm that falls short of suicide and may or may not be intended to result in death" (VandenBos & American Psychological Association, 2013, p. 414). Because the definition of parasuicide is vague, it includes NSSI. However, as a category of behaviors, parasuicide also includes attempted suicide, suicidal gestures, and passive suicide that are distinct from NSSI (VandenBos & American Psychological Association, 2013). Moreover, many of the behaviors understood to be NSSI, such as self-hitting, may not be recognizable as parasuicide, even though such behaviors meet the technical definition.

Deliberate Self-Harm

In European studies of self-injury, the term *deliberate self-harm* (DSH) is often used. DSH is a spectrum of behaviors that are intentionally destructive to the body. NSSI sits along the

spectrum of behavior considered to be self-harm. However, DSH does not distinguish between the intent or absence of intent to kill oneself (Klonsky et al., 2011; Muehlenkamp et al., 2012). Thus, it also often, though not always, includes suicidal behaviors. Indeed, some studies use the term deliberate self-harm while specifically excluding suicidal behaviors.

Self-Mutilation

Self-mutilation or *self-mutilative behaviors* (SMB) includes a range of acts that cause disfigurement (VandenBos & American Psychological Association, 2013). This construct includes some behaviors that are also considered NSSI, such as cutting one's skin, and until recently, it was frequently used to refer to NSSI (Klonsky et al., 2011). However, SMB also includes acts, such as the severing of a limb, that are more severe than the superficial harm considered to fall under NSSI (Favazza & Favazza, 1987; Klonsky et al., 2011; Walsh & Rosen, 1988). Moreover, the term self-mutilation typically excludes common acts of NSSI, such as self-hitting, that are likely to cause only bruising, other temporary visible damage, or no outwardly visible damage to the body (Klonsky et al., 2011; Walsh & Rosen, 1988). Finally, the term *mutilation* is loaded and carries stigma. The term implies permanent, visible damage to one's body. It also carries an implication of visceral disgust from third-party witnesses to the harm. In their seminal works on SMB, both Walsh and Rosen (1988) and Favazza and Favazza (1987) stress the aversion that SMB causes in those who witness SMB or its effects.

Self-Inflicted Violence and Self-Abuse

While *self-inflicted violence* and s*elf-abuse* have been used in the literature to describe NSSI, these terms are broad and lack specificity. As Klonsky et al. (2011) note, both *violence* and *abuse* have multiple definitions and "fail to capture the essence of the act being nonsuicidal in nature" (p. 6).

Cutting or Self-Cutting

Cutting is, perhaps, the most frequently invoked example of NSSI. However, cutting is but one mode of self-injury. As will be discussed below, cutting and NSSI are often treated synonymously in the literature, even within empirical studies that include other forms of self-injury. As Klonsky et al. (2011) observe, the term *wrist-cutting* is even more circumscribed and excludes similar self-injury that may occur on other parts of the bodies such as the thigh, upper arm, or abdomen.

The term *cutting* is also problematic because it is more frequently associated with females. When self-battery is included in assessments, the rates of NSSI among males and females are similar, and some studies have found no significant difference in the rates of NSSI among males and female (Whitlock et al., 2011). Finally, though frequently invoked, cutting may not be the most common mode of NSSI. Some studies found that other modes of harm, such as scratching and self-hitting, were employed by self-injurers at rates similar to or greater than cutting (Gratz, 2001; Klonsky, 2011; Muehlenkamp et al., 2013).

Nonsuicidal Self-Injury Disorder

With the inclusion of NSSI in the DSM-5 as a condition for further study, the American Psychiatric Association (2013) proposed a series of criteria for NSSI-D. The DSM-5 defines NSSI as repeated behavior intended to create superficial injuries to the body, including bruising, bleeding, or pain, and excludes from its definition socially sanctioned behaviors, such as religious rituals, behavior undertaken solely during psychosis or delirium, or compulsive behaviors, such as trichotillomania.

In defining NSSI-D, however, the American Psychiatric Association created a narrower conception of NSSI than is used by most researchers of the behavior and designated a functional

definition that excludes acts that some researchers would consider NSSI. The DSM-5 also proposes that individuals cause self-injury for just one of three reasons: to relieve negative thoughts or feelings, to produce a favorable feeling state, or to alleviate a problem of an interpersonal nature. While many researchers agree and evidence supports that these are the most common motivations for NSSI, this conceptualization limits the construct in ways that many researchers would not (Ma et al., 2021). Importantly, the DSM-5 is focused on patterns of NSSI as opposed to the phenomenology of individual acts of self-injury: in order to fulfill criteria for NSSI-D, the DSM-5 requires that an individual must have self-injured on five separate days over the course of a year.

Self-Disclosure of NSSI

Self-disclosure of NSSI is the act of purposefully telling or showing another person one's self-injury. I am specifically interested in distinguishing between those who self-injure who actively choose to disclose and those who self-injure and choose not to disclose NSSI to a third-party. Some self-injurers accidentally reveal their self-injury to other individuals. However, in this paper, I am concerned primarily with the choice to disclose self-injury; I am not exploring unintentional discovery of NSSI. More specifically, I am interested in the decision to self-disclose to someone known in real life (SD-IRL); however, I also explore some aspects of self-disclosure to individuals known only online (SD-OL).

Population

The study sampled adult internet users recruited through several social media platforms, including Facebook, Twitter, Instagram, and Reddit. To recruit participants, informational accounts were created for the study on each of the platforms. Using these accounts, I followed other popular accounts concerned with mental health and NSSI. Pages for study-related accounts

included information about the purpose of the study and links to the survey. In addition to posting on the topic of NSSI, I also posted information about the study, including links to the survey, to mental health and NSSI support groups. Participants were also recruited through word-of-mouth and messages to a listserv of clinicians and psychology students.

Overview of the Study

The study used an anonymized quasi-experimental survey of a community sample of adult internet users recruited through social media, word-of-mouth, and email. Participants were offered the opportunity to complete a survey about NSSI. The survey screened participants for NSSI in order to verify respondents had self-injured without suicidal intent. The survey assessed rates of two kinds of self-disclosure: self-disclosure to individual known to the discloser in-person (SD-IRL) and self-disclosure to individuals only known online (SD-OL). The survey included a multi-item assessment of NSSI behaviors. The survey also contained a questionnaire that asked about the motivations for self-disclosure, the categories of individuals to whom participants disclosed NSSI, and whether recipients of disclosure were known online or in real life.

The study had several goals. The primary aim of the study was to gather and report data on disclosure and nondisclosure among individuals who endorse NSSI with the goal of shedding new light on why and to whom individuals choose to disclose self-injury. The broadest data sought by the study were the rates of disclosure and nondisclosure. Subsequent to that, the inquiry sought to uncover reasons that motivate IRL disclosers to tell others about their NSSI. In aggregating and reporting these various data, the study aimed to contribute to the current body of literature on NSSI.

In the next chapter, I review the current state of literature on NSSI. Because disclosure is an interpersonal act, I give particular attention to the debate over whether NSSI itself is primarily an interpersonal or intrapersonal in nature. I also examine the empirical support for various inter– and intrapersonal models of NSSI. I consider challenges to conducting and interpreting research on NSSI, including ways in which self-injury is stigmatized and elevated, both in popular culture and scholarly literature. I examine research bias in which certain forms of NSSI are depicted as more valid and representative than others. Finally, I discuss the existing research on disclosure of NSSI and what remains unknown about this aspect of NSSI, highlighting the information gap that this study addresses.

CHAPTER II: LITERATURE REVIEW

Nonsuicidal self-injury (NSSI) is a relatively new construct developed to reduce stigma and distinguish superficial self-injury without suicidal intent from attempted suicide and severe self-injury such as eye enucleation (Martinson, 1998; Nock, 2010). NSSI has historically been considered a symptom of other conditions rather than a problem unto itself and is most often associated with borderline personality disorder or adolescent depression (Stanley et al., 2014). NSSI has, in the past, been subsumed under other, broader constructs, including "self-mutilation" and "self-harm," which included suicide attempts and even completed suicide. In more recent literature, there is general agreement that NSSI is behavior in which one purposefully causes harm to one's own body without tacit or express intent to commit suicide (Andover et al., 2010; Nock, 2010).

Conceptualizations of Self-Injury

Attempts to conceptualize self-injury have emphasized either interpersonal or intrapersonal models. As is evident in related terms such as self-mutilation, conceptualizations of NSSI have historically centered around highly visible forms of NSSI, in particular self-cutting. Perhaps because of this visibility, the literature on self-injury has often focused on the reactions of third-parties and the interpersonal functions of self-injury (Favazza & Favazza, 1987; Nock, 2010; Nock & Favazza, 2009). More recently, NSSI has come be understood with regard to its intrapersonal functions, in particular the self-regulatory effects reported by many self-injurers (Muehlenkamp et al., 2013; Whitlock et al., 2011).

Interpersonal Conceptualizations of Self-Injury

A number of interpersonal theories have been proposed to understand NSSI. Nock (2010) notes that, though self-injury has historically been understood as a means of manipulating others,

only weak support has been found for this interpretation of NSSI in current research. As investigation of NSSI has increased, researchers and theorists have sought to interpret the data in a variety of ways. In their review of research, Jacobson and Batejan (2014) identify four interpersonal models of NSSI: the communications theory, the boundaries model, the social contagion theory, and the interpersonal risk factors model. Similarly, Prinstein et al. (2009) identify several interpersonal models of NSSI alternately defined by distal factors, precipitants, interpersonal mechanisms, and interpersonal functions. Since there is significant overlap in these theories, similar models have been grouped together below.

Social Contagion Theory

The social contagion theory posits that individuals self-injure because they see the attention that is given to others who self-injure (Jacobson & Batejan, 2014). Thus, this model attempts to explain why individuals first engage in self-injury. A large survey of university students found that while many report social motivation for initiating self-injury, only 21.7% endorsed social reasons for maintaining the behavior (Whitlock et al., 2011). In a small study of 94 adolescents, Deliberto and Nock (2008) found that 38.3% of their sample endorsed learning of self-injury from peers, while 13.3% endorsed learning about NSSI from media. Taken together, these findings suggest that learning about NSSI may have some influence on initial self-injury but that such knowledge is less likely to contribute to ongoing NSSI.

In a review of literature on NSSI and social contagion, Jarvi et al. (2013) conclude that there is evidence suggestive of social contagion as a driver of NSSI. However, the same review also states that the strongest evidence of social contagion is from decades-old research predating NSSI as a construct (Jarvi et al., 2013). A look at the primary source that Jarvi et al. cite as the strongest contemporary research supporting social contagion as a driver of NSSI reveals a more

complicated set of data points. Nock et al. (2009) found that between 1.7% and 3.8% of individuals who had thoughts of suicide or NSSI endorsed receiving encouragement to engage in these behaviors from peers. Encouragement from peers, however, was not predictive of NSSI behaviors (Nock et al., 2009). Rather, the largest predictor of NSSI behavior among individuals who had thoughts of NSSI was being alone (Nock et al., 2009). This suggests that a small percentage of individuals who endorse DSH have received encouragement from others but that self-isolating is a more important factor in motivating self-harm. Moreover, the study does not adequately distinguish between self-injurious behaviors (SIB) and NSSI.

