Talking about Non-Suicidal Self-Injury:
The identification of barriers, correlates, and responses to NSSI disclosure

by
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A Thesis
presented to
The University of Guelph

In partial fulfilment of requirements
for the degree of
Doctor of Philosophy
in
Psychology

Guelph, Ontario, Canada

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ABSTRACT

TALKING ABOUT NON-SUICIDAL SELF-INJURY: THE IDENTIFICATION OF BARRIERS, CORRELATES, AND RESPONSES TO NSSI DISCLOSURE

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Non-suicidal self-injury (NSSI) is a prevalent behaviour among youth and young adults, yet little is known about why many youth choose not to disclose their NSSI. Disclosure of NSSI may have important implications for accessing treatment and eliciting support from family and friends. This dissertation sought to better understand the factors that promote and discourage NSSI disclosure, as well as gather a richer understanding of young adults’ experiences disclosing NSSI. To meet this aim, two studies were conducted. The first entailed a quantitative survey of 179 University of Guelph undergraduate students ($M_{age}$: 19 years, 85% women) with a history of NSSI. Results found that 22% of respondents had not disclosed to anyone. The majority of those who had disclosed first told a peer and rated that experience as being very difficult. Participants with self-reported scarring from NSSI reported more frequent, yet more difficult disclosure experiences, whereas those with higher levels of shame reported more difficult past disclosures and more negative attitudes toward future disclosures. Results highlight the need to further explore the impact of scarring on disclosure, as well as the role for shame-reduction messages, both in programs targeting NSSI and in individual psychotherapy. The second study sought to achieve a richer understanding of the process of disclosing NSSI and entailed a thematic analysis of interviews conducted with 17 participants (16 women and 1 man) using guidelines developed by Braun and Clarke (2006). Themes consisted of: barriers to disclosure (shame and concern about others); the role of scars (initiate disclosure, authenticate distress, enduring representation...
of pain); and responses to disclosure (silence/avoidance, understanding). Results underscored the central role of shame in NSSI disclosures, both as an experience impacting the difficulty and likelihood of disclosure and as a potential consequence of receiving avoidant responses to disclosure. Results also highlighted the role of scars from NSSI, including the impact of disclosures initiated by scars and the long-term consequences of having visible remnants of an act that carries societal stigma. Among the clinical implications discussed is the import of initiatives to reduce NSSI stigma and foster supportive and understanding responses to NSSI disclosures.
Acknowledgments

Graduate school has spanned a critical period of personal and professional growth, and I am so thankful for the remarkable people who have provided support and guidance along the way. First, I would like to thank the members of my dissertation committee, Dr. Stephen Lewis, Dr. Heidi Bailey, and Dr. Nancy Heath, for their insight, advice, and feedback throughout the development of this dissertation. In particular, I would like to express my deepest gratitude to my advisor, Dr. Lewis, for his constant support and encouragement throughout my graduate school experience. I have benefitted greatly from the depth of his knowledge, the passion with which he conducts research and clinical activities, and the gentle and respectful way he encourages his students to challenge themselves. Dr. Bailey and Dr. Heath provided invaluable guidance, clarity, and statistical and conceptual support at all stages of this dissertation, and I am thankful for the many contributions they made. I’d also like to thank the members of my examination committee, Dr. Megan McMurtry, Dr. Karl Hennig, and Dr. Allison Kelly for their insightful questions and comments, and for helping to make my dissertation defense such a positive and rewarding experience.

It’s difficult to truly appreciate the highs and lows of graduate school without having experienced it firsthand and I am so thankful for the wonderful friends and colleagues who have accompanied me along this journey: Jill, Lindsey, Lila, and Megan. They are among the most brilliant, insightful, and strong women I know and they have been an incredible source of support, both personally and professionally. Over the past seven years, we have shared many important milestones, and I am in awe of the lives they have built and the women they have become.
My family has been an unwavering source of encouragement and this dissertation would not have been possible without their support and belief in me. I have greatly appreciated the wisdom dispensed, the sound advice (both solicited and unsolicited), and the ways they have helped me to put minor frustrations and setbacks into perspective. Mom, Dad, Doug, Aude, Andrea, and Natty: thank you for all that you do and for the light you bring into my life.

Finally, my partner and best friend, Andy, has been my biggest supporter throughout this process. Every day I am thankful for his positivity, patience, and intuitive understanding of what I need most. He has reminded me of what is important during difficult moments and has shared in my joy with every major and minor achievement. Andy, I could not ask for a more loving and supportive partner to share my life with and I am so excited for what the future holds.
# Table of Contents

List of Tables ........................................................................................................ viii  
List of Figures ......................................................................................................... ix  
Introduction ........................................................................................................... 1  
  NSSI: An Overview .............................................................................................. 2  
  Disclosure as a Step Towards Recovery .............................................................. 5  
  Disclosure as a Therapeutic Act ......................................................................... 8  
  Factors Influencing Disclosure .......................................................................... 11  
  Exploring NSSI Disclosure in a University Sample ........................................ 20  
  Study 1 ............................................................................................................. 21  
  Hypotheses ....................................................................................................... 22  
Methods: Study 1 ................................................................................................ 25  
  Participants ....................................................................................................... 25  
  Measures .......................................................................................................... 25  
  Procedure ......................................................................................................... 30  
Results: Study 1 .................................................................................................. 31  
  Analytic Plan .................................................................................................... 31  
  Descriptive Statistics ....................................................................................... 33  
  Associations between Shame, Self-compassion, Self-forgiveness, and Disclosure Scales .................................................................................................................. 37  
  The Relation between Shame, Self-compassion, Self-forgiveness, and NSSI Disclosure ...................................................................................................................... 39  
  A Closer Look at the Relation between Shame, Scarring, and NSSI Disclosure .... 40  
Discussion: Study 1 .............................................................................................. 43  
  Shame, Self-compassion, Self-forgiveness, and Disclosure ................................ 44  
  Shame, Scarring, and NSSI Disclosure .............................................................. 49  
  Clinical and Conceptual Implications ............................................................... 52  
  Limitations and Future Directions .................................................................... 55  
Introduction: Study 2 ........................................................................................ 57  
Methods: Study 2 ................................................................................................ 59  
  Participants ....................................................................................................... 59  
  Data Collection ................................................................................................. 59  
  Analytic Approach ......................................................................................... 60  
  Data Analysis ................................................................................................... 61  
Results: Study 2 ................................................................................................ 62  
  Barriers to Disclosure ...................................................................................... 63  
  The Role of Scars .............................................................................................. 70  
  Responses to Disclosure .................................................................................. 76  
Discussion: Study 2 ............................................................................................ 81  
  Barriers to Disclosure ...................................................................................... 82
The Role of Scars……………………………………………………………………… 85
Responses to Disclosure……………………………………………………………… 92
Conceptual and Clinical Implications……………………………………………… 96
Limitations and Future Directions………………………………………………… 99
General Discussion and Conclusions………………………………………………. 100
Future Directions……………………………………………………………………… 103
Final Thoughts ………………………………………………………………………… 105
References……………………………………………………………………………… 106
Appendix A…………………………………………………………………………….. 123
Appendix B…………………………………………………………………………….. 129
Appendix C…………………………………………………………………………….. 130
Appendix D…………………………………………………………………………….. 132
Appendix E…………………………………………………………………………….. 134
Appendix F…………………………………………………………………………….. 135
Appendix G…………………………………………………………………………….. 137
Appendix H…………………………………………………………………………….. 142
Appendix I…………………………………………………………………………….. 146
Appendix J…………………………………………………………………………….. 148
Appendix K…………………………………………………………………………….. 152
Appendix L…………………………………………………………………………….. 154
List of Tables

Table 1. Summary of Study 1 Hypotheses ................................................................. 24
Table 2. Pattern Matrix Factor Loadings and Communalities from Principal Axis Factoring Analysis with Oblimin Rotation ................................................................. 29
Table 3. Skewness and Kurtosis Values for Predictor and Dependent Variables .......... 33
Table 4. Disclosure Recipients .................................................................................. 35
Table 5. Pearson (r) Correlations between NSSI Variables, Disclosure Variables, and Trait-level Shame, Self-compassion, and Self-forgiveness ......................................................... 39
List of Figures

Figure 1. Response of disclosure recipient during most difficult disclosure experience…… 36
Figure 2. Thematic map of Study 2 results…………………………………………………… 63
Talking about Non-Suicidal Self-Injury: The Identification of Barriers, Correlates, and Responses to NSSI Disclosure

Non-suicidal self-injury (NSSI) entails the deliberate destruction of body tissue (e.g., self-cutting, burning) in the absence of conscious suicidal intent (Nock & Favazza, 2009). By definition, it excludes any act involving intent to die, and also excludes drug overdoses and culturally sanctioned body modification rituals, such as piercing and tattoos. NSSI has gained increasing empirical and media attention over the past decade (e.g., Picard, 2011; Rabin, 2011; Templeton, 2006) and is widely considered to be a serious public health concern (Klonsky, 2011). One reason for this is its high prevalence: recent NSSI rates have consistently ranged between 14 and 24% among youth and young adults (see Rodham & Hawton, 2009). Although some individuals self-injure\(^1\) infrequently, rates of repetition are as high as three in four among young adults who engage in NSSI (Gratz, 2006; Heath, Toste, Nedecheva, & Charlebois, 2008; Whitlock, Eckenrode, & Silverman, 2006a). Despite its high rates of enactment and repetition, research suggests that at least a third of young adults who self-injure tell no one about it (Whitlock et al., 2006a). Given that disclosing NSSI may be an important step in the recovery process, understanding the factors that facilitate and discourage individuals from disclosing self-injury may represent an important objective for researchers and clinicians.

To date, very few efforts have directly addressed the nature of disclosing current or past NSSI. Of those that have, the majority have done so in the context of online message boards (e.g., Whitlock, Powers, & Eckenrode, 2006b) or other online forums (e.g., Lewis & Baker, 2011; Lewis, Heath, St. Denis, & Noble, 2011), or have focused on the appropriate therapeutic

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\(^1\) Throughout the document, NSSI is periodically referred to as “self-injury” for stylistic purposes. To be clear, all references to “self-injury” and “self-injure” refer to non-suicidal self-injury as defined in the introductory paragraph.
response to a client’s disclosure of NSSI (e.g., Connors, 1996; Walsh, 2006, 2007). There is a clear need to examine the nature of NSSI disclosure to important others from the perspective of young adults engaging in NSSI in order to gain an improved understanding of the factors involved; by virtue of examining this area, more informed and effective efforts to promote healthy disclosure and help-seeking for NSSI can be undertaken. The goal of the current dissertation is to examine the process of disclosure in the context of current and past NSSI, including the factors that may promote or deter disclosure and the potential role that physical scars may play in this process.

**NSSI: An Overview**

As described above, NSSI is a prevalent behaviour among youth and young adults; however the frequency with which individuals enact self-injury varies widely. Among young adults who have enacted NSSI, approximately 27% report having engaged in it on one or two occasions only, 40% report self-injuring once per month, 18% one to four times per month, and 13% two to seven times per week (Heath et al., 2008). Of those who engage in NSSI repeatedly, 70% report using more than one NSSI method (Whitlock et al., 2006a). The most commonly reported methods involve skin cutting, scraping, or carving, with estimates ranging from 70% to 90% of those who self-injure (Klonsky, Muehlenkamp, Lewis, & Walsh, 2011). Banging, bruising, and self-hitting are also prevalent NSSI methods, comprising 21 to 44% of NSSI episodes (Klonsky et al., 2011).

Given that NSSI runs counter to the basic human tendencies to avoid pain, NSSI research has sought to understand the reasons for and processes maintaining NSSI, often referred to as functions. Generally, functions have been classified as having either intrapersonal/automatic or interpersonal/social reinforcement properties (Klonsky & Glenn, 2008; Nock & Prinstein, 2004).
Nock’s (2010) four-function model of NSSI extends this concept further by specifying the following four reinforcement processes: intrapersonal negative reinforcement, intrapersonal positive reinforcement, interpersonal negative reinforcement, and interpersonal positive reinforcement. Intrapersonal negative reinforcement comprises the most commonly reported functions of NSSI and entails the decrease of aversive thoughts, feelings, or sensations (e.g., tension relief) following NSSI enactment. Intrapersonal positive reinforcement involves an increase in desired thoughts or feelings (e.g., satisfaction with having “punished” oneself) following NSSI. Interpersonal negative reinforcement is thought to occur when NSSI leads to a decrease or cessation of an aversive social event (e.g., peers cease bullying). Finally, interpersonal positive reinforcement entails an increase in a desired social event (e.g., attention or support). While it is important to understand the functions of NSSI on a theoretical level, and doing so has certainly helped to illuminate how and why NSSI can be an effective coping mechanism for some, the accurate assessment of functions at the clinical level is a critical aspect of case conceptualization and treatment planning (Klonsky et al., 2011).