The strongest research supporting social contagion and NSSI is Matthews' (1968) study of an epidemic of cutting among 11 adolescents in an inpatient mental hospital. While Matthews (1968) concludes that the individuals engaging in cutting were influenced by one another to self-injure, only one of the patients acknowledge by self-report that he was motivated to cut by knowing of others' self-injury. A robust body of literature on SIB and DSH—which includes both SIB and NSSI—appears to support social contagion theory for those behaviors (Do & Lee, 2010; Jarvi et al., 2013; Matthews, 1968; Nock, 2010; Taiminen et al., 1998). Moreover, rates of self-injury are known to be higher among adolescents in congregate settings (Jarvi et al., 2013; Lüdtke et al., 2018; McReynolds et al., 2017; Nock, 2010). The current research on NSSI, however, suggest only that exposure to others' NSSI may be a factor driving NSSI among inpatients with serious psychopathology and could, in theory, be a driver of outbreaks of NSSI in other congregate settings. While the existing literature is less than dispositive, a rise in media depictions of NSSI and the growth of social media's influence on society make social contagion a serious concern worthy of study (Whitlock et al., 2006, 2007, 2008, 2009). More research is

needed to clarify the nature of such social motivations and whether they support the theory of NSSI as a social contagion.

Interpersonal Risk Factors/Distal Factors Model

The interpersonal risk factors model assumes that self-injury is a reaction to past experiences of interpersonal stress, such as abuse, familial discord, or recurrent invalidation (Prinstein et al., 2009). Similarly, the distal factors model, as outlined by Prinstein et al. (2009), views NSSI as a response to maltreatment in early childhood. Jacobson and Batejan (2014) note that studies have found large proportions of individuals who self-injure have experienced sexual abuse. One study found that 89% of adolescents who reported childhood sexual abuse also endorsed NSSI (Weierich & Nock, 2008). However, other studies have found no significant link between NSSI and physical or emotional abuse (Jacobson & Batejan, 2014). Coping with dysregulation following abuse may be one motivation for NSSI; however, it does not appear that self-injurers, as a population, are more likely to have experienced physical or sexual abuse.

Interpersonal Precipitants Model

The interpersonal precipitants model looks at NSSI in the context of recent or ongoing interpersonal distress, such as rejection, betrayal, or conflict (Prinstein et al., 2009). Empirical studies support this model. Among adolescents, the most common feelings experienced prior to self-injury are rejection, self-directed anger, and anger toward others (Nock, 2009). A longitudinal study of teenagers over a 30-month period found that adolescents who engaged in NSSI perceived significantly lower social support than their non-self-injuring peers (Hankin & Abela, 2011). Another study found that individuals who reported self-injuring perceived greater social isolation than those who did not self-injure (Muehlenkamp et al., 2013).

Interpersonal Mechanisms Model

The interpersonal mechanisms model views NSSI in relation to deficient processing of social information (Prinstein et al., 2009). Studies of various designs have found evidence for this theory. Among college females, individuals who self-injured were found to have lower self-compassion than those who did not (Gregory et al., 2017), suggesting a distorted sense of self in relation to others. Individuals who self-injure have been found to have higher emotional reactivity than those who do not self-injure (Nock et al., 2008). In a similar vein, Nock and Mendes (2008) found that individuals with NSSI scored lower on measures of social problem solving. Self-injurers also endorsed a greater number of maladaptive solutions to interpersonal problems compared to their non-self-injuring peers (Nock & Prinstein, 2005).

Functional Models

The Boundaries Model

The boundaries model asserts that individuals self-injure as a way of establishing a clear differentiation between themselves and others. Rooted in object relations, this model assumes that individuals who self-injure experience a loss of self during periods of stress (Prinstein et al., 2009). There is little direct evidence for this theory in current empirical research.

The Communications Model

The communications model posits that self-injury is a means of provoking a response or eliciting help from others (Jacobson & Batejan, 2014). In a comprehensive survey of the social functions of NSSI among college students, Muehlenkamp et al. (2013) found a portion of subjects who engaged in repeated acts of self-injury endorsed direct interpersonal motivations. The study found that 13.1% of subjects who engaged in more than one act of self-injury endorsed self-injuring so that someone else would notice that they were struggling

(Muehlenkamp et al., 2013). Similarly, a survey by Nock and Prinstein (2004) found that among adolescents aged 12–17 with multiple admissions to psychiatric inpatient unit, 13.0% indicated that they self-injured to provoke attention or understanding from their parents, and 14.1% endorsed self-injuring to increase the amount of attention they received from parents. Though both of these studies found some evidence that self-injury is sometimes used to convey messages to others, this motivation was not as strongly supported as other motivations—in particular affect regulation.

The Intrapersonal Model

The most predominant current theory of NSSI is that self-injury performs an intrapersonal function by helping self-injurers regulate their emotions (Muehlenkamp et al., 2013; Nock, 2010). In a survey of individuals with NSSI, Nock and Prinstein (2004) found that among adolescent inpatients, the most commonly endorsed reason for self-injury was "to stop bad feelings" (p. 888). Similarly, Muehlenkamp et al. (2013) found that among college students, 43.2% indicated that they self-injured to "cope with uncomfortable feelings" (p. 74). The next four most endorsed responses also involved relieving negative emotions such as stress, frustration, or anger. Thus, the current research demonstrates NSSI has an affective function.

Moreover, the intrapersonal conceptualization of NSSI has been held up by multiple recent studies (Ammerman et al., 2020, 2021; Ammerman & Brown, 2018; Muehlenkamp et al., 2013; Whitlock et al., 2014; Whitlock & Rodham, 2013). Ammerman and Brown (2018) found that self-criticism and even self-hatred contribute to individuals' decisions to self-injure. In a study that sought to safely replicate self-injury in a lab, participants who were given control over the severity of an electrical shock experienced less anxiety before and after the stimulus compared to participants who were given no control over the shock, suggesting that asserting

control over one's own physical pain can help individuals manage their emotions (Ammerman et al., 2020). Intrapersonal conceptualizations are more robust for another important reason: in order to serve an interpersonal function, NSSI must be known to others. Most self-injurers, however, never disclose their NSSI (Armiento et al., 2014; Simone & Hamza, 2020). If NSSI is unknown to others, it cannot serve an overt social or interpersonal function.

Self-Disclosure

While research shows that NSSI is primarily motivated by intrapersonal concerns, NSSI occurs within an interpersonal context (Jacobson & Batejan, 2014; Muehlenkamp et al., 2013; Prinstein et al., 2009). One important interpersonal dimension of NSSI is the self-injurer's decision to disclose their self-injury to a third party. There is a small and growing body of literature on disclosure of NSSI. In a 2020 review of research on disclosure and NSSI, researchers found that many studies failed to distinguish between voluntary disclosure and involuntary discovery of NSSI (Simone & Hamza, 2020). To further complicate interpretation, many articles on the topic conflated help-seeking and self-disclosure (Simone & Hamza, 2020). Help-seeking is only one form of self-disclosure. Conflating help-seeking and self-disclosure obscures other motivations that self-injurers might have for choosing to self-disclose and likely underestimates the full number of self-injurers who self-disclose. For example, in a large phone survey of 12,006 Australians, 71.4% of individuals who endorsed self-injury reported disclosing their NSSI to a friend or family member, but only 31.6% reported seeking help for NSSI (Martin et al., 2010). These findings suggest disclosers may have other reasons for revealing their NSSI to others.

Of 41 studies reviewed by Simone and Hamza (2020), only nine reported rates of voluntary self-disclosure. Across samples, self-injurers voluntarily self-disclose at rates ranging

from 16.9–89% (Simone & Hamza, 2020). Perhaps not surprisingly, individuals receiving mental health services disclose at the highest rates (Simone & Hamza, 2020). In community samples, individuals disclosed at rates of 50–60% (Simone & Hamza, 2020). Among college students, 43% disclosed their self-injury (Armiento et al., 2014). Rates of nondisclosure were higher for men than women (69% vs. 53%, respectively; Armiento et al., 2014).

Self-injurers are more likely to disclose their NSSI to some individuals rather than others. Disclosers are most likely to reveal their NSSI to friends or peers (Armiento et al., 2014; Berger et al., 2013; Simone & Hamza, 2020). Romantic partners are also likely recipients of disclosure (Armiento et al., 2014). Compared to peers and romantic partners, self-injurers are less likely to tell parents about their self-injury; however, one study concludes that self-injurers disclose NSSI to mothers at almost twice the rate of fathers (Armiento et al., 2014).

Anticipated Stigma and Self-Disclosure

NSSI remains a stigmatized behavior. Asked about their feelings toward individuals who self-injure, most report negative attitudes (Burke et al., 2015). Self-injurers, when asked why they chose not to disclose, identified shame as the most common reason for continued secrecy (Simone & Hamza, 2020). Among adolescents, those who self-injure report stigma as a barrier to help-seeking (Rowe et al., 2014).

In their review of reactions to NSSI, Staniland et al. (2021) identify four types of stigma experienced by individuals who self-injure: public stigma, self-stigma, enacted stigma, and anticipated stigma. Public stigma is the general public's broad characterization of self-injurers as manipulative and attention-seeking—an attitude that continues to be shared by many clinicians (Simone & Hamza, 2020; Staniland et al., 2021). Self-stigma is the shame that self-injurers feel about their NSSI because of their understanding of and possible agreement with the negative

attitudes of others about NSSI (Staniland et al., 2021). Enacted stigma is self-injurers direct experience of the negative reactions of others to their own NSSI (Staniland et al., 2021). Finally, anticipated stigma is a self-injurer's expectation of negative reactions from others (Staniland et al., 2021). These forms of stigma, separately and in combination, convey the message to individuals who self-injure that their NSSI is shameful and should remain hidden.

In particular, self-injurers' anticipation of negative reactions from others is borne out in current research. A survey of college undergrads found that individuals react negatively toward self-injurers, characterizing them as dangerous and manipulative (Lloyd et al., 2018). Another survey showed that individuals have broadly negative views of self-injurers, characterizing them as unfit to be friends, romantic partners, or roommates (Burke et al., 2015). Adolescent self-injurers report internalizing these negative perceptions of NSSI, often viewing themselves as mentally ill (Mitten et al., 2016).

Stigma may be even more of an obstacle to disclosure for males who self-injure. Lloyd et al. (2018) found that males who self-injure were more likely to anticipate anger, avoidance, and an unwillingness to help from others in response to self-disclosure. A related exploration concluded that males have more stigmatizing attitudes toward self-injurers and were more likely than women to negatively view males and females who self-injure (Burke et al., 2019).

Many self-injurers do indeed experience negative reactions from others when NSSI is discovered or disclosed in person. In medical settings, self-injurers may be regarded as help-rejecting and even soulless, and some are told to avoid discussing their NSSI because it might be contagious (Lindgren et al., 2004). Self-injurers report being treated as freaks or monsters (Long, 2018). Other report being treated as disabled or damaged (Klineberg et al., 2013; Mitten et al., 2016). Self-injurers may also be treated dismissively by helping professionals and made to feel

as though their problems are invalid (Mitten et al., 2016). Some adult self-injurers report that they have been told their self-injury is merely an enactment of alternative "goth" or "emo" subcultures (Long, 2018).

Reaction to NSSI has evolved significantly over the last 50 years. Nock (2009) notes that until the 1980s, NSSI was dismissed by clinicians and researchers "as a senseless, sometimes horrific act" (p. 27) or understood merely as a form of "manipulation designed to achieve a secondary gain" (p. 27). Medical staff even denied pain relievers to self-injurers (Anonymous, 2016). In addition, as recently as a decade ago, adolescents cited such stigma as a barrier to help-seeking (Mitten et al., 2016; Rowe et al., 2014). However, the research to date suggests that the stigma IRL both maintains the cycle of isolation and self-injury for self-injurers and impedes attempts to understand and treat self-injury.

Perhaps in response to this isolation, self-injurers have formed active online communities around the topic of NSSI. One study found videos marked with euphemistic NSSI-related tags collectively received billions of views (Lookingbill, 2022). TikTok is known for its heavy moderation of content, and videos marked with explicit mentions of NSSI are instantly taken down by the site (Lookingbill, 2022). Still, the existence of such tags and users' efforts to elude moderators suggest there is a motivated community of users discussing NSSI on the platform. The size of these communities, however, remains hard to determine. On TikTok, a "view" is recorded each time a video begins playing on a user's device, regardless of whether the user swipes to the next video immediately or watches to the end (TikTok, n.d.). Moreover, because tags on these videos are purposefully ambiguous and may refer to non-NSSI subject matter, it is difficult to accurately quantify the amount of NSSI-related content on TikTok and the audience for that content. Nevertheless, with the advent of online groups and the growth in understanding

of NSSI as a coping strategy, self-injurers may have found more of a virtual community to combat their experience of marginalization (Giordano, 2023). The creation and use of euphemistic tags to promote discussion of NSSI demonstrate the existence of multiple online communities dedicated to the topic of self-injury.

Consequences of Self-Disclosure

Much of the research on NSSI has focused on the perceptions of third-parties rather than on the experiences of self-injurers (Burke et al., 2015; Lloyd et al., 2018; Nielsen & Townsend, 2018; Staniland et al., 2021). Most recipients of disclosure report a desire to help self-injurers (Bresin et al., 2013). Still, sympathy and concern are not guaranteed reactions to disclosure. In response to certain kinds of self-injury (i.e., scratching or self-hitting), participants most commonly predicted they would respond by simply telling the self-injurer to stop (Bresin et al., 2013). In a review of current literature about the reactions of recipients of disclosure to being told about NSSI, Park et al. (2021) found recipients across multiple studies responded with less sympathy when they felt the event that precipitated self-injury was within the control of the discloser. Recipients were particularly unsympathetic toward disclosure of NSSI associated with drug use. Among college students, males were more likely to respond to disclosures of NSSI with anger and were more likely to view self-injurers in a negative light (Lloyd et al., 2018). While many recipients of disclosure report sympathy for disclosers of NSSI, self-injurers hoping for support face an uncertainty when deciding to tell others about their own NSSI.

Possible Benefits of Self-Disclosure

While disclosing NSSI can open the self-injurer up to criticism and other stigmatizing reactions, disclosure can also enable the individual to receive support or treatment for NSSI. Disclosure may have other, less immediate benefits as well: adolescents who self-disclosed NSSI reported higher self-esteem (Armiento et al., 2014). Disclosure of NSSI may often elicit expressions of sympathy and concern from others (Lloyd et al., 2018). However, helpful responses are hardly assured. Among youth, disclosure to adults appears to reduce the severity of self-injury, while disclosing NSSI to peers produced no significant change in behavior (Simone & Hamza, 2020). Nevertheless, disclosure of NSSI has been found to decrease suicidal ideation for self-injurers and to improve their abilities to cope with distress (Simone & Hamza, 2020).

Motivations for Real Life Disclosure

Many current studies have included questions about in-person disclosure and motivations for disclosure as areas of secondary interest. For example, in one review of the literature, Simone and Hamza (2020) found most research into the NSSI self-disclosure concerned disclosure online. Only a few studies have examined motivations for disclosure or whether disclosers differ from nondisclosers.

In one such study of self-disclosure, Armiento et al. (2014) surveyed 286 Canadian undergraduate students who endorsed NSSI and found that 42.5% of self-injurers had verbally disclosed their self-injury to another person. Men were less likely to disclose NSSI, with 31% endorsing past disclosure, compared to women (47%). Almost two-thirds of disclosers had told only informal sources (i.e., friends, parents, or romantic partners) about their NSSI, whereas 26% had told formal sources, such as a medical doctor, teacher, or counselor. Statistical analysis by

the authors found that disclosure was associated with higher self-esteem and friendship-quality, as well as greater suicidal ideation (Armiento et al., 2014).

Other studies suggest the decision to disclose is closely linked to disclosers' expectations for support or at least hope for the possibility they might be met with compassion. Some self-injurers have stated, for example, that, though they expected stigmatizing responses, they disclosed their NSSI out of a desire or need for care from others (Shaw, 2006). For some, the fear of further marginalization makes it even harder for them to disclose. Gender minority individuals who have disclosed self-injury, for example, described being frequently failed by systems and by individuals close to them (Jackman et al., 2018). This sense of disaffection may lead individuals to avoid help for NSSI (Jackman et al., 2018). Stigmatizing responses to disclosure are common. Among disclosers, those who indicated they would disclose again and those who indicated they would maintain secrecy, both groups experienced negative reactions to self-disclosure at similar rates (Ammerman & McCloskey, 2021). Nevertheless, social connection plays an important role in self-injurers' decisions to disclose. Individuals who suggested they would disclose in the future perceived higher levels of overall social support compared to those endorsing future secrecy (Ammerman & McCloskey, 2021). Despite stigmatizing reactions from others, self-injurers with adequate social supports maintain that they would reveal their NSSI in the future.

Modes of Self-Injury

As one of the most visible forms of self-injury (along with burning), cutting remains the prototypical form of NSSI for many researchers and clinicians and is often cited as the most common form (Berger et al., 2015; Gagnon & Hasking, 2012; Heath et al., 2011). There are, however, many less visible forms of injury such as head-banging, hair-pulling, and self-battery

(Nock & Favazza, 2009; Whitlock, 2006). Moreover, according to at least one recent large study, scratching may be more common than cutting, and self-battery rates as a close third (Muehlenkamp et al., 2012).

While no list could be comprehensive, there are three commonly used multi-item behavioral assessments for NSSI that give an idea of the range of commonly seen NSSI behaviors. The Functional Assessment of Self-Mutilation (FASM), developed by Lloyd-Richardson et al. (2007)—its name notwithstanding—to assess NSSI, lists 11 specific forms of self-injury, including: cutting or carving, hitting, pulling out hair, self-tattooing, wound-picking, burning, biting, scraping, inserting objects under the nails, picking at oneself until blood is drawn, and "erasing" one's own skin. The Non-suicidal Self-Injury Assessment Tool (Whitlock et al., 2014) adds dripping acid on oneself, rubbing glass into the skin, breaking or attempting to break bones, banging or punching objects, preventing wounds from healing, and engaging in fights or other activities with the specific intent to be hurt. The Inventory of Statements About Self-Injury (Klonsky & Glenn, 2009) also includes among its list of behaviors: rubbing one's skin against rough surfaces, sticking oneself with needles, and swallowing dangerous substances.

Conclusion

NSSI is a recently developed construct that distinguishes superficial self-harm from suicidal behavior or severe self-injury that causes permanent damage to one's body, such as amputation. NSSI has often been understood from the perspective of observers of self-injury rather than from the vantage of self-injurers themselves. Relatedly, a number of interpersonal models for NSSI have been devised. Current research has shown more support for intrapersonal functions of NSSI, namely as a coping method to regulate one's emotions.

Nevertheless, interpersonal factors cannot be excluded from our understanding of NSSI. Self-injury often occurs in the context of interpersonal distress (Muehlenkamp et al., 2013; Nock, 2009; Prinstein et al., 2009). Additionally, the stigma experienced by self-injurers is an interpersonal phenomenon. Disclosure of self-injury is one aspect of NSSI that requires additional research. Understanding the conditions in which individuals choose to hide or disclose their self-injury will improve the assessment and treatability of NSSI. Expanding this body of knowledge may also open avenues into understanding the dynamics at play when discussing NSSI and how clinicians can provide better support for, and validate the experiences of, self-injurers in order to provide more effective treatment.

Research Questions

The current study explores the following questions:

1. Demographic differences: Are there demographic differences between those who choose to disclose IRL and those who do not, particularly with regard to race, gender identity, or age?
2. Motivations for disclosure: Are IRL self-disclosers more likely than IRL nondisclosers to endorse pro-social and help-seeking motivations for disclosure over provocative motivations?
3. Incidence of NSSI: Do individuals who endorse SD-IRL self-injure more frequently compared to IRL nondisclosers?
4. Recipients of disclosure: To whom are self-disclosers most likely to disclose?
5. Online versus IRL disclosure: Are participants more likely to report SD-OL than SD-IRL?

CHAPTER III: METHODOLOGY

Research Methodology

The study employed a survey design to examine characteristics of individuals who endorse NSSI and to determine whether there are differences between individuals who disclosed NSSI in real life and those who did not using primarily descriptive analyses.

Procedure

An online survey was created using Google Forms. The survey was open to participants from February 10, 2022 to May 5, 2022. The initial page of the survey included an informed consent that identified the topic of the survey as NSSI (see Appendix B). The informed consent also indicated that the survey was fully anonymous. Responses to the survey were hosted on an encrypted server accessible to only to the researcher. Final data were downloaded and sorted on an encrypted, password-protected hard-drive accessible only to the researcher. Analyses were performed using IBM SPSS and Microsoft Excel.

Measures

The survey included a short demographic questionnaire (see Appendix C), the *Brief Nonsuicidal Self-Injury Assessment Tool* (BNSSI-AT), and a questionnaire about self-disclosure of NSSI (see Appendix E).

Demographic Questionnaire

The demographic questionnaire asked participants about their age, gender, and race. The gender item offered respondents seven options: “male,” “female,” “trans male,” “trans female,” “nonbinary or genderqueer,” “other,” and “prefer not to say.” The race item included the following options: “prefer not to say,” “white,” “Asian,” “Black or African American,”

"American Indian or Alaska Native," "two or more races," and "Hispanic or Latinx." See Appendix C for the full questionnaire.

Brief Nonsuicidal Self-Injury Assessment Tool

The BNSSI-AT is a validated assessment for NSSI (Whitlock et al., 2014). The BNSSI-AT measures five domains of self-injury: forms, functions, recency and frequency, wound locations, and habituation and perceived life interference. The BNSSI-AT also includes two items to discriminate between respondents whose primary motivation for self-injury was to attempt suicide and respondents whose self-injury is nonsuicidal. For sample items, see Appendix D.