Another important aim for NSSI research has been delineating sex differences in self-injury. The predominant view supported by early NSSI research suggested that women were more likely to self-injure than men (Suyemoto & MacDonald, 1995; Zlotnick, Mattia, & Zimmerman, 1999). Recent research has suggested that the relation between sex and NSSI is more complex. A number of studies have found no sex difference in lifetime rates of NSSI (Gratz, 2001; Klonsky et al., 2003; Muehlenkamp & Gutierrez, 2004), however research has found that young adult women engage in more frequent self-injury compared with their male counterparts (Whitlock et al., 2006a).
In addition to potential sex differences in NSSI frequency and the pattern of NSSI enactment over the lifetime (Whitlock et al., 2006a), there is evidence to suggest that males and females differ in several features of NSSI. Adolescent and young adult females have been found to engage in cutting more than males (Sornberger, Heath, Toste, & McLouth, 2012; Whitlock et al., 2006a), whereas young adult males have been found to punch objects as a means of self-injuring more frequently (Sornberger, Heath, Toste, & McLouth, 2012; Whitlock, Muehlenkamp, & Eckenrode, 2008; Whitlock et al., 2006a). In terms of location on the body where NSSI occurs, research has found that males injure their hands more, whereas females injure their wrists and thighs more (Whitlock et al., 2006a).

Not only is NSSI prevalent among youth and young adults, it is also often associated with mental health difficulties, including psychiatric illness and suicidality (Cooper et al., 2005; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Whitlock & Knox, 2007). Specifically, NSSI is associated with a number of symptoms that interfere with daily functioning, including higher levels of depression and anxiety, lowered self-esteem (Jacobson & Gould, 2007), and feelings of hopelessness (Webb, 2002). NSSI is often used as a method to cope with these negative feelings (for a review see Klonsky, 2007). Although NSSI is distinct from acts with suicidal intent, NSSI and suicide are related. NSSI has been found to share a robust relationship with attempted suicide, one that is larger than the respective relationships between attempted suicide and depression, anxiety, impulsivity, and borderline personality disorder (Klonsky, May, & Glenn, 2013). Further, NSSI has been proposed as a unique risk factor for suicide as it relates to heightened suicidal desire and capability, both of which are necessary conditions for attempted suicide according to Joiner’s (2005) Interpersonal-Psychological Theory of Suicide. The emotional distress associated with NSSI correlates with suicidal desire (Klonsky et al., 2003;
TALKING ABOUT NON-SUICIDAL SELF-INJURY

Klonsky et al., 2013) and NSSI can lead to habituation to self-inflicted pain, thereby heightening suicidal capability (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). It has also been suggested that some individuals who engage in NSSI to cope with distress may turn to suicide when their distress overwhelms their ability to functionally cope using self-injury (Glenn & Klonsky, 2009; Muehlenkamp & Gutierrez, 2004; Nock et al., 2006; Whitlock & Knox, 2007). Furthermore, having a longer history of NSSI, engaging in multiple methods of NSSI, and reporting no physical pain during NSSI have all associated with attempting to die by suicide (Nock et al., 2006). Finally, the social context present when one injures has been found to relate to risk of attempted suicide. That is, those who self-injure when isolated may be at higher risk of attempting suicide (Glenn & Klonsky, 2009).

Because NSSI often functions to help cope with distressing emotions or thoughts, it can be very difficult to recover from the behaviour without first acquiring other coping mechanisms (Klonsky, 2007, 2009; Klonsky & Glenn, 2009). Unfortunately, many youth and young adults who self-injure do not seek help for their NSSI and therefore do not receive treatment. Without the support of important others and/or professional treatment, recovery from NSSI can be an ongoing struggle (Zivin, Eisenberg, Gollust, & Golberstein, 2009). Even more concerning is the fact that many young adults who self-injure tell no one about it (Whitlock et al., 2006a), thereby missing out on potential support from informal sources, such as friends and family.

**Disclosure as a Step Towards Recovery**

Disclosing NSSI may represent an important and sometimes necessary step in the recovery process. Yet, research suggests that very few young adults struggling with NSSI are receiving professional help for self-injury. For example, a study conducted in Australia found that professional help-seeking was reported by less than 25% of participants who self-injure,
while just over a third of the sample reported seeking help from family or friends (Nada-Raja, Morrison, & Skegg, 2003). Whitlock and colleagues (2006a) found that 64% of a college sample reported that at least one person knew about their self-injurious behaviours, while 21% had disclosed their self-injury to a mental health professional. Overall, research indicates that friends are the preferred recipients of disclosure and help-seeking (Whitlock et al., 2006a). Adolescents report feeling most able to talk to a friend about NSSI, in contrast to parents and teachers, and are most likely to seek and receive help from friends (Evans, Hawton, & Rodham, 2005). Importantly, we know little about what these disclosure experiences look like and whether they are perceived to be helpful, unhelpful, or even harmful. A study investigating the role of disclosure and support in the cessation of NSSI found that young adults were more likely to have found conversations about their NSSI with friends to be unhelpful, compared with conversations with a trusted adult (e.g., physicians, parents, teachers; Pietrusza, Rothenberg, & Whitlock, 2011). There is also evidence to suggest that young adults who first disclose and seek help from friends and family are more likely to subsequently seek professional help (Nada-Raja et al.; Whitlock et al., 2006a).

While some individuals may cease to self-injure on their own, research suggests that for many young adults NSSI does not simply remit within a short period of time (Glenn & Klonsky, 2011a; Zivin et al., 2009). A study investigating NSSI among American university students found that 40% of students who endorsed NSSI in 2005 continued to endorse it in 2007 (Zivin et al.). Indeed, the presence of NSSI in 2005 was a significant predictor of NSSI in 2007, while depression, anxiety, and suicidal thoughts endorsed in 2005 were not. Similarly, in their study of prospective predictors of NSSI, Glenn and Klonsky (2011a) found past NSSI to be one of the
few predictors of NSSI at a 12-month follow-up. Approximately 80% of young adults who endorsed current NSSI at baseline continued to report NSSI 12-months later.

Researchers are just beginning to explore the role of professional support in NSSI recovery. In a study exploring the role of psychotherapy in NSSI cessation, over half of participants (58.6%, all of whom considered themselves recovered from NSSI at the time of the survey) had attended therapy during the period of time they were engaging in self-injury. Approximately half of these individuals (52%) found therapy to be helpful in stopping NSSI (Pietruzsa, Shea, & Whitlock, 2010). While it is problematic that a large proportion of individuals in therapy did not find it to be helpful in the cessation of their NSSI, the majority of individuals who did find therapy helpful should not be discounted. As such, there may be merit in promoting disclosure as it can lead to professional treatment, which has been shown to benefit some individuals who engage in NSSI (Nada-Raja et al., 2003; Whitlock et al., 2006a).

Although there is somewhat limited empirical research informing treatment guidelines for NSSI (e.g., Muehlenkamp, 2006), there is support for a number of therapeutic interventions including Problem-Solving Therapy and Dialectical Behaviour Therapy, both of which have been found to reduce NSSI (Muehlenkamp). It has been hypothesized that one critical component common to both approaches is the functional assessment of NSSI, which entails determining the functions served by NSSI, as it allows for the identification and remediation of skill deficits that may be reinforcing the continued use of NSSI. Given that therapeutic intervention has been found to be helpful in the treatment of NSSI and the evidence that for some young adults NSSI does not simply cease with time (Zivin et al., 2009), it remains important to promote help-seeking for NSSI. As disclosing NSSI often is a necessary step in the help-seeking
process, it may be helpful to encourage young adults to talk about their NSSI to trusted friends, family, and professionals who can help.

**Disclosure as a Therapeutic Act**

Disclosure may be an important initial step in the recovery process, as one part of getting help for NSSI is telling others about it. Importantly, disclosure is oftentimes therapeutic in itself. Talking to others about stressful or traumatic life events is associated with improved wellbeing, life satisfaction, and symptom reduction (Frattaroli, 2006; Lyubormirsky, Sousa, & Dickerhoof, 2006). For instance, young adults who wrote about emotionally difficult material in the context of a research study reported that they found the experience to be valuable and meaningful and, if given the choice, 98% of study participants reported they would participate again (Pennebaker, 1997). The therapeutic effects of writing and talking have been found to be comparable (Pennebaker & Seagal, 1999); whether this trend would hold for disclosing experiences that are not easily shared, like NSSI, is not presently known.

The stigma surrounding NSSI (Adler & Adler, 2007; Hodgson, 2004; Whitlock et al., 2006a) is one feature that likely engenders silence and reticence to discuss NSSI with others. As such, it may be useful to consider research examining the disclosure of other stigmatized behaviors in order to better understand NSSI disclosure. For many people, the deliberate destruction of bodily tissue can be a difficult concept to relate to, as it runs counter to the human tendency to seek pleasure and avoid pain (Walsh, 2006). This is one reason NSSI is often stigmatized. Furthermore, NSSI is often associated with certain marginalized social groups, such as those involved in the “emo” or Goth subcultures (a persistent stereotype), which may further propagate the stigma surrounding self-injury (Nock, 2008). Research conducted on the nature of disclosing stigmatized behaviours in general points to the toll continued concealment might have
on mental health and relationships and the positive effects of disclosure (Cepedo-Benito & Short, 1998; Pachankis, 2007). Not only does prolonged concealment increase feelings of distress, guilt, and anxiety (Cepedo-Benito & Short; Pachankis), individuals who continue to conceal their stigmatized identity may feel increasingly isolated and rejected and view themselves more negatively (Kelly, 2002). Conversely, evidence suggests that disclosure can associate with greater feelings of self-acceptance (Pachankis) and a more unified sense of self (Kelly). It is important to note that not all disclosures are equal and certain disclosure experiences may not associate with positive psychological outcomes (Ullman, 2010).

In their Disclosure Process Model (DPM), developed to address when and why interpersonal disclosures may be beneficial, particularly for individuals with a concealable stigmatized identity (e.g., mental illness, HIV-positive diagnosis, sexual assault survivor; Pachankis, 2007), Chaudoir and Fisher (2010) emphasized the importance of the disclosure outcome in determining the helpfulness of the disclosure. The DPM proposed that a feedback loop exists within disclosure experiences, such that disclosure events associated with positive outcomes (e.g., enhanced well-being) serve to increase the likelihood of future disclosures, while negative outcomes serve to decrease future disclosure likelihood. In support of this proposition, research has found that people living with HIV/AIDS who reported a positive and supportive recent disclosure experience were more likely to participate in a subsequent disclosure at a 6-month follow-up (Chaudoir, 2009). They were also more likely to report greater feelings of social support, less perceived communication difficulties, and fewer negative HIV-related thoughts during said subsequent disclosure experience (Chaudoir).

The response of the disclosure recipient is an important factor in determining whether the disclosure is likely to be experienced as positive, supportive, and, overall, beneficial. Research
has found that the feedback received after disclosing a stigmatized behaviour or experience has the potential to greatly impact feelings of self-worth (Pachankis, 2007). For instance, Ahrens (2006) explored the silencing impact negative responses to disclosures of rape had on survivors’ subsequent willingness to disclose their assault experiences. Women who were met with blaming or insensitive responses to their disclosures were effectively silenced; in some cases, women kept their experiences of rape to themselves for years after their initial negative disclosure experience (Ahrens). Similarly, women who disclosed their experience of abortion to recipients they felt were not completely supportive did not experience the reduced psychological distress typically associated with disclosure (Major et al., 1990).

Given that NSSI is a stigmatized behaviour that is often concealed from others (e.g., Walsh, 2006; Whitlock et al., 2006a), it is possible that the same negative effects associated with concealment and positive effects associated with supportive disclosure experiences apply. Preliminary research investigating the disclosure experiences of adolescents who engage in self-harm (a broader category encompassing both NSSI and overdosing behaviours) found that some youth linked their reluctance to disclose with a fear of negative responses (Klineberg, Kelly, Stansfeld, & Bhui, 2013). Furthermore, youth from the aforementioned study who had had their self-harm discovered reported being met with shocked responses that communicated a lack of emotional understanding (Klineberg et al.). The impact of disclosure has not often been studied in the context of NSSI, and it is important to study not only the reaction given by the disclosure recipient, but also other personal and relational characteristics that may play a role in the likelihood of initial and subsequent NSSI disclosures.
Factors Influencing Disclosure

Limited research has been conducted on the process of disclosing current and past NSSI and the factors influencing it, despite the fact that disclosure may have continued relevance throughout treatment, remission, and even after an individual has been recovered for some time. Therefore, an important objective for NSSI researchers is to better understand why the behavior may not be readily disclosed to others and, in doing so, identify the factors that may influence when and why it is disclosed.