Self-Disclosure Questionnaire

The self-disclosure questionnaire included seven items. The survey first asked whether participants have disclosed their NSSI to someone they know in person and, if so, whom they told. The questionnaire then asked participants to indicate their motivation for disclosing NSSI. To analyze the results, I characterized the responses as belonging to three categories of motivations for disclosure: help-seeking, prosocial motivations (i.e., help-giving or social curiosity), and antagonism. Of the items following the question about respondents' motivation for disclosure, I categorized three as help-seeking: "I wanted to get help or support," "I wanted to get advice about how to stop self-injuring," or "I wanted to get advice about coping with my emotions." One item offers a specifically prosocial motivation: "I wanted to help or support the person I told." Two more—"I wanted to know whether other people self-injure," and "Someone asked, and I didn't want to lie"—are broadly prosocial in that they are based on social curiosity or a desire to be honest. Finally, one item offers an antagonistic motivation: "I wanted to upset or get a reaction from someone." A second part of the self-disclosure questionnaire asks whether

participants have disclosed online and, if so, their motivation for doing so. To see the full questionnaire, see Appendix E.

Ethical Considerations

Though the survey did not target a specific protected or vulnerable group, given the cultural stigma toward self-injury, the survey had the potential to be upsetting to respondents. However, multiple studies have shown that surveying individuals about self-injury does not provoke or increase self-injury (Gould et al., 2005; Reynolds et al., 2006). In order to mitigate any potential risk, on each page of the survey, I provided contact information for the National Hope Line and SAFE Alternative, a treatment organization whose mission is to help individuals seeking to stop self-injuring. As indicated by the Informed Consent, by participating in the study, individuals could possibly contribute to the body of research on NSSI, from which they might indirectly benefit by deepening cultural and clinical understanding of self-injury. As an incentive for completing the survey, respondents could opt to enter a raffle for one of five Amazon gift cards. One respondent, chosen at random, received a $100 gift card. Four others, also randomly chosen, received gift cards in the amount of $25 each. In order to maintain anonymity, respondents wishing to opt in to the drawing were directed to a secondary submission page, where they submitted email addresses to an encrypted, password-protected database. In this way, personal email addresses could not be linked to survey responses.

CHAPTER IV: RESULTS

Participants

I recruited adult participants through four social media platforms, including messages posted to the primary recruitment accounts and on mental health and NSSI support groups. (For the recruitment poster, see Appendix A.) Participants were also recruited through word-of-mouth and an email to a listserv of university-affiliated clinicians. No data were collected on how individuals found the survey. However, most responses were completed after links to the survey were posted on one social media platform—Reddit. Notably, Reddit allows users to generate their own usernames, and users are thus able to remain anonymous on the platform.

Data for this study were analyzed for 536 eligible participants out of 640 responses. Of these 640 protocols, 45 survey respondents were excluded as minors, and their responses were expunged from the dataset. As part of the survey, participants were screened to include only NSSI; 51 more individuals were then excluded for endorsing suicidality or being unsure of their suicidal intent. An additional seven individuals were excluded for endorsing no self-injury; one respondent was excluded for not completing the entire survey.

Based on individuals' answers on the survey, participants were divided into two groups. Individuals who indicated they had self-disclosed their NSSI to someone they knew in person (as opposed to someone known only online) were designated as IRL disclosers (n = 332). Those who denied disclosing to anyone known in person were placed a group, IRL nondisclosers (n = 204). For a separate comparison, the full sample of participants, including both IRL disclosers and nondisclosers, was used to create a group of OL disclosers (n = 307).

Demographics

Participants in the study ranged in age from 18 to 55 years old (M = 22.36, SD = 6.1). Most participants (51.69%, n = 277) identified as cisgender females. Gender minorities represented 33.02% of the sample, including trans male (7.46%, n = 40), trans female (3.36%, n = 18), and nonbinary individuals (20.34%, n = 109), as well as those who endorse "other" (2.05%, n = 11). Cisgender males constituted 13.25% (n = 71) of the sample. Two percent of participants in the sample declined to indicate a gender (n = 11).

A large majority of participants identified as white (78.73%, n = 422), followed by two or more races (6.34%, n = 34), Hispanic or Latinx (4.85%, n = 26), Asian (4.29%, n = 23), Black or African-American (1.68%, n = 9), and American Indian or Alaska Native (1.12%, n = 6). The remaining 2.99% (n = 16) identified as other races or declined to identify themselves by race. For a full report of participants' demographic details, see Table 4.1.

Table 4.1

Demographic Characteristics of Participants

Characteristic	Full Sample		IRL Disclosers		IRL Nondisclosers	
	n	%	*n*	%	*n*	%
Gender						
Cisgender female	277	51.7	168	50.6	109	53.4
Cisgender male	71	13.2	48	14.5	23	11.3
Trans male	40	7.5	27	8.1	13	6.3
Trans female	17	3.2	11	3.3	6	2.9
Nonbinary or genderqueer	109	20.3	67	20.2	42	20.6
Other	11	2.1	6	1.8	5	2.5
Prefer not to say	11	2.1	5	1.5	6	2.9
Total	536	100.1	332	100.0	204	99.9
Race						
White	422	78.7	269	81.0	153	75.0
Black or African American	9	1.7	6	1.8	3	1.5
Hispanic or Latinx	26	4.9	13	3.9	13	6.4
Two or more races	34	6.3	17	5.1	17	8.3
Asian	23	4.3	16	4.8	7	3.4
American Indian or Alaska Native	6	1.1	3	0.9	3	1.5
Prefer not to say	10	1.9	4	1.2	6	2.9
Other	6	1.1	4	1.2	2	0.9
Total	536	100.0	332	99.9	204	99.9

Note: N = 536. For disclosers *n* = 332. For nondisclosers *n* = 204. Participant age did not differ significantly between groups.

Demographic Differences Between Groups

The results of the survey were subjected to statistical analyses to determine whether demographic differences existed between groups. There was no significant difference in the mean ages between the disclosure (M = 22.20, SD = 5.77) and nondisclosure groups (M = 22.62, SD = 6.61), $t(386.10) = -0.751$, $p = .453$. A chi-square test of independence was performed to examine the relationship of gender and the decision to disclose NSSI to someone known IRL. The relationship between these variables was not statistically significant, $\chi^2(2, N = 536) = 3.276$, $p = .774$. To examine the relationship of race and the choice to disclose to someone known offline, the variables "Other" and "Prefer not to say" were combined. A chi-square test of independence was performed to examine the relationship of race and self-disclosure. The relationship between these variables was not statistically significant, $\chi^2(2, N = 536) = 6.194$, $p = .402$. For a detailed comparison of the two groups, see Table 4.2.

Table 4.2

Demographic Characteristics of IRL Disclosure and IRL Nondisclosure Groups

Characteristic	IRL Disclosers		IRL Nondisclosers		$\chi^2(2)$
	n	%	*n*	%	
Gender					3.28
Cisgender female	168	50.60	109	53.43	
Cisgender male	48	14.46	23	11.28	
Trans male	27	8.13	13	6.37	
Trans female	11	3.31	6	2.94	
Nonbinary or genderqueer	67	20.18	42	20.59	
Other	6	1.80	5	2.45	
Prefer not to say	5	1.50	6	2.94	
Race					6.19
White	269	81.0	153	75.0	
Black or African American	6	1.8	3	1.5	
Hispanic or Latinx	13	3.9	13	6.4	
Two or more races	17	5.1	17	8.3	
Asian	16	4.8	7	3.4	
American Indian or Alaska Native	3	0.9	3	1.5	
Prefer not to say	4	1.2	6	1.5	
Other	4	1.2	2	0.9	

Note: N = 536. For disclosers *n* = 332. For nondisclosers *n* = 204. Participant age did not differ significantly between groups.

Rates of Real-Life Disclosure by Gender

Examining gender groups, cisgender and trans males self-disclosed IRL at similar rates (respectively, 67.6%, *n* = 71 and 67.6%, *n* = 40). Among trans females (*n* = 18), 66.7% endorsed

SD-IRL, and individuals identifying as nonbinary (*n* = 109) endorsed SD-IRL at a rate of 61.5%. Sixty-one percent of cisgender females endorsed SD-IRL. Participants who indicated "other" when asked about their gender and participants who declined to indicate a gender disclosed, respectively, at rates of 54.6% (*n* = 11) and 45.5% (*n* = 11).

Rates of Real-Life Disclosure by Race

Asian participants (*n* = 23) disclosed IRL at a rate of 69.6%. Sixty-four percent of self-identified white participants (*n* = 422) endorsed SD-IRL. Half of all Hispanic or Latinx participants (*n* = 26) endorsed SD-IRL. Multiracial participants (*n* = 35) endorsed SD-IRL at a rate of 48.6%. While representation within the sample of some minority groups was small, participants of color (*n* = 105) disclosed IRL at a combined rate of 56.2%. Rates of SD-IRL by demographic factors are detailed in Table 4.3.

Table 4.3

Rates of Disclosure by Demographic Characteristic

Characteristic	IRL Disclosers		OL Disclosers		Full Sample
	n	%	*n*	%	*n*
Gender					
Cisgender female	168	60.7	149	53.8	277
Cisgender male	48	67.6	33	46.5	71
Trans male	27	67.5	26	65.0	40
Trans female	11	64.7	11	64.7	18
Nonbinary or genderqueer	67	61.5	75	68.8	109
Other	6	54.6	5	45.5	11
Prefer not to say	5	45.5	8	72.7	11
Race					
White	269	63.7	241	57.1	422
Black or African American	6	66.7	5	55.6	9
Hispanic or Latinx	13	50.0	8	30.8	26
Two or more races	17	48.6	24	70.6	35
Asian	16	69.6	16	69.6	23
American Indian or Alaska Native	3	50.0	5	83.3	6
Prefer not to say	4	40.0	5	50.0	10
Other	4	66.7	3	50.0	6

Note: N = 536.

Motivations for Disclosure

The most frequently endorsed motivation for disclosure was direct help-seeking: 71.4% of IRL disclosers indicated they had told someone about their NSSI because “I wanted to get help or support.” Asked why they disclosed, 52.7% (*n* = 175) of IRL disclosers indicated “Someone asked, and I didn't want to lie” as a motivation for disclosure. Thirty-six percent of disclosers endorsed the statement, “I wanted to get advice about coping with my emotions.” IRL disclosers endorsed the statement, “I wanted to know whether other people self-injure” at a rate of 22.3% (*n* = 74). The statement, “I wanted to help or support the person I told” was endorsed by 17.5% (*n* = 58) of IRL disclosers. Ten percent indicated agreement with the statement “I wanted to upset or get a reaction from someone.” Seven percent (*n* = 24) of IRL disclosers endorsed disclosing in order to “get advice about how to stop self-injuring.” Detailed results for motivations for self-disclosure are shown in Table 4.4.