An important feature of NSSI that may differentiate its disclosure from the disclosure of other sensitive or stigmatized behaviours is the fact that NSSI may be disclosed both directly (via verbal communication) and indirectly (via the display or discovery of wounds and/or scars). Both forms of disclosure are pertinent to the experience of youth and young adults who have self-injured. While this dissertation will primarily focus on direct forms of disclosure by asking participants about their experiences telling others about their NSSI, indirect disclosures will be addressed in a qualitative exploration of participants’ disclosure experiences.

Based on research investigating the disclosure and concealment of stigmatized behaviours in general, and correlates associated with NSSI in particular, the following characteristics may be important in the study of NSSI disclosure.

The role of shame. Shame is widely considered a self-conscious emotion, as it tends to emerge through self-reflection (Lewis, 2003). In this way it differs from the primary emotions of sadness, anger, happiness, etc. Izard (1977) described shame as a “heightened degree of self-conscious self-awareness or self-attention: our consciousness is filled with self and we are aware of some aspect of self we consider innocuous or inadequate” (p. 389). Shame differs from guilt in that an action is not necessarily the cause of the shame (as is understood to be the case with
guilt). Rather, shame typically arises from a state of self-devaluation, which may arise from how others evaluate us, although not necessarily (Lewis, 1971). Shame is differentiated from embarrassment by the intense feelings of pain, discomfort, and anger often associated with it, as well as the fact that shame reflects a global assessment of the self as being unworthy and inadequate (Lewis, 2003).

Shame has been conceptualized in a multitude of ways. One such characterization is the distinction between internal and external shame. Internal shame is understood to arise from negative beliefs about the self, for example that one is inadequate, worthless, or flawed. External shame arises from believing a negative view of the self exists in the minds of others, for example believing that others view one as unattractive or not worthwhile, and is related to the fear that others would respond with disgust or rejection if exposed to one’s behaviours, appearance, or character (Gilbert et al., 2010). As such, it is understandable that shame is associated with a tendency to hide the self from others (Lindsay-Hartz, 1984).

The association between mental illness and shame is well documented (e.g., Andrews, Qian, & Valentine, 2002; Corrigan, 2004; Hinshaw & Cicchetti, 2000), including the specific relation between shame and NSSI (Brown, Linehan, Comtois, Murray, & Chapman, 2009; Gilbert et al., 2010). Heightened character shame (i.e., feeling ashamed of one’s personal habits, personal ability, or the sort of person one is), behavioural shame (i.e., shame about doing something wrong), and bodily shame (i.e., feeling ashamed of one’s body or any part of it) have all been linked with NSSI (Gilbert et al., 2010). Brown and colleagues found that higher levels of shame behaviour were associated with a higher likelihood of subsequent NSSI among women with borderline personality disorder and emphasized the importance of shame in the development and maintenance of NSSI. Higher shame-proneness has also been found to
associate with higher frequencies of NSSI among college-aged individuals (VanDerhei, Rojahn, Stuewig, & McKnight, 2013) and among a community sample of women (Schoenleber, Berenbaum, & Motl, 2014).

Recent research has investigated shame regulation functions of NSSI. Schoenleber and colleagues (2014) found that shame aversion (i.e., the experience of shame as an especially painful and unwanted emotion) was higher among women who engage in NSSI. The researchers employed a laboratory task to assess the role of NSSI in regulating feelings of shame. They found that women with and without a history of NSSI experienced reductions in shame following a pressure pain task, suggesting that NSSI may serve to down-regulate feelings of shame.

The relation between shame and NSSI disclosure has not been formally studied; however, research has found that shame is associated with the avoidance of seeking treatment for emotional and mental health problems (Corrigan, 2004; Hinshaw & Cicchetti, 2000), lack of disclosure of emotional distress to friends, family, and professionals (MacDonald & Morley, 2001), and, more broadly, a fear of intimacy (Lutwak, Panish, & Ferrari, 2003). While shame may lead individuals to conceal stigmatized identities like mental illness, the continued concealment of personal information can also lead to feelings of shame, if only because it is seen as worthy of being hidden (Kelly, 2002). A study investigating the relation between stigma-related secrets and negative emotions found that students who possessed a concealable stigma reported higher anxiety, depression and lower self-esteem than visibly stigmatized students (Frable, Platt, & Hoey, 1998). That a concealable stigma would associate with more negative affect than a visible stigma suggests that concealment, and possibly the shame associated with concealment, is an important factor.
Overall, existing research investigating the relation between shame and concealment indicates that shame may play a role in the disclosure, or lack thereof, of NSSI. Moreover, without being directly measured, it has been proposed that individuals who feel high levels of shame with regard to their NSSI may be more likely to repeatedly self-injure, as shame may prevent them from disclosing NSSI and accessing help (Brown et al., 2009). Thus, it seems important to explore the role of shame in the disclosure of current and past NSSI.

**The role of self-forgiveness.** Another factor that may play a role in the context of disclosing NSSI is self-forgiveness. Self-forgiveness is the tendency to forgive oneself and abandon self-resentment while also acknowledging one’s own wrongdoing, and is associated with a number of positive mental health outcomes, including higher self-esteem and life satisfaction and reduced neuroticism, depression, anxiety, and hostility (Coates, 1997; Hall & Fincham, 2008; Leach & Lark, 2004; Maltby, Macaskill, & Day, 2001; Mauger et al., 1992; Thompson et al., 2005), as well as recovery from mental illness in general (McGrath, 2009).

Research suggests that self-forgiveness follows a temporal pattern, whereby it increases linearly with time; however, the course of self-forgiveness has not been investigated over the long-term and has generally focused on the process of forgiving oneself following a specific, solitary transgression (e.g., behaving in a way that was hurtful to someone within the preceding three days; Hall & Fincham), rather than an ongoing pattern of behaviour, like that typical of recurrent NSSI (Klonsky & Olino, 2008). Studies examining the association between NSSI and self-forgiveness are scant. Among the studies that have explored this relation, a lack of self-forgiveness has been found to be associated with greater lifetime frequency of NSSI (Westers, 2010), while lower levels of self-forgiveness have been found to associate with engaging in NSSI for emotion regulation, self-punishment, and communication reasons (Westers, Rehfuss,
Olson, & Biron, 2012). Westers and colleagues (2012) noted that adolescents who engage in NSSI share a tendency toward self-criticism and perfectionism with individuals low in self-forgiveness. The self-punishment function of NSSI may help to explain the relation between NSSI and low levels of self-forgiveness, as engaging in NSSI may serve as a form of self-penitence for perceived transgressions.

While it has been purported that disclosure of one’s transgressions can promote self-forgiveness (Farber, Khurgin-Bott, & Feldman, 2009), the relation between self-forgiveness and disclosure of NSSI has not been explored. As self-forgiveness has been shown to associate with positive psychological outcomes, the role of self-forgiveness throughout the process of NSSI recovery, from disclosure to treatment, merits further study, as it may have important therapeutic implications.

The role of self-compassion. Self-compassion is a construct that has arisen from the mindfulness movement in Eastern philosophy and psychology and entails “being kind toward oneself in instances of pain or failure; perceiving one’s experiences as part of the larger human experience; and holding painful thoughts and feelings in balanced awareness” (Neff, Rude, & Kirkpatrick, 2007b, p. 908). Self-compassion has been conceptualized as involving three main components: self-kindness, common humanity, and mindfulness (as compared to self-judgment, isolation, and over-identification, respectively; Neff et al., 2007b). It is distinct from the concept of self-esteem in that self-compassion is a way of relating to oneself that does not rely on performance evaluations of the self (Neff, 2003). Compared to self-esteem, self-compassion has been found to predict more stable, less contingent feelings of self-worth (Neff & Vonk, 2009). Self-compassion has been proposed as an antidote to the experience of shame (Gilbert, 2005) and self-criticism (Gilbert & Procter, 2006), in that connecting to self-kindness helps to counter
judgmental and shaming ways of relating to the self. Self-compassion is thought to activate the same soothing system that is associated with comfort and care from others, thereby countering the threat system elicited by feelings of shame (Gilbert, 2009).

A clear association between self-compassion and mental health has been demonstrated in the literature (Kelly, Carter, Zuroff, & Borairi, 2013; Neff, 2003b; Neff, Kirkpatrick, & Rude, 2007a; Neff et al., 2007b). Lower levels of self-criticism, depression, anxiety, rumination, and enhanced life satisfaction and social connectedness have all been linked to higher levels of self-compassion (Neff, 2003b), as have elevated happiness, optimism, positive affect, wisdom, personal initiative, curiosity and exploration, agreeableness, extroversion, and conscientiousness (Neff et al., 2007b). Given this demonstrated link between self-compassion and enhanced wellbeing, self-compassion may be a useful construct to explore in the context of disclosure, help-seeking, and recovery from mental illness.

Along these lines, self-compassion research has been conducted with individuals admitted to day and inpatient treatment for eating disorders. In addition to frequently co-occurring (Claes, Vandereycken, & Vertommen, 2003), eating disorder pathology and NSSI share an association with emotion dysregulation, body dissatisfaction, and depressive symptomatology (Muehlenkamp, Peat, Claes, & Smits, 2012). As such, the relation between self-compassion, eating disorder pathology, and response to treatment may offer insight into potential associations between NSSI and self-compassion. Among individuals receiving treatment for eating disorders, higher self-compassion was found to associate with lower shame and less severe eating disorder pathology, while lower self-compassion and higher fear of self-compassion (i.e., resistance to treating oneself compassionately for fear that one is undeserving of it, will become dependent on it, and/or will experience a drop in personal standards)
associated with no significant changes in shame or eating disorder symptoms over the course of treatment (Kelly et al., 2013). These findings suggest that self-compassion has important implications for treatment and recovery from eating disorder pathology. Compassion-focused therapy (CFT) has been proposed as a treatment approach for NSSI (Van Vliet & Kalnins, 2011). CFT is an integrated, multimodal therapeutic approach designed to help individuals develop internal experiences of warmth, safety, and soothing through compassion and self-compassion (Gilbert, 2009). To date there has been little empirical work investigating the efficacy of using compassion-focused treatments for NSSI.

A recent study conducted by Sutherland and colleagues (2014) investigated expressions of self-compassion in online accounts of NSSI experiences. Examples of self-compassion aligned with Neff’s (2003a) definition of self-compassion and its components (i.e., self-kindness, common humanity, and mindfulness) and study findings suggest that components of self-compassion may operate to foster greater acceptance of NSSI experiences.

One potential pathway by which self-compassion and disclosure may be related is through social connectedness (Neff, 2003a). If those with higher levels of self-compassion are more socially connected, it is possible that they are also more likely to disclose their self-injury to another. Self-compassion may also help protect against self-evaluative anxiety in the face of perceived personal weaknesses (Neff et al., 2007a). Furthermore, the degree of self-compassion an individual possesses is likely related to whether they believe they deserve the compassion of others, which may have important implications for disclosure of self-injury and help-seeking. Individuals with higher levels of self-compassion may be more likely to see themselves as worthy and deserving of care and support, which in turn could help to counter feelings of shame.
that may accompany NSSI. Together these factors may encourage an individual to disclose his or her history of NSSI.

**The role of scarring.** An important consequence of NSSI that sets it apart from many other mental health difficulties are the physical remnants left behind in the form of wounds and scars. These signs of NSSI may stay with an individual long after he or she has recovered. While not all individuals who self-injure will have scars or marks as a result, scars do associate with many of the more common methods of NSSI, including cutting, scratching, and burning (Whitlock et al., 2006a).

It is important to note that both wounds (i.e., immediate tissue damage) and scars (i.e., the development of fibrous connective tissue due to incomplete wound healing) are relevant when considering the physical consequences of NSSI. Wounds have been the focus of past research investigating the role of seeing blood in NSSI (Glenn & Klonsky, 2010), however the topic of scarring has been largely overlooked by researchers, especially in the context of recovery and disclosure. The present study has opted to focus on scarring from NSSI due to the long-term relevance of scars (e.g., wounds may heal within a week or two, whereas scars often remain for years) and the implications they have for the continued concealment or disclosure of NSSI. It is, however, important to note that the boundary between wound and scar may not always be clear, and wounds have the potential to similarly impact disclosure experiences. As such, the issue of wounds from NSSI will be periodically addressed throughout this paper.

As noted above, scars may influence disclosure in a number of ways, especially depending on the location and degree of scarring present. For one, scars themselves may act as a means of disclosure if they are not deliberately concealed. Questions or comments about scars or
wounds made by others may prompt an individual to disclose even if he or she had not intended to do so at that time.

Research exploring online NSSI communities and the information that is exchanged points to a desire among some individuals to conceal or minimize the scars and wounds that can associate with NSSI (Lewis & Baker, 2011; Lewis, Rosenrot, & Messner, 2012; Whitlock et al., 2006b). This desire to hide evidence of NSSI behaviour suggests that some individuals do not want others to know about their NSSI. Further, among individuals with Borderline Personality Disorder (BPD), scars resulting from self-injurious behaviours have been found to associate with body image disturbances, with scar visibility, but not size, associating with a more negative body image (Dyer, Hennrich, Borgmann, White, & Alpers, 2013). That the perceived visibility, rather than overall size, of scars was linked to body image disturbance points to the potential social concerns related to scarring from NSSI. For some, the social consequences of having scars from NSSI may be as pertinent as the existence of the scars themselves.