Table 4.4

Table 4.4

Motivations for Disclosure of NSSI

	IRL Disclosers (n = 332)		OL Disclosers (n = 307)	
Reasons for self-disclosure endorsed	*n*	%	*n*	%
I wanted to get help or support.	237	71.4	182	59.3
Someone asked, and I didn't want to lie.	175	52.7	94	30.6
I wanted to help or support the person I told.	58	17.5	110	35.8
I wanted to upset or get a reaction from someone.	34	10.2	25	8.1
I wanted to know whether other people self-injure.	74	22.3	104	33.9
I wanted to get advice about how to stop self-injuring.	24	7.2	88	28.7
I wanted to get advice about coping with my emotions.	120	36.2	127	41.4
Other	65	19.6	63	20.5

Among IRL Disclosers, 19.6% (*n* = 65) indicated that they self-disclosed for reasons other than the options offered by the survey, and 38.6% (*n* = 128) of IRL disclosers provided written responses when asked about their motivations for self-disclosing. Answers included:

- Felt guilty.
- Confusion about what I was feeling.
- I didn't want them to be shocked when they saw the cuts.
- I wanted someone to know how much pain I was in.
- I couldn't keep it to myself anymore.
- I was drunk and it slipped out.

Additionally, nine IRL disclosers stated that they disclosed their NSSI because they required medical attention or help bandaging a wound.

Incidence of NSSI

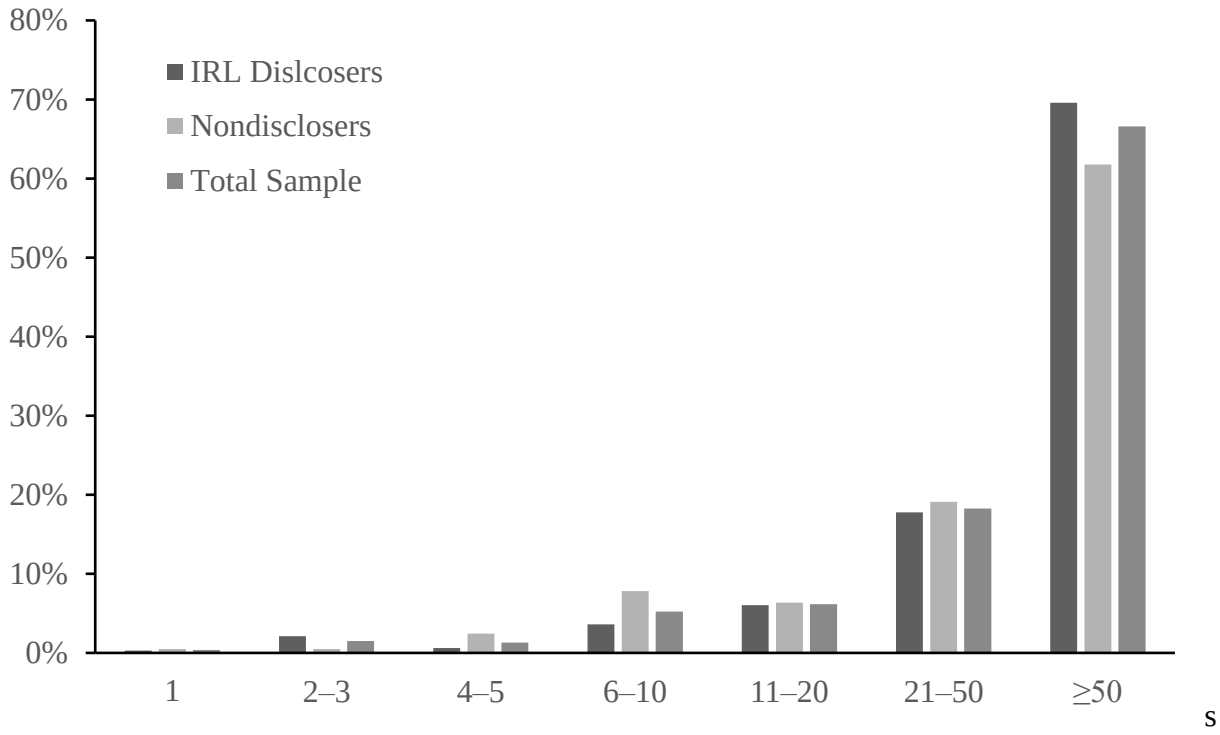
Two items on the *BNSSI-AT* ask respondents to estimate the number of times they self-injured. The first item asks respondents to select from a series of ranges. Respondents are then asked to enter the number of times they estimate they have self-injured. In the current study, for the latter item, many IRL disclosers gave narrative answers that were not quantitatively interpretable (e.g., "Somewhere in the thousands"). Therefore, it is not possible to calculate or compare the mean incidence of NSSI for either group.

Eighty-seven percent of IRL disclosers (*n* = 290) and 80.9% of IRL nondisclosers (*n* = 165) had self-injured at least 21 times. A chi-square test of independence was performed to examine the relationship between high incidence (21 or more instances) of NSSI and the decision to disclose NSSI to someone known IRL. The relationship between these variables was not

statistically significant, $\chi^2(2, N = 536) = 4.120$, $p = .042$. IRL disclosers were no more likely to endorse 21 or more instances than IRL nondisclosers. The modal response for both the disclosure and nondisclosure groups was "More than 50 times." The relationship between endorsing more than 50 instances of NSSI and the decision to disclose NSSI to someone known IRL was analyzed using a chi-squared test for independence. The relationship between these variables was not statistically significant, $\chi^2(2, N = 536) = 3.468$, $p = .062$. Individuals in the IRL nondisclosure group were as likely to endorse more than 50 instances of NSSI as those in the IRL disclosure group. Sixty-seven percent of participants in the full sample endorsed greater than 50 instances of NSSI. For details results on incidence of NSSI by group, see Figure 4.1 and Table 4.5.

Figure 4.1

Reported Lifetime Incidence of NSSI



s

Table 4.5

Approximate Number of Incidents of Nonsuicidal Self-Injury

	IRL Disclosers (*n* = 332)		IRL Nondisclosers (*n* = 204)		Full Sample (*N* = 536)	
	n	%	*n*	%	*n*	%
1 time	1	0.3	1	0.5	2	0.4
2–3 times	7	2.1	1	0.5	8	1.5
4–5 times	2	0.6	5	2.5	7	1.3
6–10 times	12	3.6	16	7.8	28	2.2
11–20 times	20	6.0	13	6.4	33	6.2
21–50 times	59	17.8	39	19.1	98	18.3
More than 50 times	231	69.6	126	61.8	357	66.6
Blank	0	0.0	2	1.0%	2	0.4

Recipients of Disclosure

Participants in the current study who endorsed IRL disclosure were subsequently offered a list of types or categories of people they might have told about their NSSI. On average, IRL disclosers self-disclosed to two relational categories of individuals (e.g. “a friend,” “a partner or significant other”). Sixty-one percent of IRL disclosers disclosed their NSSI to individuals in two or more relational categories. Fewer than a third (31.9%) disclosed to three or more categories of individuals.

Friends were the most likely recipients of real-life disclosure; 75.6% of the IRL disclosure group endorsed having told friends about their NSSI. Among IRL disclosers, 47.6% revealed their NSSI to a counselor or therapist. Slightly more than a third (33.7%) indicated they had self-disclosed to a romantic partner or significant other. More than a quarter (27.4%) disclosed to a parent, and 15.1% revealed their NSSI to a nonparent family member. Eight percent of IRL disclosers indicated they had discussed their NSSI with a category of individuals other than those listed above. The survey did not have an open text box to enter specific recipients for these disclosures. For a complete summary of these data, see Table 4.6

Table 4.6

Categories of Individuals IRL Disclosers Told About Their NSSI

Recipients of disclosure	*n*	%
A parent	91	27.41
A family member other than a parent	50	15.06
A partner or significant other	112	33.74
A counselor or therapist	158	47.59
A friend	251	75.60
Other	25	7.53

Note: For disclosers $n = 332$.

Online Versus Real-Life Disclosure

Overall, 82.6% of the sample had disclosed NSSI in some form, either in-person or online. Fifty-seven percent ($n = 307$) of participants disclosed their NSSI to someone they knew only through the internet, compared to 61.9% ($n = 332$) who endorsed disclosing NSSI to someone known in real life. More than half of individuals in the IRL nondisclosure group (54.4%, $n = 111$) had disclosed their NSSI online. Fifty-nine percent of individuals who disclosed to their NSSI to someone known in real life had *also* disclosed their NSSI online ($n = 186$).

The endorsed motivations for online disclosure spanned a range of response but did not match exactly the motivations for real life disclosure. Fifty-nine percent of those who disclosed online endorsed help-seeking as a motivation, compared to 71.4% ($n = 237$) of IRL disclosers. In contrast, 41.4% ($n = 127$) of online disclosers—versus 36.2% ($n = 120$) of IRL disclosers—indicated that they disclosed NSSI in order to elicit advice about coping with their emotions. Four times as many online disclosers (28.7%, $n = 88$) as IRL disclosers (7.2.3%;

n = 24) endorsed disclosing to find out whether others self-injure. A large proportion of participants (35.8%, *n* = 110) endorsed disclosing their NSSI online in order to help someone else, while about half as many IRL disclosers (17.5%, *n* = 58) told someone about their NSSI for the same reason. Asked whether they disclosed online in order to get advice about how to stop self-injuring, 28.7% (*n* = 88) agreed, compared to 22.3% (*n* = 74) of IRL disclosers. Eight percent of online disclosers (*n* = 25) and 10.2% of IRL disclosers (*n* = 34) agreed that they disclosed NSSI in order to upset someone else. For a complete summary of these data, see Tables 4.4 and 4.7.

Table 4.7

Endorsed Motivations for Disclosing NSSI Online

	Online Disclosers (n = 307)		OL Disclosers who also disclosed IRL (n = 196)		OL Disclosers who never disclosed IRL (n = 111)	
Reasons for self-disclosure endorsed	*n*	%	*n*	%	*n*	%
I wanted to get help or support.	182	59.3	118	60.2	64	57.7
Someone asked, and I didn't want to lie.	94	30.6	52	25.5	42	37.8
I wanted to help or support the person I told.	110	35.8	77	39.1	33	29.7
I wanted to upset or get a reaction from someone.	25	8.1	16	8.2	9	8.1
I wanted to get advice about how to stop self-injuring.	88	28.7	56	28.6	32	28.8
I wanted to know whether other people self-injure.	104	33.9	76	38.8	28	25.3
I wanted to get advice about coping with my emotions.	127	41.4	79	40.3	48	43.2
Other	63	20.5	29	14.8	34	30.6

Note: N = 536.

CHAPTER V: DISCUSSION

This study sought to explore a range of factors and motivations that could contribute to self-injurers' decisions to disclose NSSI. The study addressed a variety of questions. IRL nondisclosers and IRL disclosers were, as groups, demographically similar with regard to age, race, and gender. IRL disclosers were most likely to endorse help-seeking motivations for telling a third party about their self-injury. IRL disclosers and IRL nondisclosers endorsed high incidence of NSSI at the same rates. IRL disclosers were most likely to have revealed their NSSI to a parent or therapist.