The fear of having to disclose by virtue of the evidence left by wounds and scars may lead some individuals to avoid intimate relationships (Hodgson, 2004). While it is possible, albeit difficult at times, for individuals to conceal wounds and scars from parents and friends, the intimacy commonly present in romantic relationships makes scar concealment more difficult. Alternatively, individuals may worry about the professional repercussions of having visible scarring from NSSI. Scars can serve as a visible marker of past behaviour and psychological difficulties, which may, unfortunately, lead to workplace discrimination. Because NSSI scars may remain for years following recovery, and in many cases leave permanent visible marks, there remains the potential for continued psychological, professional, and relational difficulties,
as individuals may need to repeatedly hide or disclose past NSSI. Therefore, understanding how wounds and scars impact NSSI disclosure seems particularly important.

**Exploring NSSI Disclosure in a University Sample**

The goal of the current dissertation was to explore the act of disclosure to important others (e.g., friends, family, romantic partners, teachers) among individuals who have self-injured. To do this, two studies were conducted: in the first participants completed a series of online questionnaires assessing their levels of shame, self-compassion, self-forgiveness, and NSSI characteristics, including perceived visibility of scarring, frequency and methods of NSSI, age of onset, and current self-injury status, as well as their experiences disclosing their NSSI. In the second, individual interviews were conducted with participants from Study 1 who volunteered to participate in a second study, with an aim of developing a richer, more in-depth understanding of disclosure barriers, processes, and experiences.

The information gathered in these studies may contribute to an improved understanding of NSSI disclosure, which may have important therapeutic implications and may be particularly relevant with regards to the creation of intervention programs. For example, targeting characteristics (e.g., self-compassion) found to be important for disclosure in NSSI intervention programs may promote healthy disclosure to friends, family and professionals for young adults struggling with NSSI. Similarly, such important variables might be targeted in therapy to help ease the burden of future disclosures, which are often necessary even after recovery due to the scarring that remains.

Disclosure to important others, such as friends and family, may be an important step towards recovery from NSSI, yet many young adults do not tell anyone about their self-injury (Whitlock et al., 2006a) and we know relatively little about the experiences of those who do. By
virtue of examining this area, more informed and effective effort to promote healthy disclosure and help-seeking for self-injury may be undertaken.

Finally, questions and conversations about scars from NSSI may be an unavoidable experience for youth who have visible scarring from self-injury. While some youth manage to avoid answering questions about their scars (Hodgson, 2004), others may feel compelled to disclose their NSSI in response to questions about scars or marks (Hodgson). We know from the general disclosure literature that these conversations have the potential to be helpful or harmful, depending, in part, on the response of the recipient (Chaudoir, 2009). It is, therefore, important to understand what helpful or harmful disclosure responses entail from the perspective of young adults who have experienced them.

**Study 1**

In this study, the potential role of feelings of shame, levels of self-forgiveness and self-compassion, and perceived visibility of scarring was examined in the context of NSSI disclosure. The following aspects of the disclosure experience were investigated: whether or not NSSI had been disclosed to anyone prior to taking part in the study, the self-rated difficulty of past disclosure experiences, the anticipated difficulty of future disclosure experiences, the anticipated likelihood of future disclosures, and categories of recipients (i.e., confidantes) disclosed to (e.g., mother, father, friend, romantic partner, teacher, etc.). Participants were asked to reflect on the relative ease or difficulty of their first disclosure, their most difficult disclosure, their easiest disclosure, as well as the quality of recipient responses to their disclosures.

One limitation that is inherent to the study of disclosure is the fact that all participants must disclose their NSSI status in order to take part. By virtue of the fact that disclosure was a requirement for participation in this study, all participants disclosed to at least one person (i.e.,
TALKING ABOUT NON-SUICIDAL SELF-INJURY

the lead investigator via online survey) by the conclusion of their study participation. Exploring differences amongst participants who had not disclosed previously compared with participants who had disclosed to many different people may help to elucidate the characteristics associated with a willingness to disclose NSSI.

Hypotheses

It was hypothesized that higher levels of self-reported shame would be associated with having disclosed to fewer people (as measured by recipient categories; H1a), more difficult past disclosures (H1b), and a reluctance to disclose to others in the future (H1c). Research investigating the link between shame and mental illness has shown that shame is associated with a lack of disclosure of emotional distress to friends, family, and professionals (MacDonald & Morley, 2001) and a broader fear of intimacy (Lutwak et al., 2003). It was expected that heightened shame among youth who self-injure would similarly impact attitude toward NSSI disclosure, in the manner hypothesized above.

The influence of perceived visible scarring (i.e., scarring that participants reported as “visible”) on the relation between shame and disclosure was also explored. Based on research linking scars from self-injurious behaviours with body image disturbances among individuals with BPD (Dyer et al., 2013), as well as research suggesting individuals who self-injure seek advice on how to conceal or minimize wounds (Lewis & Baker, 2011; Lewis et al., 2012) it was hypothesized that those with perceived visible scarring would have higher levels of shame (H2a). It was also hypothesized that individuals with perceived visible scarring would have disclosed to more people (H2b) and would anticipate a higher likelihood of future disclosures (H2c). Visible scars may prompt questioning from concerned or curious others and it is possible that some of those questions may lead to NSSI disclosures. Given the relative dearth of research investigating
the influence of scarring on the disclosure experience, no a priori hypotheses were made about the impact of scarring on the ease or difficulty of disclosures.

Research investigating the relation between self-forgiveness and NSSI is scant, and there have been no studies to date exploring the relation between self-forgiveness and NSSI disclosure. A lack of self-forgiveness, however, has been found to associate with greater lifetime frequency of NSSI (Westers, 2010), while lower levels of self-forgiveness have been found to associate with engaging in NSSI for emotion regulation, self-punishment, and communication reasons (Westers et al., 2012). More broadly, research suggests that self-forgiveness may be a factor in recovery from mental illness in general (McGrath, 2009). As such, it stands to reason that self-forgiveness may play a role in the disclosure and recovery process. The following hypothesizes were made about the relation between self-forgiveness and NSSI disclosure: it was hypothesized that higher levels of self-forgiveness would be associated with having disclosed to a greater number of people (as measured by recipient categories; H3a), less difficult past disclosures (H3b), and a more positive attitude toward future disclosures (H3c).

It was hypothesized that higher levels of self-compassion would be associated with having disclosed to a greater number of people (as measured by recipient categories; H4a), less difficult past disclosures (H4b), and a more positive attitude toward future disclosures (H4c). Preliminary research investigating the relation between self-compassion and NSSI suggests that self-compassion may foster greater acceptance of NSSI experiences (Sutherland et al., 2014), which may lead to increased openness, thereby impacting the likelihood or ease of disclosure. Furthermore, self-compassion has been linked to higher levels of social connectedness (Neff, 2003a). If those with higher levels of self-compassion are more socially connected, it is possible that they have more opportunities and may be more likely to disclose their self-injury to others.
Given the theoretical relatedness of the variables in Study 1, it was expected that the variables would relate in the following ways. Those with higher levels of shame were expected to have lower levels of self-compassion, and lower levels of self-forgiveness (H5). The unique contributions of shame, self-compassion, self-forgiveness, and scarring from self-injury in predicting the likelihood of future disclosures and the reported difficulty of past disclosures were also explored. This was done in order to determine whether any variable offered unique predictive power. Given that these factors had not been collectively examined in the context of NSSI disclosure, no a priori hypotheses were made. For a summary of Study 1 hypotheses, see Table 1, below.

Table 1.

Summary of Study 1 Hypotheses

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1</td>
<td>Higher levels of self-reported shame expected to associate with fewer past disclosures (H1a), more difficult past disclosures (H1b), and reluctance to disclose in the future (H1c)</td>
</tr>
<tr>
<td>H2</td>
<td>Perceived visible scarring expected to associate with higher levels of shame (H2a), greater number of past disclosures (H2b), and higher likelihood of future disclosures (H2c)</td>
</tr>
<tr>
<td>H3</td>
<td>Higher levels of self-forgiveness expected to associate with greater number of past disclosures (H3a), less difficult past disclosures (H3b), and more positive attitude toward future disclosures (H3c)</td>
</tr>
<tr>
<td>H4</td>
<td>Higher levels of self-compassion expected to associate with greater number of past disclosures (H4a), less difficult past disclosures (H4b), and more positive attitude toward future disclosures (H4c)</td>
</tr>
<tr>
<td>H5</td>
<td>Higher levels of shame expected to associate with lower levels of self-compassion, and lower levels of self-forgiveness</td>
</tr>
</tbody>
</table>
Methods: Study 1

Participants

Participants were University of Guelph undergraduate students. Of the 207 participants who took part in the study, only 179 were included in the analyses\(^2\) (154 women and 25 men). Participants ranged in age from 17 to 29 years, \(M_{age} = 18.98; SD_{age} = 1.75\). Participants were recruited via the Psychology Participant Pool and received course credit for study participation. Consistent with study inclusionary criteria, all participants were proficient in the English language and endorsed a history of NSSI. Participation was voluntary and confidential. Prior to commencing the study, clearance was obtained from the University of Guelph’s research ethics board.

Measures

Demographics questionnaire (Appendix B). A brief demographics questionnaire was administered to collect information about the sex, age, and ethnicity of participants.

Non-suicidal self-injury (Appendix C). The Inventory of Statements about Self-injury (ISAS; Klonsky & Glenn, 2009) was used to assess participants’ lifetime history of NSSI, including the frequency, methods, and age at first and most recent incident of NSSI. For example, to collect data about both frequency and method of NSSI, participants were asked to estimate the number of times in their life they had intentionally performed each type of non-

\(^2\) Thirteen participants were removed from analyses because they had fewer than 5 lifetime instances of self-injury. A minimum of five episodes of self-injury was chosen based on the DSM-5 criteria for NSSI as a Condition for Further Study (American Psychiatric Association, 2013). An additional eight participants were removed from analyses because they endorsed self-starvation, purging, or overdosing on prescription medication as their sole form of self-harm. Three participants were removed from analyses because they had more than 20% missing data for any single questionnaire within the survey. Another three participants were removed from analyses because they were identified as outliers and a final participant was removed from analyses because this person’s age fell outside of the range for the target population (i.e., young adults in university).
suicidal self-injury listed (e.g., cutting, biting, burning, carving, pinching, severe scratching). Participants reported their best estimate of the frequency for each method and, if applicable, provided their best frequency estimate for NSSI methods not listed. The ISAS has been shown to be a reliable and valid measure of NSSI frequency (Glenn & Klonsky, 2011b).

**Self-compassion** (Appendix D). Participants completed the 26-item Self-Compassion Scale (SCS; Neff, 2003a). The SCS assesses the three facets of self-compassion and their inverse components: self-kindness (e.g., “I’m tolerant of my own flaws and inadequacies”) vs. self-judgment (e.g., “I’m disapproving and judgmental about my own flaws and inadequacies”); common humanity (e.g., “When things are going badly for me, I see the difficulties as part of life that everyone goes through”) vs. isolation (e.g., “When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world”); mindfulness (e.g., “When something upsets me I try to keep my emotions in balance”) vs. over-identification (e.g., “When I’m feeling down I tend to obsess and fixate on everything that’s wrong”). Responses are given on a five-point Likert scale that ranges from “Almost Never” to “Almost Always”. Subscale scores are computed by calculating the mean of subscale item responses. A total self-compassion score is computed by reverse scoring the negative subscale items (self-judgment, isolation, and over identification) and then calculating a total mean score. Possible total scores range from 26 to 130. Participants from this study reported total scores that ranged from 32 to 97 ($M = 59.21$, $SD = 13.33$). The SCS has been found to have an appropriate factor structure as well as good reliability and construct validity (Neff, 2003a). The SCS demonstrated good internal consistency (Cronbach’s alpha = .89) with this sample.

**Self-forgiveness** (Appendix E). The forgiveness of self subscale of the Heartland Forgiveness Scale (HFS; Thompson et al., 2005) was administered to assess respondents’ trait
levels of self-forgiveness. The forgiveness of self subscale consists of six items that are assessed using a seven-point Likert scale that ranges from “Almost Always False of Me” to “Almost Always True of Me”, yielding possible scores that range from 6 to 40. Negative items were reverse coded and then items were totaled to yield a composite score. Sample items include, “I hold grudges against myself for negative things I’ve done” and “It is really hard for me to accept myself once I’ve messed up”. Respondents in the present study reported self-forgiveness scores that ranged from 6 to 40 (M = 22.05, SD = 6.21). The HFS has been shown to be psychometrically sound (Thompson et al.), with a Cronbach’s alpha that fluctuates from .76 to .83 (Dehghan, Kord Tamini, & Arab, 2014). The HFS forgiveness of self subscale was found to have adequate internal consistency (Cronbach’s alpha = .78) with this sample.

**Shame** (Appendix F). Participants completed the 25-item Experience of Shame Scale (ESS; Andrews et al., 2002), which is designed to assess trait levels of characterological shame, behavioural shame, and bodily shame. Four aspects of characterological shame are assessed: shame of personal habits, shame about manner with others, shame about the sort of person you are, and shame about personal ability. Three aspects of behavioural shame are assessed: shame about doing something wrong, shame about saying something stupid, and shame about failure in competitive situations. The aspect of bodily shame assessed by the ESS is feeling ashamed of your body or any part of it. Sample items include, “Have you worried about what other people think of the sort of person you are?” (characterological shame), “Have you tried to cover up or conceal things you felt ashamed of having done?” (behavioural shame), and “Have you wanted to hide or conceal your body or any part of it?” (bodily shame). Items are rated on a four-point Likert scale ranging from “Not at All” to “Very Much”, yielding possible total scores that range from 25 to 100. Respondents from the present study reported total shame scores that ranged from
TALKING ABOUT NON-SUICIDAL SELF-INJURY

41 to 100 ($M = 75.68$, $SD = 14.74$). The ESS has been shown to be a psychometrically sounds measure, with good construct and discriminant validity (Andrews et al., 2002). The overall scale showed high internal consistency (Cronbach’s alpha = .94) with this sample.

**Disclosure** (Appendix G). Participants were asked to complete brief screening questions regarding their history of NSSI disclosure(s). Given that there is presently no developed scale for NSSI disclosure, questions were straightforward and designed to screen for a history of NSSI disclosure, ease or difficulty of past NSSI disclosure experiences, and willingness to disclose NSSI in the future. An exploratory factor analysis using principal axis factoring (PAF) was conducted on five disclosure items. The initial eigenvalues supported a two-factor solution (i.e., factor 1 and factor 2 had eigenvalues over 1.0, whereas additional factors did not) and the solution was rotated using oblimin rotation with kaiser normalization for ease of interpretation. On the basis of the PAF results, two disclosure scales were created (for factor loadings see Table 2, below).

The first scale (“disclosure difficulty”) assessed the reported difficulty of past disclosure experiences and included three items: “Thinking about the first time you told someone about your self-injury, how difficult did you find it?”, “Thinking of the easiest time you had telling someone about your self-injury, how difficult did you find it?”, and “Thinking of the most difficult time you had telling someone about your self-injury, how difficult did you find it?”. Each item was measured using a Likert scale ranging from 1 (no difficulty at all) to 7 (the most difficult thing I’ve ever done). Higher scores represented more difficult disclosure experiences. The scale showed an adequate level of internal consistency (Cronbach’s alpha = .79).

The second scale (“future disclosure”) assessed participants’ attitudes toward future disclosures and included two items. The first item asked, “Thinking about possible future
disclosures, how easy or difficult would it be for you to tell someone else about your self-injury?” and was measured using a Likert scale ranging from 1 (no difficulty at all) to 7 (the most difficult thing I’ve ever done). The second item asked, “How likely is it that you will tell someone else about your self-injury?” and was measured using a Likert scale ranging from 1 (not at all likely) to 7 (completely certain). The second item was reversed scored so that higher scores on both items represented less favourable attitudes toward future disclosure experiences. The scale showed a low but acceptable (Murphy & Davidshofer, 1988) internal consistency coefficient (Cronbach’s alpha = .66).

Participants were also asked to indicate to whom they had disclosed (e.g., mother, father, sibling, friend, teacher) and the degree to which responses to disclosures had been supportive.

Table 2.

*Pattern Matrix Factor Loadings and Communalities from Principal Axis Factoring Analysis with Oblimin Rotation*

<table>
<thead>
<tr>
<th>Item</th>
<th>Disclosure difficulty</th>
<th>Future disclosure</th>
<th>Communality</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Thinking about the first time you told someone about your self-injury, how difficult did you find it?”</td>
<td>.99</td>
<td>-.05</td>
<td>.95</td>
</tr>
<tr>
<td>“Thinking of the easiest time you had telling someone about your self-injury, how difficult did you find it?”</td>
<td>.72</td>
<td>-.03</td>
<td>.50</td>
</tr>
<tr>
<td>“Thinking of the most difficult time you had telling someone about your self-injury, how difficult did you find it?”</td>
<td>.45</td>
<td>.38</td>
<td>.47</td>
</tr>
<tr>
<td>“Thinking about possible future disclosures, how easy or difficult would it be for you to tell someone else about your self-injury?”</td>
<td>-.03</td>
<td>.78</td>
<td>.59</td>
</tr>
<tr>
<td>“How likely is it that you will tell someone else about your self-injury?”</td>
<td>-.02</td>
<td>.65</td>
<td>.42</td>
</tr>
</tbody>
</table>
**Scar severity and location** (Appendix H). Participants were asked to describe the presence, location, and severity of wounds and scarring from previous NSSI incidents. Given that there is presently no scale developed to assess scarring as a result of NSSI, participants were asked a series of categorical questions including whether they have any visible scarring (or wounds) as a result of self-injury, whether others have noticed and/or commented on their scars (or wounds), their level of concern regarding their scarring (or wounds), the parts of their body where visible scarring is present, and the severity of the scarring on the area of the body they considered most affected by NSSI scarring.

**Procedure**

Participants were recruited mainly through the University of Guelph participant pool, which allows undergraduate students to participate in research for course credit. Students recruited through the participant pool accessed the study via a secure website operated by the University of Guelph. A smaller group of participants learned about the study via notices placed on course websites. In these instances, the instructor granted course credit for research participation.

Interested persons contacted the principal investigator of this dissertation via email using their University of Guelph email account. They were asked to indicate their consent to participate by copying and pasting into an email the following sentence from the informed consent document available on the project website: *I have read the information provided for the study ‘Understanding factors related to the disclosure of non-suicidal self-injury’ as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.*
Participants were then sent a unique username and password, which allowed them to access the online questionnaires. By completing the questionnaires online, participants were able to fill out the questionnaires at a time and place that was convenient for them. They also had the option to complete one questionnaire at a time or do all of them at once. To ensure that participants’ data remained confidential, they were required to complete an entire questionnaire in one sitting, otherwise the data would not be saved. Furthermore, participants no longer had access to their responses once a questionnaire was complete.

Participation in this study was voluntary and participants had the option to withdraw from the study at any time without penalty. Individuals who participated through the University of Guelph subject pool received one credit point toward their final grade in applicable undergraduate psychology courses. They received course credit regardless of whether they completed the entire study or opted to terminate their participation before completing all questionnaires. Additionally, all participants were informed of the opportunity to hear about the results of the study should they wish to be contacted for follow-up and feedback.

Results: Study 1

Analytic Plan

An a priori power analysis was conducted using G*Power software (Faul, Erdfelder, Buchner, & Lang, 2009) to determine the sample size needed for statistical power. Based on a hypothesized medium effect size ($f^2 = 0.15$; Cohen, 1992), which is the average effect size for social psychological phenomena (Richard, Bond Jr., & Stokes-Zoota, 2003), a minimum sample size of 138 participants was suggested. Following data collection, the data were checked for potential outliers. The distribution of variables was examined using boxplots and frequency distributions. Data that fell outside the range of three standard deviations above and below the
mean were considered outliers. One participant (aged 36 years) fell out of the age range for the
target population (young adults attending university), and this person’s data were removed from
the dataset. An additional three participants were identified as outliers on variables of interest
(e.g., NSSI frequency, self-compassion, shame, self-forgiveness) and thus were removed from
the dataset. A total of 21 additional participants were removed from the dataset due to not
meeting study eligibility requirements (as outlined in the methods section).

The data were also examined for normality using the Shapiro-Wilk test of normality.
While self-forgiveness approximated a normal distribution ($p = .85$), the other variables of
interest were found to be non-normal ($p < .05$). Difficulty of past disclosures, attitude toward
future disclosures, shame, and self-compassion did not indicate extreme levels of skewness or
kurtosis (i.e., statistic less than three times the value of the standard error)$^3$. In contrast, the
number of past disclosure recipient groups and number of past NSSI incidents exhibited more
severe skewness and kurtosis. As such, the number of disclosure recipient groups was square
root transformed and the number of NSSI incidents was log transformed (see Table 3 for
skewness and kurtosis values).

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$^3$ Due to the non-normality of these variables, analyses were also run with transformed shame,
self-compassion, disclosure difficulty, and future disclosure scales. Results were consistent with
non-transformed data.
Table 3.

Skewness and Kurtosis Values for Predictor and Dependent Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Skewness</th>
<th>Standard error</th>
<th>Kurtosis</th>
<th>Standard error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclosure recipients</td>
<td>1.01</td>
<td>.182</td>
<td>.34</td>
<td>.36</td>
</tr>
<tr>
<td>Square Root recipients*</td>
<td>.49</td>
<td>.18</td>
<td>-.58</td>
<td>.36</td>
</tr>
<tr>
<td>Past NSSI incidents</td>
<td>4.40</td>
<td>.18</td>
<td>19.91</td>
<td>.36</td>
</tr>
<tr>
<td>Log NSSI incidents*</td>
<td>.28</td>
<td>.19</td>
<td>-.50</td>
<td>.38</td>
</tr>
<tr>
<td>Shame</td>
<td>-.46</td>
<td>.20</td>
<td>-.53</td>
<td>.39</td>
</tr>
<tr>
<td>Self-compassion</td>
<td>.51</td>
<td>.20</td>
<td>.33</td>
<td>.39</td>
</tr>
<tr>
<td>Self-forgiveness</td>
<td>.01</td>
<td>.20</td>
<td>-.10</td>
<td>.39</td>
</tr>
<tr>
<td>Disclosure difficulty</td>
<td>-.63</td>
<td>.21</td>
<td>.13</td>
<td>.41</td>
</tr>
<tr>
<td>Future disclosure</td>
<td>-.44</td>
<td>.21</td>
<td>-.29</td>
<td>.42</td>
</tr>
</tbody>
</table>

* Transformed

Next, descriptive statistics and Pearson correlations between variables were calculated. Given the significant correlations between the predictors, independent variables (i.e., shame, self-forgiveness, and self-compassion) were centered using grand-mean centering to reduce the impact of multicollinearity. A series of multiple linear regressions were conducted to explore the relations between the predictor variables (shame, self-forgiveness, and self-compassion) and the dependent variables (number of past disclosure recipient categories, difficulty of past disclosure experiences, and attitude toward future disclosure). Next, the relation between shame, scarring and NSSI disclosure was explored via a series of hierarchical linear regression analyses.

Descriptive Statistics

Approximately 84% of the sample self-identified as being White or of European descent, while the remaining participants reported belonging to various ethnicities, including Asian, First
Nations, Middle Eastern, African-Canadian, Hispanic, and mixed ethnic backgrounds. Participants endorsed various methods of NSSI, including cutting, biting, burning, carving, severe scratching, pinching, self-hitting, and sticking self with needles. Ninety-two percent (n=165) of participants reported using multiple methods of NSSI (e.g., cutting and burning), while 7.8% (n=14) reported using only one method. Approximately 50% (n = 90) of participants endorsed cutting as their primary method of self-injury, 11% (n = 21) endorsed self-hitting or banging, 8% (n = 14) endorsed severe scratching, and 4% (n = 7) endorsed biting. Other primary methods of self-injury (e.g., burning, carving, pinching) were each endorsed at a proportion of 3% or less. An aggregate NSSI frequency score was computed by summing participants’ lifetime incidents for each of the various methods of self-injury. This aggregate score ranged from five lifetime incidents of self-injury to 2410, with a mean score of 181.55 (SD = 333.92). Approximately 69% (n = 123) of respondents reported that they had engaged in NSSI within the year prior to taking part in the survey. Seventy-eight percent (n = 138) of respondents reported a desire to stop self-injuring (either current or past, depending on whether they identified as recovered at the time of the survey).

Participants also reported on their disclosure experiences, including various types of disclosure recipients (e.g., friends, family, mental health professionals, etc.). Approximately 22% of respondents (n = 40) reported that they had not disclosed to anyone in the past. Although data concerning the number of individuals disclosed to was not collected, participants did report the different categories of recipients to whom they had disclosed. Approximately 24% (n = 43) reported having disclosed to one type of recipient (e.g., peers), while 21% (n = 37) reported having disclosed to two different types of disclosure recipients. A cumulative disclosure variable was computed by summing the different categories of disclosure recipients reported by each
respondent, in order to provide a proxy for the number of past disclosures. Responses ranged from 0 (i.e., no past disclosures) to 12 (i.e., disclosures had been made to every type of recipient listed), with an average of 3.25 types of disclosure recipients ($SD = 2.70$). In terms of the recipient group most commonly disclosed to, 47.5% ($n = 85$) of respondents reported that they had first disclosed to a friend, while 19% ($n = 34$) had first disclosed to a romantic partner, 7% ($n = 12$) had first disclosed to their mother, and 6% ($n = 11$) had first disclosed to a sibling. A smaller proportion of first disclosures were spread across various recipient groups (see Table 4).