Much of the previous research has found that most self-injurers do not disclose their NSSI (Armiento et al., 2014; Evans et al., 2005; Whitlock, 2006). Contrary to expectations, a large majority of the current sample (61.9%) had disclosed NSSI to someone they knew in person. In a sample of university students, Armiento et al. (2014) found that 57% of self-injurers never disclosed NSSI. By contrast, rates of online disclosure in the current study were an inverse of those findings (57.3%). My methodology—recruitment via internet users—may explain this difference. It is possible that my sample of internet users was more open to disclosing their NSSI compared to other populations. Since most participants were recruited through social media platforms and specifically from forums dedicated to mental health and NSSI, the sample may more closely resemble clinical samples with regard to self-disclosure. Moreover, the fact that nearly half of the sample disclosed NSSI to a therapist or counselor suggests that a significant portion of the sample was concurrently engaged with mental health systems. It is also possible that internet users willing to complete a survey on NSSI and disclosure constitute a self-selecting group who are more likely to have self-disclosed self-injury. Finally, because the sample skewed toward younger adults, it is possible respondents were more likely to disclose because of

generational differences and a relatively diminished sense of stigma about NSSI and, more generally, mental health.

Demographics

There were no significant differences in the gathered demographic data between groups of IRL disclosers and nondisclosers. The lack of demographic differences may relate to relative homogeneity of the sample, since there were fewer cisgender males and nonwhite-identifying individuals relative to the population. Moreover, the overall sample skewed young: though no one under 18 years old could participate, the median age of participants was 20.

Though participants represented a range of diverse genders, a majority identified as female. This is consistent with literature showing higher rates of NSSI among women (de Vries & Olff, 2009; Gollust et al., 2008; Whitlock et al., 2011). However, the numerical gap between male and female participants was much larger than current research would suggest. Perhaps more surprising, a greater portion of the sample identified as nonbinary than as male. The large representation of nonbinary, as well as transgender and gender-queer, individuals in the current study is notable. However, comparisons between the current study and past research are complicated by the fact that previous studies have surveyed gender using only binary male-female categorization. The current body of literature does not provide data sufficient to explain why so many nonbinary, trans, and gender-queer individuals participated in the current study. However, as Muehlenkamp et al. (2015) found, most individuals who identify as a members of a sexual minority self-injure at some point over the course of their lifetimes.

By contrast, relatively few cisgender males participated in the current study. The difference could be explained by lower rates of self-injury among men. Research by Andover et al. (2010), which found that males are less likely to self-disclose NSSI, opens another possibility:

males may also be less likely to engage with a study about self-disclosure of self-injury. Finally, as the title of Strong's (1999) influential book, *A Bright Red Scream*, demonstrates, the nonacademic literature on self-injury has been largely oriented toward females who engage in self-cutting. Despite evolution in the understanding and definition of self-injury, males may still be less likely to recognize their behavior as NSSI, much less seek support online for self-injury or participate in a study recruiting from online forums.

Motivations for Disclosure

A minority of IRL disclosers endorsed a provocative motivation for self-disclosure. Past research shows NSSI is driven by intrapersonal, rather than provocative, interpersonal, motivations (Muehlenkamp et al., 2013). The current data accords with this past research and suggests that individuals who disclose self-injury are most often seeking help from those to whom they disclose. Indeed, help-seeking was endorsed by a large majority of IRL disclosures as the most popular motivation for self-disclosure, followed by not wanting to lie to someone asking about NSSI and seeking advice for coping with emotions.

This finding highlights the need for compassionate responses to self-injurers disclosing NSSI. By responding with curiosity and a desire to help, recipients of disclosure may be able to mitigate some of the shame that self-injurers experience about NSSI, as well as the anxiety self-injurers likely experience when disclosing self-injury. Conversely, recipients who respond to disclosure in ways that heighten self-injurers' shame are likely to produce counterproductive outcomes. First, they may cut off the opportunity to learn more about the problem and what motivates the self-injurers' behavior. Second, recipients are likely to miss the opportunity to provide either direct help or helpful resources. Third, they are likely to discourage future

disclosure of self-injury. Finally, they may increase self-injurers' sense of isolation, which may motivate further self-injury (Burke et al., 2019; Long, 2018).

As discussed, literature about NSSI has often focused on the experiences and reactions of those who discover or are told about another's self-injury (Ammerman & McCloskey, 2021; Berger et al., 2014; Burke et al., 2019; Park & Ammerman, 2020). The current study accords with other recent research showing that, for self-injurers, NSSI is a largely private activity disclosed when one needs help. This recent research highlights the need to change the discourse about NSSI toward the immediate phenomenological experience of self-injury to self-injurers and away from the ex post facto reactions of others to self-injury. That is, the interpersonal consequences of NSSI may be less significant for understanding and treating self-injury than the in-the-moment experiences of self-injurers at the point of self-injury. Moreover, if disclosure of NSSI is primarily motivated by help-seeking or help-giving, then it should be seen as a vulnerable attempt to connect with others, rather than a ploy for negative attention.

Incidence of NSSI

I initially sought to collect continuous estimates of participants' incidence of NSSI. The survey did not capture this data. However, given thresholds of 21or 51 instances of NSSI, IRL nondisclosers endorsed high incidence at similar rates. One reason I considered the question of whether IRL disclosers and nondisclosers would self-injure at similar rates was the possibility frequent self-injurers might have a higher need for help-seeking. Alternately, I wondered whether frequent self-injury might be a proxy for higher psychopathology and, thus, related to provocative motivations for self-injuring that would necessitate disclosure. In past research, for instance, individuals in psychiatric inpatient settings reported self-injuring higher rates compared to noninpatient samples (Andover & Gibb, 2010). Hospitalized individuals were also more likely

to endorse negative interpersonal motivations for NSSI that require disclosure (e.g., self-injuring to upset another person; Andover & Gibb, 2010). Based on the collected date, however, the assumptions that high frequency self-injurers would be more likely to disclose NSSI for help-seeking or provocative reasons appear false.

It seems important to note that a large majority of participants in the current study, as a whole, reported high incidence of NSSI. Sixty-six percent of respondents reported having self-injured more than 50 times with only an 7.8% difference between the IRL disclosure and nondisclosure groups. While individuals willing to complete a voluntary survey about NSSI may constitute a self-selecting group, the high incidence of NSSI is surprising. The fact that so many respondents endorsed high rates of NSSI illustrates the magnitude of the problem among this group of social media users engaged with self-injury and mental wellness support groups.

Recipient of Disclosure

Friend and romantic partners were among the most likely recipients of IRL self-disclosure. Friends were, by far, the most likely recipients of disclosure, with 75.6% of IRL disclosers indicating they had disclosed NSSI to a friend.

Surprisingly, therapists and counselors were the second most likely category of recipients of SD-IRL. This finding is notable for two reasons. First, it suggests self-injurers in my online sample are much more likely to disclose self-injury to therapist and counselors than anticipated. A greater proportion of IRL disclosers told a mental health professional about their NSSI than researchers found in previous studies of university students (Armiento et al., 2014; Muehlenkamp et al., 2013). Moreover, in past research, self-injurers engaged in psychotherapy were much less likely to disclose their self-injury to therapist. While over half of individuals who

have self-injured more than once have attended therapy at some point, only 1 in 20 self-disclose to a therapist (Whitlock, 2006).

Second, the rate at which participants in the current study disclosed to therapists indicates almost half of self-injurers have been engaged at some level with the mental health system. Again, this finding might be attributable, at least in part, to my recruitment strategy. Given that many—if not most—participants found the survey from postings on social media forums dedicated to mental health, individuals in the current sample may have been especially motivated to find help for NSSI both OL and IRL. Finally, this finding may also be understood in the context of the increased utilization of mental health services among the current cohort of young adults (Abram, 2022).

Romantic partners were less likely to be recipients of disclosure than anticipated. Armiento et al. (2014) note in their study that emerging adulthood is a key developmental time for learning how to trust in intimate relationships, and it appears that my generally younger sample did not typically rely on partners for support with NSSI. Notably, I gathered data during a period when many social distancing measures resulting from the COVID-19 were still in place; my sample skewing younger thus reflected the experiences of college-aged emerging adults recovering from unprecedented isolation. Early in the pandemic, adolescents reported physically distancing from partners (Yarger et al., 2021). While some predicted a sharp upward turn in sexual and romantic activity among youths following social distancing restrictions (Lindberg et al., 2020), only one in five university students surveyed a year before the current study reported forming new relationships during the pandemic (Chopik et al., 2023).

The pandemic may have inhibited young people's ability to initiate romantic relationships or develop the level of intimacy required for self-injurers to feel safe disclosing

NSSI to partners. That is, it is possible that many in the younger cohort sampled in the current study may have lacked romantic partners to whom they could disclose, and those in romantic relationships may have had insufficient time to build the trust they needed to discuss NSSI IRL. Moreover, emerging adults look to the internet as a primary source of information about mental health (Rickwood et al., 2015). It is, therefore, also likely that online support has supplemented the loss of IRL intimacy these past few years for emerging adults suffering from all types of mental health challenges, including NSSI.

Online Versus Real-Life Disclosure

Overall, more participants self-disclosed to someone they knew in person than to someone they knew online. Previous research suggested online forums provided self-injurers with support they would not be able to obtain in real life (Whitlock et al., 2006). Other studies have indicated that the internet could provide a level of anonymity that could be helpful to self-injurers wary of stigmatizing reactions to NSSI (Lewis & Seko, 2016; Whitlock et al., 2006).

Despite the benefit of anonymity, self-injurers may anticipate more hostility discussing NSSI online than with trusted in-person individuals. For both IRL and OL disclosers, help-seeking was the most frequently endorsed motivation for telling someone about NSSI. However, OL disclosers were less likely to endorse help-seeking as a motivation: 12.1% fewer OL disclosers indicated they disclosed NSSI to elicit help from someone else. This wariness toward discussing sensitive mental health issues online may be well-founded. The need for caution may also vary from platform to platform. As discussed, most participants were recruited from Reddit. As a whole, Reddit is known for both its sense of community and its tolerance for hostile responses to posts on the platform (Brown et al., 2018). Despite being a popular resource, Reddit is not a venue that rewards vulnerability. Though many users may look to the site for

mental health support, they may do so covertly to avoid stigma or negative reactions from others (Brown et al., 2018; Rickwood et al., 2015). Having anonymity, after all, hardly takes away the sense that one is being personally targeted when being trolled by others.

By contrast, in-person disclosure has several potential benefits, mostly notably the possibility for carefully selecting someone who might respond kindly. Choosing the recipient of disclosure may give self-injurers a sense of control by allowing them to test how others respond to vulnerable information shared by self-injurers. They could enter the conversation more cautiously than on a mental health forum, determining safety by ascertaining someone's response and receptivity to other personal but less sensitive information before telling them about NSSI.

Similarly, online culture may shape the type of advice or support one seeks when they do disclose NSSI. Over a third of OL disclosers indicated they sought advice to stop self-injuring, whereas only 7.1% of IRL disclosers endorsed seeking similar advice. Both clinicians and researchers have expressed concern that, online, self-injurers may seek encouragement to continue self-injuring (Whitlock et al., 2006, 2007). The preponderance of participants who endorse help-seeking would seem to argue against self-injurers going online to seek encouragement for NSSI. Still, though there is nothing in the data suggesting that self-injurers seek community to perpetuate NSSI, the current study did not directly ask this question.