Table 4.

Disclosure Recipients

<table>
<thead>
<tr>
<th>Disclosure Recipient Group</th>
<th>First Disclosure</th>
<th></th>
<th>Subsequent Disclosures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
<td>%</td>
</tr>
<tr>
<td>Friend</td>
<td>85</td>
<td>47.5</td>
<td>69</td>
<td>38.5</td>
</tr>
<tr>
<td>Romantic partner</td>
<td>34</td>
<td>19.0</td>
<td>58</td>
<td>32.4</td>
</tr>
<tr>
<td>Mother</td>
<td>12</td>
<td>6.7</td>
<td>45</td>
<td>25.1</td>
</tr>
<tr>
<td>Sibling</td>
<td>11</td>
<td>6.1</td>
<td>32</td>
<td>17.9</td>
</tr>
<tr>
<td>Mental health professional</td>
<td>10</td>
<td>5.6</td>
<td>53</td>
<td>29.6</td>
</tr>
<tr>
<td>Father</td>
<td>9</td>
<td>5.0</td>
<td>28</td>
<td>15.6</td>
</tr>
<tr>
<td>Guidance counselor</td>
<td>6</td>
<td>3.4</td>
<td>24</td>
<td>13.4</td>
</tr>
<tr>
<td>Teacher</td>
<td>6</td>
<td>3.4</td>
<td>9</td>
<td>5.0</td>
</tr>
<tr>
<td>Anonymous Internet interaction</td>
<td>5</td>
<td>2.8</td>
<td>20</td>
<td>11.2</td>
</tr>
<tr>
<td>Medical Doctor</td>
<td>2</td>
<td>1.1</td>
<td>27</td>
<td>15.1</td>
</tr>
<tr>
<td>Other family member</td>
<td>2</td>
<td>1.1</td>
<td>11</td>
<td>6.1</td>
</tr>
<tr>
<td>Non-anonymous Internet interaction</td>
<td>1</td>
<td>0.6</td>
<td>13</td>
<td>7.3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1.7</td>
<td>7</td>
<td>3.9</td>
</tr>
</tbody>
</table>
Participants also rated the response received from the disclosure recipient of their most difficult disclosure experience ($M=4.84; SD=2.02$), with response options ranging from 1 (not supportive at all) to 7 (incredibly supportive). Of those who had disclosed previously, 30% of respondents rated the response as being incredibly supportive, while only 12% rated the response as not supportive as all (see Figure 1, below).

![Figure 1. Response of disclosure recipient during most difficult disclosure experience](image)

Seventy-two percent ($n = 129$) of respondents reported that they had visible scarring from NSSI. Of those, 57% ($n = 74$) reported having more conspicuous scarring, such that others had both noticed and commented on their scars in the past. While the remaining 43% ($n = 55$) of this subset of respondents considered their scarring to be visible, they reported that others had not commented about it in the past. Twenty-six percent ($n = 46$) of respondents reported having no visible scarring from self-injury.
Associations between Shame, Self-compassion, Self-forgiveness, and Disclosure Scales

**Shame.** Pearson (r) correlations were computed between shame, self-compassion, self-forgiveness, number of disclosure recipients, past disclosure difficulty, attitude toward future disclosures, past NSSI incidents, and the presence of scarring from NSSI (see Table 3 for summary of correlation coefficients). Shame was negatively associated with both self-compassion, $r(155) = -.64, p < .001$, and self-forgiveness, $r(168) = -.58, p < .001$; as participants reported higher levels of shame, they also reported lower levels of self-compassion and self-forgiveness. Self-compassion and self-forgiveness were positively associated with one another, $r(158) = .73, p < .001$, meaning that participants who reported higher trait self-compassion scores tended to also report higher trait self-forgiveness scores. Neither shame nor its subscales showed a significant association with the number of disclosure recipient categories ($p > .05$). Shame did, however, significantly and positively associate with reported difficulty of past disclosure experiences, $r(128) = .27, p = .002$, and a reluctant attitude toward future disclosure experiences, $r(131) = .21, p = .016$, meaning that participants who reported higher trait levels of shame also reported more difficult disclosure experiences and a lower likelihood of disclosing their NSSI in the future.

**Self-forgiveness.** Self-forgiveness did not associate significantly with the number of disclosure recipients ($p > .05$), however, it did show a trend-level negative association with difficulty of past disclosure experiences, $r(135) = -.16, p = .059$, meaning that participants who reported lower levels of trait self-forgiveness also reported more difficult past disclosure experiences. Self-forgiveness did not associate with attitude toward future disclosures ($p > .05$).

**Self-compassion.** Overall, self-compassion did not associate significantly with the number of disclosure recipients ($p > .05$). The over-identify subscale of the self-compassion
construct did exhibit a small, negative association with the number of disclosure recipients, $r(174) = -.16, p = .037$, meaning a higher tendency to over-identify with emotional experiences associated with a lower number of disclosure recipients (as measured by the number of recipient categories). Self-compassion also did not associate significantly with either disclosure scale ($p > .05$), however it did negatively associate at trend-level with difficulty of past disclosure experiences ($p = .070$), meaning as trait self-compassion scores decreased, reported difficulty of past disclosures increased.

**Disclosure scales.** The number of past disclosure recipient types significantly and negatively associated with attitudes toward future disclosures, $r(138) = -.36, p < .001$, meaning the higher the number of different disclosure recipient types, the more positive respondents’ attitudes were toward potential future disclosures. The number of past disclosure recipients positively associated with number of past NSSI incidents, $r(179) = .28, p < .001$, and severity of NSSI scarring, $r(175) = .44, p < .001$, indicating that participants who had disclosed to more recipients had engaged in NSSI more frequently and had more severe scarring related to NSSI.
Table 5.

*Pearson (r) Correlations between NSSI Variables, Disclosure Variables, and Trait-level Shame, Self-compassion, and Self-forgiveness*

<table>
<thead>
<tr>
<th></th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Self-compassion</td>
<td>--</td>
<td>--</td>
<td>.73**</td>
<td>- .13</td>
<td>- .17</td>
<td>- .081</td>
<td>- .27**</td>
<td>- .16*</td>
</tr>
<tr>
<td>3. Self-forgiveness</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>- .044</td>
<td>- .16</td>
<td>- .12</td>
<td>- .25**</td>
<td>- .15</td>
</tr>
<tr>
<td>4. Disclosure recipients</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>- .089</td>
<td>- .36**</td>
<td>.28**</td>
<td>.44**</td>
</tr>
<tr>
<td>5. Disclosure difficulty</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>.33**</td>
<td>.068</td>
<td>.18*</td>
</tr>
<tr>
<td>6. Future disclosure</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>- .15</td>
<td>- .050</td>
</tr>
<tr>
<td>7. Past NSSI incidents</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>.24**</td>
</tr>
<tr>
<td>8. NSSI scarring</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Note: Disclosure recipients = Number of past disclosure recipient groups  
Disclosure difficulty = Reported difficulty of past disclosure experiences  
Future disclosure = Attitude toward future disclosure experiences (where higher values correspond to reluctant attitude to disclose in future)  
* = p < .05; ** = p < .001

**The Relation between Shame, Self-compassion, Self-forgiveness, and NSSI Disclosure**

Two simultaneous linear regression analyses were conducted to examine the extent to which trait levels of shame, self-compassion, and self-forgiveness predicted the self-reported difficulty of past disclosure experiences and attitudes toward future disclosure opportunities. Together the variables accounted for 6.7% of the variance in difficulty of past disclosures, \( R^2 = .067, F(3, 113) = 2.72, p = .048 \); however, only shame uniquely predicted past disclosure difficulty, \( b = .077, t(116) = 2.19, p = .030, sr^2 = .040 \), with higher levels of shame predicting more difficult disclosure experiences. This represents a small to medium effect.
In terms of attitudes toward future disclosures, although the total model did not account for a significant proportion of the variance, $R^2 = .049$, $F(3, 114) = 1.97$, $p = .123$, shame alone did significantly predict attitudes toward future disclosure, $b = .053$, $t(117) = 2.24$, $p = .027$, $sr^2 = .042$, with higher levels of shame predicting more negative attitudes toward future disclosure opportunities.

**A Closer Look at the Relation between Shame, Scarring, and NSSI Disclosure**

Pearson ($r$) correlations were computed to assess the relation between the degree of self-reported visibility of NSSI scarring and the three facets of shame measured (i.e., characterological, behavioural, and bodily-related shame). More visible scarring (e.g., others had both noticed and commented on scarring) was associated with higher levels of self-reported bodily shame, $r(175) = .19$, $p = .011$, indicating that those with perceived visible scarring from NSSI endorsed higher levels of bodily-related shame. Self-reported visible scarring from NSSI did not significantly associate with higher levels of characterological shame or behavioural shame ($p > .05$).

Next, three hierarchical linear regressions were computed to determine the extent to which levels of shame, the presence of scarring, and the interaction between shame and scarring predicted the number of past disclosure groups, difficulty of past disclosure experiences and attitudes toward future disclosure, while controlling for the approximate number of past self-injury incidents.

**Number of past disclosure groups.** To control for past NSSI incidents, disclosure recipient groups was regressed on participants’ aggregate NSSI scores (log transformed). The number of previous NSSI incidents accounted for 12.5% of the variance in number of different disclosure groups, $F (1, 169) = 24.04$, $p = .0001$. Next, degree of shame (grand-mean centered),
presence of scarring from self-injury (dummy variable where 0 = visible scarring and 1 = no scarring), and their interaction term were added to assess their incremental utility in predicting the number of past disclosure groups. Together these variables accounted for an additional 27.5% of variance in number of disclosure recipient groups, $\Delta F(4, 169) = 15.64, p = .0001$, indicating a large effect (Cohen, 1992). Only the presence of scarring accounted for a unique proportion of the variance, $b = -5.53, t(168) = -5.45, p = .0001, sr^2 = .13$, indicating that respondents with visible scarring had disclosed to significantly more types of recipients, and presumably, have had more disclosure experiences.\(^4\)

**Past disclosure difficulty.** First, past disclosure difficulty was regressed on participants’ aggregate NSSI scores (log transformed). Results indicated that the number of previous NSSI incidents did not account for significant variance in past disclosure difficulty, $F(1, 127) = .40, p = .53$. After accounting for the variance in past NSSI frequency, degree of shame (grand-mean centered), presence of scarring from self-injury (dummy variable), and their interaction term were added to assess their incremental utility. Together these variables accounted for an additional 13.6% of variance in difficulty of past disclosures, $\Delta F(4, 127) = 4.84, p = .001$, representing a medium effect size. Shame accounted for a unique proportion of the variance in disclosure difficulty, $b = .074, t(126) = 2.56, p = .012, sr^2 = .046$, as did presence of scarring, $b = -2.56, t(126) = -2.92, p = .004, sr^2 = .060$. This suggests that higher trait-level shame associates with more difficult past disclosure experiences, as does the presence of visible scarring from NSSI. The interaction between shame and scarring did not significantly account for variance in difficulty of past disclosure ($p = .63$).

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\(^4\) A Poisson regression was run to address the fact that one of the assumptions underlying ordinary least squares regression (i.e., continuous data) was not met. Results were consistent with those found using linear regression.
To examine the impact of the various aspects of shame on past disclosure difficulty, another hierarchical regression was computed. Participants’ aggregate NSSI scores were entered into the first step of the regression equation to control for NSSI severity. Presence of scarring from self-injury (dummy variable) and the character shame, behaviour shame, and body shame subscales (all grand-mean centered) were entered simultaneously into the next step of the regression equation. While none of the subscales accounted for significant unique variance in past disclosure difficulty, character shame (i.e., shame experienced about one’s character) exhibited a trend-level association, $b = .121$, $t(126) = 1.75$, $p = .083$, $sr^2 = .021$, suggesting that shame about the sort of person one is may be the most relevant aspect of shame the difficulty of disclosing NSSI.

**Attitude toward future disclosures.** In the final set of regression analyses conducted, attitude toward future disclosures was first regressed on participants’ aggregate NSSI scores (log transformed). The number of previous NSSI incidents accounted for 3.4% of the variance in attitudes toward future disclosures, $F(1, 130) = 4.48$, $p = .036$. After accounting for the variance in past NSSI frequency, degree of shame (grand-mean centered), presence of scarring from self-injury (dummy variable), and their interaction term were added to assess the extent to which they predicted attitudes toward future disclosures. Together these variables accounted for an additional 10.9% of the variance in attitudes toward future disclosures, $\Delta F(4, 130) = 3.85$, $p = .006$, with only shame accounting for a unique proportion of the variance, $b = .053$, $t(129) = 2.72$, $p = .007$, $sr^2 = .052$. This suggests that higher trait-levels of shame are associated with more negative attitudes toward future disclosure experiences (i.e., reported lower likelihood of disclosing in the future and higher anticipated difficulty of potential disclosure experiences).
To examine the impact of various aspects of shame on attitudes toward future disclosure, the future disclosure scale was regressed on presence of scarring from self-injury (dummy variable), character shame subscale, behaviour shame subscale, and body shame subscale (all grand-mean centered), after first controlling for the number of NSSI incidents. Character shame was the only aspect of shame that accounted for a significant portion of variance in attitude toward future disclosures, $b = .097$, $t(129) = 2.09$, $p = .039$, $r^2 = .031$, suggesting that those with higher degrees of character-related shame have more negative attitudes toward future disclosure experiences.

**Discussion: Study 1**

This study explored the impact of feelings of shame, self-forgiveness, self-compassion, and perceived presence of scarring from NSSI on individuals’ experiences of, and attitudes toward, NSSI disclosure. While approximately half of respondents endorsed cutting as their primary method of NSSI, the majority (92%) reported engaging in more than one method of self-injury; both findings are consistent with past research examining NSSI among young adults (Gratz, 2001; Whitlock et al., 2006a). Participants varied greatly in the extent of their NSSI, with some reporting as few as five past NSSI incidents and others reporting past NSSI episodes in the thousands. There are a number of potential reasons for this large discrepancy. First, there is considerable variability in individuals’ experience with NSSI, and it is reasonable to expect there would be a range in past NSSI incidents. The nature of the measure used to assess participants’ NSSI characteristics also likely impacted the variability in NSSI estimates. Research has shown that providing a list of possible forms of injury (e.g., cutting, scraping, biting, etc.) results in higher incidence reporting (Heath, Toste, Nedecheva, & Charlebois, 2008). As a result of this variability, the total number of NSSI incidents was controlled for in disclosure analyses.
The majority of respondents (78%) reported a desire to stop self-injuring (either current or past, depending on whether they were actively engaging in NSSI at the time of the survey). While NSSI cessation can occur with and without others knowing about the behaviour, research suggests that sharing stigmatized identities with others can lead to greater feelings of self-acceptance and wellbeing, and can facilitate future disclosure experiences (Chaudoir, 2009; Pachankis, 2007), and, for some, aid in recovery (Pietrusza et al., 2010). As such, it was concerning that 22% of respondents had not disclosed their NSSI to anyone before (though consistent with past research investigating NSSI disclosure; Pietrusza et al., 2010; Whitlock et al., 2006a). In keeping with past research (Heath et al., 2009; Muehlenkamp et al., 2013; Pietrusza et al., 2011), peers were the most common disclosure recipients, with almost half (47.5%) of respondents having first disclosed to a friend and 19% having first disclosed to a romantic partner. Importantly, the helpfulness of conversations about NSSI can vary greatly, and the impact of negative responses to disclosures of NSSI can bring more harm than good (Ahrens, 2006; Pachankis, 2007). Past research has found peer conversations about NSSI to be mostly unhelpful (Pietrusza et al., 2011) and an improved understanding of the factors that contribute to positive and negative disclosure experiences is needed. A more in-depth look at the experience of disclosing NSSI and helpful and unhelpful responses to disclosure will be explored in Study 2.

**Shame, Self-compassion, Self-forgiveness, and Disclosure**

As predicted (H5), shame negatively associated with self-forgiveness and self-compassion, while self-forgiveness and self-compassion positively associated with one another. Shame typically arises from a state of self-devaluation, and often entails relating to oneself through a harsh and judgmental lens (Lewis, 1971). As such, it follows that individuals high in shame would experience little compassion or forgiveness for themselves, as these traits require
one to abandon self-resentment, in the case of self-forgiveness (Hall & Fincham, 2005), and be kind to oneself in instances of pain and failure (Neff et al., 2007a), in the case of self-compassion. Individuals low in self-forgiveness show a tendency toward self-criticism (Wester et al., 2012), a concept closely related to shame. Further, self-compassion has been labeled the “antidote” to feelings of shame (Gilbert, 2005) and has been proposed as an important component of interventions targeting shame (Gilbert, 2009); thus, one would expect these constructs to be negatively correlated.

Consistent with predictions (H1b, H1c), shame positively associated with reported difficulty of past disclosures and a reluctant attitude toward future disclosure experiences. Shame is associated with an action tendency to hide the self from others (Lindsay-Hartz, 1984). Disclosure, and particularly disclosure of a stigmatized behaviour like NSSI, requires one to present vulnerable, and potentially embarrassing, facets of the self to others – an act that directly opposes the desire to hide. It makes sense that individuals who experience high levels of shame would find the process of disclosing NSSI to others difficult and would have reservations about disclosing NSSI in the future. While the association between shame and NSSI disclosure has not been examined previously, this finding is consistent with research examining the relation between shame and disclosure more broadly. Shame has been found to associate with a reticence to disclose emotional distress to friends, family, and professionals (MacDonald & Morley, 2001) and avoidance of seeking treatment for emotional and mental health concerns (Corrigan, 2004; Hinshaw & Cicchetti, 2000).

Both self-forgiveness and self-compassion showed a trend-level negative association with difficulty of past disclosures. Self-forgiveness and self-compassion require individuals to exercise a degree of kindness toward themselves (Hall & Fincham, 2008; Neff, 2007), so it may
not be surprising that lower levels of these traits associated with a perception of past disclosures as being more difficult. Past research has found that individuals who engage in NSSI and endorse lower levels of self-forgiveness report engaging in NSSI for reasons including self-punishment (Westers et al., 2012). In fact, “self-hatred” and “angry at self” were reported as feelings precipitating nearly half of instances of NSSI in an ecological momentary assessment study conducted by Nock and colleagues (2009). If NSSI represents a form of atonement for individuals low in self-forgiveness, it is understandable that these individuals would experience disclosures as being particularly difficult. Not only would their reason for engaging in NSSI be particularly personal, individuals low in self-forgiveness may not believe they deserve understanding or forgiveness for their actions, making disclosures difficult and potentially invalidating. Similarly, individuals low in self-compassion may struggle to approach disclosures with self-kindness and a sense of common humanity (e.g., humans are imperfect and failure is part of the human condition), or may believe they are not deserving of the compassion of others, thereby making NSSI disclosures more difficult. Conversely, individuals with higher levels of self-compassion may be more likely to see themselves as worthy and deserving of care and support, which in turn could help to counter feelings of shame that may accompany NSSI and make disclosure experiences less difficult. It is important to note that constructs in this study were measured using retrospective self-report methodology. It is possible that individuals low in self-forgiveness and self-compassion not only experienced their disclosures as being more difficult at the time, but also recalled them as being more difficult when reflecting on the experience.

It is interesting that, contrary to predictions (H1a, H3a, H4a), shame, self-compassion, and self-forgiveness did not relate to the number of disclosure recipients reported by participants.
It is possible that the number of disclosure recipient groups (e.g., friends, romantic partners, siblings) was not a good proxy for the number of disclosure experiences, or for openness to disclose more broadly. For example, a participant who had disclosed to one friend, one parent, and one teacher would have had a higher disclosure score than a participant who had disclosed to five friends, despite the fact that the second individual had disclosed to more people overall. Perhaps asking participants for the total number of individuals to whom they had disclosed would have better approximated openness about NSSI. It may also be that shame, self-compassion, and self-forgiveness do not relate to the number of disclosures and that other factors have more salience in these contexts. For example, questions that prompt conversations about NSSI (i.e., those related to the presence of scars or wounds from NSSI) may be a more pertinent factor in determining the number of disclosure experiences, as opposed to characteristics related to an individual’s openness about NSSI. Another factor that may play a role is the quality of interpersonal relationships a young person has. Individuals with supportive familial and peer relationships may be more inclined to disclose difficult personal information, such as a history of NSSI, even in the context of feelings of shame. Individuals who consider themselves to be further along in the recovery process (e.g., no longer engaging in NSSI or actively trying to stop) may also be more open to disclosing their NSSI.

Finally, respondents who had disclosed to a greater number of recipient groups (e.g., friends, romantic partners, siblings) reported more positive attitudes toward potential future disclosures. These results are consistent with the feedback loop proposed in the Disclosure Process Model (Chaudoir & Fisher, 2010): disclosure events associated with positive outcomes (e.g., enhanced well-being) serve to increase the likelihood of future disclosures (Chaudoir & Fisher, 2010). Research conducted with people living with HIV/AIDS found that individuals
who experienced a positive and supportive disclosure were more likely to participate in subsequent disclosures (Chaudoir, 2009). Approximately 65% of participants in the present study who had previously disclosed their NSSI reported that responses to their most difficult disclosure experience ranged from moderately supportive to incredibly supportive. Only 12% of participants perceived the response to their disclosure as not supportive at all. As such, it is possible that previous acts of disclosing NSSI helped to cultivate more positive attitudes toward future disclosures, particularly for those participants who had received supportive responses to their disclosures.

Together, shame, self-compassion, and self-forgiveness predicted how difficult participants’ past disclosures had been; however, only shame offered unique predictive utility, with higher levels of shame predicting more difficult disclosure experiences. These results indicate that shame may be particularly salient in the NSSI disclosure process, which is consistent with the documented role of shame in the concealment of other mental health concerns (e.g., Corrigan, 2004; Hinshaw & Cicchetti, 2000; MacDonald & Morley, 2001). That shame would be more central in explaining the difficulty of disclosure experiences than either self-compassion or self-forgiveness is interesting, although not entirely surprising given its’ importance in disclosure processes more generally. Research investigating the role of self-compassion in eating disorder recovery found that individuals who showed no change in eating disorder symptomatology over the course of a 12-week treatment program were not only low in self-compassion but also high in fear of self-compassion (Kelly et al., 2012). Kelly and colleagues proposed that patients who were fearful of self-compassion might have avoided sharing their feelings and eliciting support from others throughout treatment, thereby accounting
for their poor treatment response. Given these findings, perhaps it would be fruitful to examine the role of fear of self-compassion in the disclosure of NSSI in the future.

**Shame, Scarring, and NSSI Disclosure**

Seventy-two percent of respondents reported having visible scarring from NSSI. Of those, more than half shared that others had both noticed and commented on their scarring in the past. The impact of scarring from NSSI has been largely neglected in the NSSI literature, despite the potential long-term consequences of having visible remnants associated with a behaviour that carries considerable social stigma (Hodgson, 2004). The large proportion of respondents reporting visible scarring underscores the need for research examining the impact of scarring from NSSI. Scarring is an interesting component of NSSI; its presence ostensibly differentiates it in some ways from other mental health concerns (e.g., depression, anxiety). In this way NSSI straddles the boundary between a stigmatized behaviour that is and is not concealable, depending on the presence and visibility of scarring. As previously noted, researchers have found that the act of concealing personal information is associated with negative emotional outcomes (Frable et al., 1998; Pachankis, 2007). The participants in this study who endorsed higher degrees of scarring visibility (as measured by whether others had both noticed and commented on their scars) endorsed higher levels of bodily-related shame, suggesting that those with visible scars from NSSI may grapple with shame about their body or certain parts of it. As such, it seems fair to suggest that the disclosure process would be influenced by the relative concealability of one’s NSSI. Individuals who are able to conceal signs of their NSSI (e.g., those without visible scarring or scarring only in areas of the body that are easily covered) may have more flexibility in determining when to disclose, how to disclose, and to whom to disclose. In contrast,
individuals with visible scarring may be compelled to disclose at inopportune times and on terms that are not their own.

That perceived visible scarring uniquely predicted the number of disclosure recipients (as measured by the number of different recipient categories disclosed to) is not surprising. Preliminary research suggests that the visibility of NSSI scars may be more salient for psychosocial functioning than other scar features, like size (Dyer et al., 2013). Specifically, Dyer and colleagues found scar noticeability, but not scar size, to associate with negative body image. The association between perceived visible scarring and disclosure found in the present study may relate to the tendency for visible scars to precipitate questioning and conversations about NSSI; individuals with visible scarring are more likely to receive questions that may lead them to disclose than individuals without visible scarring. Even if an individual has recovered from NSSI he or she may have to contend with continued disclosure conversations if visible scarring remains.

Together, shame and perceived visible scarring predicted more difficult past disclosure experiences. Considered individually, it makes sense that possessing higher levels of shame and visible scarring would both contribute to more difficult disclosures. A fear of negative evaluation and rejection associate with shame (Pachankis, 2007); individuals high in shame may find disclosing NSSI particularly difficult, as it requires them to tolerate these uncomfortable negative feelings while sharing a vulnerable aspect of themselves. Visible scars, on the other hand, may prompt discussions about NSSI, leading individuals to promptly decide whether to disclose without the benefit of having time to plan and prepare. Considered together, however, the impact of high levels of shame and visible scarring from NSSI may be even more painful. Conceptually, shame is associated with a desire to hide oneself from others (Lindsay-Hartz, 1984). Individuals
with visible scarring may have more difficulty concealing their NSSI, especially if the scars are on more visible parts of the body (e.g., lower arms, wrists). If this is the case, individuals who experience greater shame (and, likely, a greater desire to conceal their NSSI), but who are compelled to disclose due to the presence of scarring, may experience disclosures as being more difficult.