Limitations of the Current Study

This study had a robust sample size and liberal criteria for participation. Yet, the chosen methodology revealed several limitations worth noting. First, recruitment was limited to potential participants' willingness and ability to find and complete an online survey about NSSI. It was also limited by recruitment via social media forums dedicated to NSSI, mental health, or both. The results may not be generalizable to individuals less willing to interact with online

forums concerning NSSI and mental health or individuals less willing to engage, more generally, with mental health resources. Additionally, the survey may not have captured individuals without reliable internet access or older generations less likely to use these platforms.

While the study sought to recruit broadly among internet users, a large portion of participants appear to have discovered the survey through Reddit. I advertised the study on Reddit after it had previously been promoted through other social media platforms, and while responses to earlier advertisements had tapered off, about five out of six participants responded after the information about the survey was placed on Reddit. Thus, the survey was more representative of Reddit users interested in NSSI than other internet users or members of other social media platforms. Nevertheless, the sample was younger, whiter, and more female than users of Reddit at large (Pew Research Center, 2021). While the proportions vary, the data are skewed compared to users of Facebook, Twitter, or Instagram (Pew Research Center, 2021). Given the mix of social media platforms sampled and the demographic skews of participants, it is difficult to generalize the data to Reddit users, a broader population of social media users, or, more generally, self-injurers as a group.

The study is also limited by demographic factors. While the gender diversity represented in the study is a strength, cisgender males responded to the survey at lower rates than individuals identifying as cisgender female or nonbinary. The results of this study may not be generalizable to the broader population of self-injurers. While my study gathered some data about self-harm among gender minorities, the availability of multiple gender categories inhibits my ability to compare data to prior studies using only binary gender demographics.

The survey failed to capture continuous estimates of participants' instances of self-injury. Continuous data may have detected a difference in the mean instances of self-injury between

groups. However, I was not able compare these data in this study due to the limitations of the survey.

Finally, the study is limited by the demographics of participants, both in terms of the makeup of the sample and the demographic information sought by the survey. People of color were underrepresented in the survey, in particular Black or African American individuals and persons from Hispanic or Latinx backgrounds. The study also did not collect data about socio-economic status, education, ability, trauma exposure, or other, comorbid mental health problems.

Areas for Further Research

Based on the current results and the existing literature, there are several questions about NSSI that additional research might well address. First, the current study focused on self-injurers' motivations for disclosure. Researchers and clinicians would also benefit from understanding the converse question: why do self-injurers choose not to disclose NSSI? Existing literature suggests that stigma plays a large role in inhibiting disclosure (Burke et al., 2019; Lloyd et al., 2018; Staniland et al., 2021). Still, there may be other factors that contribute to self-injurers decisions to hide NSSI, especially as stigma becomes less of an obstacle and concerns about social isolation among younger generations grow.

Second, nearly half of disclosers had told a therapist or counselor about their self-injury. In order to disclose to a therapist, one must have a therapist. Therefore, this finding suggests that at least half of participants in the current study are or have been engaged at some level with the mental health system. It would be useful to ascertain what percentage of self-injurers engaged with the mental health system choose not to reveal their NSSI to a clinician. On a related note,

clinicians would benefit from better understanding the factors that may encourage self-injurers to maintain secrecy, even in the consulting room.

Third, while the current study adds to the understanding of disclosure of self-injury, additional research could illuminate the contextual factors that contribute to self-injurers' decisions to disclose NSSI. Prior research has suggested self-injurers would likely prefer the anonymity of disclosing online to the more personal and vulnerable exposure of in-person disclosure (Burke et al., 2019; Lloyd et al., 2018; Long, 2018; Whitlock et al., 2006). In the current study, however, self-injurers engaged with online forums about NSSI and mental health were more likely to have disclosed IRL than online. Perhaps self-injurers weigh competing interests between help-seeking and limiting their vulnerability to invalidating or hostile responses to disclosure. Further study could deepen clinicians' and researchers' understandings of what motivates disclosers to choose to disclose online or in-person. It could be important to understand whether one's perceptions of social support contribute to decisions to disclose online or in real life. Might one be more likely to disclose online if the individual felt less likely to receive support in real-life—or, alternately, might a perceived lack of social support inhibit all disclose? Future research could also uncover whether one's online or platform-specific engagement plays any role in disclosure. For example, are individuals more likely to disclose on video- or text-based platforms, and does the culture of individual platforms, such as Reddit or TikTok, affect one's decision to disclose? Finally, future research could shed light on whether and to what degree self-injurers perceive disclosure online or IRL to be helpful.

Fourth, a large percentage of participants in the current study identified as being on the transgender spectrum. Existing research shows gender minority individuals are more likely to self-injure compared to cisgender persons (Muehlenkamp et al., 2015; Swannell et al., 2014). A

number of factors could contribute to these findings, including: gender dysphoria, social invalidation of one's gender, difficulty articulating one's experience of gender, or socio-political vulnerabilities related to one's minority identification. Further research could determine the degree to which these or other factors are drivers of NSSI.

Finally, the current study collected circumscribed data about race, gender, and age and found no relation between these factors and self-disclosure. More comprehensive comparisons of factors, such as education, socio-economic status, sexuality, or generational identification, could help uncover why, whether, and how demographic differences influence disclosure.

In the current study, the question is more salient relative to gender. Far fewer men participated in the current study compared to current estimates of men who self-injure (Armiento et al., 2014). This is surprising because the study recruited most participants from a platform (i.e., Reddit) where 67% of users are male (Pew Research Center, 2021). Compared to women, men are less likely to disclose NSSI (Armiento et al., 2014). Moreover, single item assessments of NSSI appeared to underestimate rates of self-injury among males, whereas multi-item assessments capture rates closer to those for women (Swannell et al., 2014). This suggests that men are less likely to identify their behavior as NSSI or as a problem. Still, more targeted research could determine what unique problems men and boys face in revealing or even recognizing NSSI.

Clinical Implications

While current research supports the conceptualization of NSSI as a coping strategy, much of the historical literature on self-injury has characterized it as an outward-facing act of provocation (e.g., Nock, 2010). In line with recent research, an overwhelming majority of participants (19 out of 20) indicated they self-injured to relieve uncomfortable feelings or stress.

Most participants also endorsed other intrapersonal and self-regulatory motivations for NSSI (see Table 5.8). By contrast, only 6.5% indicated that one reason for self-injuring was a desire to upset someone else. The only motivation endorsed at lower rates was related to social contagion— self-injuring "because my friends hurt themselves." While these numbers were not part of the primary data this study sought to analyze, they help contextualize both NSSI and its disclosure. Self-injurers, as a group, have often been mischaracterized by the very small portion who self-harm to provoke others. Participants' responses in the disclosure questionnaire further support the idea that most self-injure to cope rather than provoke. Though it is true that one in ten IRL disclosers endorsed telling someone else about their self-injury in order to upset the individual, the vast majority of participants who endorsed SD-IRL indicated they told a third party about their NSSI in order to elicit help.

Table 5.8

Endorsed Motivations for Nonsuicidal Self-Injury

I hurt myself to…	IRL Disclosers (*n* =332)		IRL Nondisclosers (*n* = 204)		Full Sample (*N* = 536)	
	n	%	*n*	%	*n*	%
…to feel something	269	81.0	154*	75.9	423*	79.1
…because my friends hurt themselves	17**	5.2	10*	4.9	27	5.1
…as a self-punishment or to atone for sins	252	75.9	144	70.6	396	73.9
…to get a rush or surge of energy	233*	70.4	132	64.7	365*	68.2
…to deal with frustration	311	93.7	183	89.7	494	92.2
…to cope with uncomfortable feelings (e.g., depression or anxiety)	328*	99.1	193	94.6	521*	97.4
…in hopes that someone would notice that something is wrong or that so others will pay attention to me	142	42.8	69	33.8	211	39.4
…so I do not hurt myself in other ways	158*	47.7	94*	46.3	252**	47.1
…because it feels good	249	75.0	144	70.6	392	73.3
…to deal with anger	234	70.5	141*	69.5	375*	70.1
…to get control over myself or my life	240**	72.7	158	77.5	398**	74.4
…to shock or hurt someone	21	6.3	14	6.9	35	6.5
…to avoid committing suicide	125	52.7	96	47.1	271	50.6
…because I get the urge and cannot stop it	282	84.9	145	71.1	427	79.7
…to relieve stress or pressure	319	96.1	190*	93.6	509	95.1
…to change my emotional pain into something physical	290*	87.6	175*	86.2	465**	87.1
…because of my self-hatred	273	82.2	162	79.4	435	81.2
…because I like the way it looks	193	58.1	104*	51.2	297*	55.5
…because I could not tell anyone what I was feeling	240	72.3	164*	80.8	404*	75.5
…because I could not describe what I was feeling	255*	77.0	152**	76.1	408***	76.5

* Data is missing for 1 participant.
** Data is missing for 2 participants.
*** Data is missing for 3 participants.

These findings have several implications in a clinical setting. First, clinicians should not assume that that clients self-injure or disclose NSSI to elicit a response from others. Therapists should be mindful of the social stigma placed on self-injury and should show sensitivity for the

difficulty self-injurers experience in disclosing NSSI. That is, clinicians should be aware clients may be hesitant to disclose NSSI during risk screenings. Some clients may not recognize their behavior as NSSI, and asking normalizing questions about various methods of self-injury is likely to elicit more accurate screenings than asking in a broad manner whether clients have ever purposefully injured themselves.

Male clients may be especially difficult to screen. Based on the current study and existing literature, male self-injurers appear less likely to disclose NSSI, may hold more self-stigmatizing views about their behavior, and are less likely to seek help for self-injury (Armiento et al., 2014; Swannell et al., 2014). Therefore, clinicians should attend to these factors when assessing the NSSI of male clients. Past constructs, in particular self-mutilation, have framed self-injury as a problem typified by cutting, and in doing so, these framings have tended to over-pathologize women while under-estimating the problem among males. Though many men and boys who self-injure cut themselves, males are more likely to hit themselves or use other modes of self-injury that may seem less representative (Armiento et al., 2014; Whitlock et al., 2011). It is important, then, that clinicians ask about various ways of self-injuring when screening males, including not just cutting and scratching, but also wall-punching, self-hitting, and fighting or risk-taking with the intention of getting hurt.

Clinicians should also be cognizant of their own countertransference. Self-injurers are likely to be sensitive to negative reactions they may anticipate or have actually gotten from others—including previous therapists. Still, it is difficult to bear witness to clients causing themselves harm. Clinicians may find it necessary to attend to their own self-care or seek consultation or supervision regarding their reactions to NSSI. While would be impossible to suggest an appropriate response for disclosure in every situation, broad guidance might suggest

that clinicians normalize NSSI as a common coping mechanism while expressing open concern for the client's future well-being.

Moreover, clinicians are quickly developing treatments specific to NSSI. For example, Selekman (2009) has developed strengths-based NSSI treatment for various modalities. He has adapted his collaborative solution-focused model to work with not just individuals but with families, couples, and groups (Selekman, 2009). In another evidence-based strategy, Walsh (2008) has created a skills-based cognitive-behavioral therapy for individuals and families.

There are at least two manualized treatments with demonstrated efficacy in randomized controlled trials (RCTs), the Cutting Down Program (CDP) and Treatment for Self-Injurious Behaviors (T-SIB). CDP has a particularly strong evidence base that includes a pilot study and three RCTs (Calvo et al., 2022; Edinger et al., 2020; Fischer et al., 2013; Kaess et al., 2020; Taylor et al., 2011). T-SIB is supported by a pilot study and two small RCTs, in which it was found to be effective at reducing incidence of NSSI both over the course of treatment and at a three-month follow-up (Andover et al., 2015, 2017, 2020; Calvo et al., 2022). Other treatments, including Emotional Regulation Individual Therapy for Adolescents and Intensive Contextual Treatment, appear to be effective in small trials (Bjureberg et al., 2017; Calvo et al., 2022; Wijana et al., 2018).

Finally, the current study, like previous literature, supports the idea that most self-injurers view NSSI primarily as a coping strategy. Among both online and IRL disclosers in the current study, help-seeking was the most popular motivation for disclosure. Among IRL disclosers, however, only one in 14 disclosed their NSSI in order to stop self-injuring. Clinicians will do well to teach clients more adaptive coping strategies while honoring NSSI as the modality they have found regulatory in important ways. NSSI should be understood in the context of the

client's experience, which may include a long history of invalidation, trauma, and broader mental health struggles. Moreover, given the relationship between NSSI and experiences of isolation, clients may lack resources necessarily to access more adaptive strategies without support and guidance. Indeed, in the full context of one's lived experience, the client may feel self-injury is the most effective, if ultimately costly, coping tool available to them. Safer coping strategies may have been unavailable, less effective at alleviating their distress, or may have had less immediate results. With these contextual factors in mind, some clients may find cessation untenable and may benefit from a harm reduction model that seeks to decrease the frequency and dangerousness of self-injury, rather than ceasing altogether while, through treatment, building a richer and more socially-connected set of alternative strategies.

Conclusion

NSSI is complex and may be motivated by multiple factors. The current study sought shed light on self-injurers' rates and motivations for disclosure. Findings support past research suggesting NSSI is a nonprovocative act motivated primarily by a desire to regulate one's own emotions. Most participants in the current study endorsed help-seeking as a motivation for self-disclosing NSSI both IRL and online. IRL disclosers appear to value trust and confidentiality when choosing to whom they reveal their NSSI, and more participants disclosed self-injury IRL than online. Participants were most likely to disclose NSSI to friends or therapists. Given these findings, clinicians should be mindful of social stigma against NSSI, as well as negative responses self-injurers may have received when disclosing NSSI in the past.

One of the overarching themes I have found in the literature of NSSI is self-injury's relationship to isolation. Most who self-injure do so in solitude, and NSSI often serves to further alienate self-injurers from those around them. Self-injury is borne of disconnection and too often

held in lonesome, self-protective secrecy. Disclosure, on the other hand, presents an opportunity for reconnection that underscores the importance of responding to self-injurers with compassion and concern. I find it reassuring that research and social perceptions of self-injury have begun to shift away from lurid terminology such as self-mutilation and toward an interest in the phenomenology of NSSI; away from the marginalizing reactions of others and toward a deeper understanding of the lived experience of self-injurers.

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APPENDIX A: FLYER ADVERTISING THE CURRENT STUDY

NONSUICIDAL SELF-INJURY SURVEY

WHAT IS THE STUDY?

There is growing awareness that many individuals self-injure without suicidal intent. The Nonsuicidal Self-Injury Survey aims to better understand nonsuicidal self-injury (NSSI) and why individuals choose to tell or not tell others that they self-injure.

WHY PARTICIPATE?

- You could provide important information that helps others understand self-injury.
- You may help mental health providers better assist individuals who self-injure.
- You may help others understand why they or someone they care about self-injures.
- Participants are eligible to enter a drawing for a $100 Amazon gift card or one of four (4) $25 Amazon gift cards.

WHO CAN PARTICIPATE?

Participants must be 18 years or older.

For more information or to participate, please visit
www.facebook.com/NSSIstudy
For questions, please email
[redacted]

APPENDIX B: INFORMED CONSENT

NSSI Survey

This is a survey about self-injury.

You will not benefit directly by participating in this survey. By participating, you could help others learn more about self-injury. By responding to the survey, you may also contribute to future research and mental health treatment.

By completing the survey, you will be eligible to enter a drawing for one of five Amazon gift cards. One participant will receive a $100 Amazon gift card. Four participants will receive $25 Amazon gift cards. Gift card recipients will be chosen at random. At the end of the survey, you may enter the drawing by submitting your email address. No information will link your answers to your email address.

There are few, if any, risks from participating. The survey is anonymous. The researcher will not know your identity. Reports may be published based on this survey. These reports will contain no information that could personally identify you.

This survey is part of my dissertation research at Antioch University. The study will fulfill some requirements for my PsyD in clinical psychology. The survey data may be used for future research without additional consent.

Your participation is voluntary. Some of the questions may be difficult to think about. The survey should take 5–15 minutes. You may discontinue the survey at any time by closing your web browser. At the bottom of each page of the survey is a list of mental health resources.

This project has been approved by the Institutional Review Board at Antioch University. If you have any questions about your rights as a research participant, please contact IRB Chair Kevin Lyness at [redacted] or Provost Shawn Fitzgerald at [redacted].

This consent form was approved by the IRB on 02/09/2022.

I am 18 years old or older. By selecting the checkbox below, I am indicating that I have read and understood this consent form. By selecting the checkbox below, I am also agreeing to participate in this research study.

☐ Yes, I am at least 18 years old. I fully understand the information above. I agree to have my answers recorded for research.

You may print a copy of this page for your records. Thank you for your participation!

APPENDIX C: SURVEY: DEMOGRAPHIC QUESTIONNAIRE

Age

_____

Gender Identity

- Male
- Female
- Trans male
- Trans female
- Nonbinary or genderqueer
- Other
- Prefer not to say

Race

- Prefer not to say
- White
- Asian
- Black or African American
- American Indian or Alaska Native
- Two or more races
- Hispanic or Latinx
- Other: _____

APPENDIX D: SURVEY: BRIEF NONSUICIDAL SELF-INJURY ASSESSMENT TOOL

With permission of author Janis L. Whitlock, the survey includes the *Brief Nonsuicidal Self-Injury Assessment Tool* (BNSSI-AT), a validated assessment of nonsuicidal self-injury (Whitlock, Exner-Cortens, & Purington, 2014). Three sample items are listed below.

Have you ever done any of the following ***with the purpose of intentionally hurting yourself?***

- Severely scratched or pinched with fingernails or other objects to the point that bleeding occurs or marks remain on the skin
- Cut wrists, arms, legs, torso or other areas of the body
- Dripped acid onto skin
- Carved words or symbols into the skin
- Ingested a caustic substance(s) or sharp object(s) (Drano, other cleaning substances, pins, etc.)
- Bitten yourself to the point that bleeding occurs or marks remain on the skin
- Tried to break your own bone(s)
- Broke your own bone(s)
- Ripped or torn skin
- Burned wrists, hands, arms, legs, torso or other areas of the body
- Rubbed glass into skin or stuck sharp objects such as needles, pins, and staples into or underneath the skin (not including tattooing, body piercing, or needles used for medication use)
- Banged or punched *objects* to the point of bruising or bleeding
- Punched or banged *oneself* to the point of bruising or bleeding
- Intentionally prevented wounds from healing
- Engaged in fighting or other aggressive activities with the intention of getting hurt

How true are the following statements about why you hurt yourself? Please select the most accurate response.

I hurt myself…	Strongly Disagree (1)	Somewhat Disagree (2)	Somewhat Agree (3)	Strongly Agree (4)
…to feel something.				
…because my friends hurt themselves.				

APPENDIX E: SURVEY: DISCLOSURE QUESTIONNAIRE

After you self-injured, have you ever intentionally told someone else that you know in-person (not only online)?

- ○ Yes
- ○ No

Whom did you tell? (Check all that apply.)

- ☐ A parent
- ☐ A family member other than a parent
- ☐ A partner or significant other
- ☐ A counselor or therapist
- ☐ A friend
- ☐ Other

Why did you decide to tell someone about your self-injury? (Please choose all that apply.)

- ☐ I wanted to get help or support.
- ☐ Someone asked, and I didn't want to lie.
- ☐ I wanted to help or support the person I told.
- ☐ I wanted to upset or get a reaction from someone.
- ☐ I wanted to know whether other people self-injure.
- ☐ I wanted to get advice about how to stop self-injuring.
- ☐ I wanted to get advice about coping with my emotions.
- ☐ Other

Please list any other reasons you told someone about your self-injury.

_____

Prior to this survey, have you ever told anyone about your self-injury whom you know only online or through social media?

- Yes
- No

Why did you decide to tell someone you know online about your self-injury? (Please choose all that apply.)

- ☐ I wanted to get help or support.
- ☐ Someone asked, and I didn't want to lie.
- ☐ I wanted to help or support the person I told.
- ☐ I wanted to upset or get a reaction from someone.
- ☐ I wanted to get advice about how to stop self-injuring.
- ☐ I wanted to know whether other people self-injure.
- ☐ I wanted to get advice about coping with my emotions.
- ☐ Other

Please list any other reasons you told someone you know online about your self-injury.

_____

APPENDIX F: PERMISSION TO USE THE BRIEF NONSUICIDAL SELF-INJURY ASSESSMENT TOOL

The author sent the following email to Janis L. Whitlock on July 28, 2021:

> Dr. Whitlock,
>
> I'm currently a 5th year PsyD student at Antioch University New England, and I'm working to propose a dissertation on NSSI and disclosure. I was wondering whether it would be possible to use the NSSI-AT or B-NSSI-AT as part of an online survey to conduct this research.
>
> I was also wondering whether it might be possible to see an informed consent form that you have used for your research. If so, that would be incredibly helpful as a guide to use when crafting my own form and presenting it to our IRB.
>
> Thank you so much for your time.
>
> Best,
>
> Matthew B. Tanner

On August 3, 2021, Janis L. Whitlock sent the following reply:

> Hi Matt,
>
> Thank you so much for being in touch and for your interest in our tool. Yes of course you can use either one of those. The informed consent really varied according to study design. I am attaching one I used for an early study with this survey. I hope it helps!
>
> Please do let me know if I can be of further assistance. Good luck with your research!
>
> Janis

The author sent the following email to Janis L. Whitlock on July 5, 2023:

> Hi Dr. Whitlock,
>
> I hope you've had a nice holiday. Last we communicated, I was asking for permission to use the NSSI-AT for a survey for my dissertation. I've now completed the study and successfully defended the paper.

> My chair had asked me to include some sample items from the NSSI-AT in an appendix of my paper. I've attached the excerpted items below. I wanted to check in and make sure it is OK to include a portion of the measure in the paper. I'm happy to change or pare back the sample items as necessary.
>
> Best,
>
> —Matt

On July 10, 2023, Janis L. Whitlock sent the following reply:

> Hi Matt,
>
> Congratulations! I'd love to know what you found, can you pass me a copy of your dissertation or a published paper?
>
> And yes, of course it's fine to include sample items from the NSSI-AT. Thanks for checking in though!
>
> Warmly,
>
> Janis