Shame alone uniquely predicted more negative attitudes toward future disclosures (i.e., reported lower likelihood of disclosing in the future and higher anticipated difficulty of potential disclosure experiences). Again, given shame’s association with NSSI more generally (Brown et al., 2009; Gilbert et al., 2010), as well as its association with the concealment of emotional distress (MacDonald & Morley, 2001) and mental illness (Corrigan, 2004), it is understandable that shame would associate with a reluctance to disclose NSSI to others. Individuals who experience high levels of shame likely do not want to disclose their NSSI, and therefore anticipate a low likelihood of future disclosure and a greater anticipated difficulty of potential disclosures. Notably, scarring did not account for significant variance in attitude toward future disclosures. It may be that the mechanism by which scarring impacts disclosure (i.e., eliciting disclosures at inopportune and unwanted times) is important in the context of past disclosure difficulty, but less relevant for future disclosure likelihood and anticipated difficulty. Some individuals with visible scarring who have been forced to disclose on terms that were not their own may assume that future disclosures are inevitable, whereas others may have resolved to better conceal their scars or respond to inquiries in a manner they feel comfortable with (e.g., decline to discuss).

When the impact of shame was examined at the level of the character, behaviour, and body shame subscales, character-related shame was found to account for the most variance in
disclosure difficulty and attitude toward future disclosures. This is consistent with research examining disclosure in the context of treatment for eating disorders, which found that non-disclosure associated with higher levels of characterological shame (Swan & Andrews, 2003). Given that negative feelings about one’s habits and character are particularly personal and disclosure is often an intimate and exposing act, it follows that characterological shame would make disclosure experiences especially difficult and negatively impact feelings about future disclosure possibilities.

**Conceptual and Clinical Implications**

This study was one of only a few investigations into the process of NSSI disclosure and the first to collectively examine the role of shame, self-forgiveness, self-compassion, and scarring from NSSI specifically. Disclosure has largely been overlooked in the NSSI literature and a better understanding of the factors that promote and discourage conversations about NSSI or simply make the disclosure experience more challenging is important for a number of reasons. For one, disclosure may play a role in recovery from NSSI, as one aspect of getting help for self-injury is talking about it. Given the increased risk of suicidality (Glenn & Klonsky, 2009; Klonsky & Olino, 2008; Whitlock & Knox, 2007) associated with NSSI, it is important to target NSSI in treatment. NSSI also associates with emotional distress and psychiatric concerns (e.g., depression, anxiety, etc.; Klonsky & Olino, 2008; Nock, Prinstein, & Sterba, 2009; Whitlock et al., 2006a). Oftentimes these concerns may be part of what underlies the behaviour (Klonsky, 2007; Nock et al., 2009; Whitlock et al., 2006a). As such, not only is it important to encourage the disclosure of NSSI to access treatment for the behaviour itself, but also because treatment may address the emotional concerns with which it associates.
While it is true that some individuals recover from NSSI without disclosing to anyone, this means that they have to contend with the emotional distress associated with NSSI and NSSI concealment alone. Disclosure of NSSI is, therefore, important to understand on the basis of its therapeutic value alone. Disclosure to trusted and supportive others should be promoted if only to increase the informal emotional support available for individuals struggling with NSSI and to guard against the negative consequences associated with concealment (Cepedo-Benito & Short, 1998; Pachankis, 2007). As a result, it is important to not only understand the personal characteristics associated with difficult (or positive) disclosure experiences, but also delineate the types of responses that lead to positive disclosure outcomes.

The results of this study suggest that it may be useful to target trait-level shame (e.g., shame-based patterns of thought, shameful feelings about NSSI, and shame related to the self) in interventions for NSSI and mental health more broadly, especially, in programs promoting the healthy disclosure of mental health difficulties, including NSSI. Shame (and, in particular, characterological shame), was found to predict both the difficulty of past disclosure experiences and attitudes toward future disclosures. As such, it may be useful to incorporate shame reduction tactics and messages into educational programs targeting NSSI and other symptoms of psychopathology. Concepts drawn from Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) and Compassion Focused Therapy (CFT; Gilbert, 2009), may help to counter feelings of shame by promoting acceptance, emotional distance from critical thoughts, and self-compassion. It has been proposed that practicing the skills of self-compassion (e.g., compassionate imagery, reasoning, and behaviour) may be particularly important for individuals high in shame and self-criticism (another trait that has been found to associate with NSSI; Gilbert & Procter, 2006; Gilbert, 2009; Gilbert et al., 2010). Given that continued concealment
can heighten feelings of shame and lead to other psychosocial difficulties, the results of this study underscore the importance of having conversations about NSSI with others.

The results of this study also highlight the need to further explore the impact of scarring from NSSI, including how it relates to disclosure. A large portion of the sample reported having visible scars as a result of NSSI and many shared that others had both noticed and commented on those scars. The presence of visible scarring from NSSI predicted the difficulty of disclosure experiences, such that individuals with visible scars reported more difficult disclosures, as well as a higher number of disclosure recipient groups. If individuals with visible scarring are disclosing more frequently, yet having more difficult disclosure experiences, it is important to determine exactly what is leading to their distress and how to help make those conversations less aversive. Importantly, the long-term socioemotional impact of living with scars from NSSI, including how they might impact relational and professional prospects, is not presently known. It may be pertinent to incorporate information about scarring from NSSI into intervention and educational programs (e.g., addressing bodily shame associated with scarring), however more information is needed to determine how best to target this sensitive topic.

One possible stakeholder group with which to share information about the impact of scarring from NSSI are those who may be asked to treat them: physicians, psychotherapists, and other mental health professionals. Indeed, if a client is in the process of recovery from NSSI and has NSSI-related scarring, facilitating acceptance of scars and preparing for possible inquiries about the scars may be a focus of treatment. Compassion-focused therapy (CFT; Gilbert, 2009) may be a useful treatment approach to help clients build acceptance of their scars and relate to themselves more compassionately. In CFT, the therapist aims to help the client internalize the
skills of self-compassion by demonstrating and modeling the skills and attributes of compassion (Gilbert, 2009).

It is also important to highlight the finding that responses to NSSI disclosure in this sample were overwhelmingly supportive. Approximately two-thirds of respondents reported that responses to their most difficult disclosure had been supportive. Given that there remains considerably stigma associated with NSSI, it is imperative for youth and young adults to know that many of their peers have had positive disclosure experiences.

**Limitations and Future Directions**

The exploratory nature of this study necessitated the creation of scales and questionnaires designed to target NSSI scarring and disclosure. Unfortunately, it was not possible to validate those scales prior to collecting data and there are a number of associated limitations as a result. Although information was collected about specific recipients participants had disclosed to (e.g., mother, father, sibling), for disclosure recipient categories where more than one disclosure might have taken place (e.g., friends), we were only able to determine whether participants had ever disclosed to a friend, not the number of friends to which they disclosed. The number of disclosure recipient categories endorsed by participants was used as a proxy for the number of disclosure experiences and provided an indication of participants’ relative openness regarding their NSSI; however it would have been helpful to also have an estimate of the number of disclosure conversations participants had engaged in. It is possible that the lack of association between number of disclosure recipients and shame, self-compassion, and self-forgiveness was, in part, due to this imperfect measurement of participants’ disclosure experiences. Further, the disclosure difficulty and future disclosure scales were respectively comprised of three and two items each. Although this structure was supported by the factor analysis that was conducted,
including more items would have increased the internal consistency of the scales. Future research should seek to replicate the factor structure with another sample.

Another potential limitation related to the creation of the disclosure scales is that in some instances participants’ first and most difficult (or easiest) disclosure experiences may have been one and the same. As items related to participants’ first, easiest, and most difficult disclosure experiences were summed to create the ‘past disclosure difficulty’ scale, this oversight may have artificially inflated the scale. Future research should seek to clarify and control for this confound.

The data for this study were collected via a secure online survey, allowing participants to complete the study in the comfort and privacy of their own home. While this may have enabled participants to respond to questions in a forthright manner, it also did not afford them the benefit of clarifying any questions about the study content or what they were being asked to do. It also meant that all data was self-reported and, as such, subject to potential errors in reporting. Along similar lines, much of the data collected was retrospective in nature and, therefore, subject to potential errors in recollection. Future research ought to adopt prospective approaches or ask participants about the temporal nature of their disclosure experiences.

The study sample itself may limit the generalizability of results. Young adults are considered by some to be the highest risk group for NSSI (Rodham & Hawton, 2009) and thus are an important group with which to explore NSSI and the disclosure of NSSI. That being said, research conducted with this group may not generalize to other groups at risk for NSSI, such as adolescents. Further, this sample was a community sample of relatively high functioning young adults in a university setting, the majority of whom were women of White or European descent. This limits the generalizability of the study findings to other populations, such as young adults.
from differing ethnic groups and those whose mental health difficulties severely impact functioning (e.g., clinical populations).

In addition to the above, while the aim of this study was to understand the extent to which certain personal factors facilitate or hinder the disclosure process, this study captured just one perspective in a dyadic process. Without access to the disclosure recipients it was difficult to gain a fuller picture of just how easy or difficult past disclosure experiences had been. Along these lines, participants were not asked to provide detailed information about past disclosure experiences. As such, important information about the timing of disclosures (i.e., how recently they had occurred), as well as a broader understanding of the nature of disclosure experiences (e.g., who initiated the conversation, where they took place) was not collected.

Finally, the variables examined in this preliminary study represent a limited subset of many potential variables that may impact the disclosure process. Future research should aim to assess the impact of stigma, relationship quality, perceived support, isolation, personality constructs, et cetera, on the disclosure process.

Despite these limitations, the results of this study helped to elucidate the role of shame as a barrier to NSSI disclosure and provided preliminary insight into the role scarring may play in the disclosure process. While this study contributes to our knowledge and understanding of NSSI disclosure, it also underscores the need for a richer and more in-depth account of the process of disclosing self-injury and the impact of perceived scarring from NSSI in the words of individuals who have themselves experienced it.

**Introduction: Study 2**

The overarching goal of Study 2 was to gain a broader understanding of the nature of NSSI disclosure, including the factors that may facilitate or act as barriers to disclosure. Apart
from knowing that many youth who self-injure do not tell anyone about it and those who do tend to tell their friends (Whitlock et al., 2006a), very little is known about what disclosure experiences are like for individuals who self-injure. The individual interviews conducted in Study 2 aimed to elicit an understanding of participants’ experiences disclosing their NSSI. There was a clear need to examine the nature of NSSI disclosure from the perspective of young adults who have engaged in NSSI themselves. Hearing individuals’ personal accounts provided insight into this little understood experience and helped to build an understanding of the varying disclosure experiences individuals have. As the nature of the disclosure process is complex and differs greatly from person to person, an in-depth exploration of the experiences of a sample of young adults was meant to provide insight into what those experiences might look like and what factors may influence how and why disclosures do or do not occur.

A qualitative methods approach was employed for Study 2, which allowed participants to share their personal experiences with NSSI disclosure. One objective of this study was to identify factors that influence disclosure that might otherwise be missed by using quantitative approaches, including what it has been like to disclose NSSI in the past and what has prevented one from disclosing, if applicable. The objective of this component of Study 2 was to identify factors that relate to the ease or difficulty of NSSI disclosure that may not be captured by the self-report measures in Study 1 and to gather a richer and deeper understanding of the experience of disclosing (or choosing not to disclose) NSSI to others. Given the exploratory nature of this component, there were no a priori hypotheses as to which themes might emerge during the semi-structured interviews and subsequent thematic analysis.

Study 2 also explored the role of scarring in the context of disclosure in general, however given that the research on disclosure and scarring is scant, no a priori hypotheses were made. The
researcher’s position at the outset of the study was that the relation between scarring and disclosure would likely be complex. In some cases, it was thought that scarring might hinder disclosure due to an increase in shame-related scar concealment and secrecy. Conversely, it was understood that visible scarring might prompt questions from others and/or lead to discussion about NSSI, thereby resulting in unexpected or inadvertent disclosure. Overall, this study aimed to elucidate the ways in which scarring might impact NSSI disclosure using a thematic analysis of participant interviews.

**Methods: Study 2**

**Participants**

Fifty participants from Study 1 indicated they would be willing to be contacted for a follow-up study. Of those, 17 participants (16 women and one man) volunteered to be interviewed for Study 2 after corresponding with the student investigator. Participants ranged from 18 to 22 years of age ($M = 18.82; SD = 1.04$); however, it is important to note that some participants described disclosure experiences that occurred in adolescence. Clearance was obtained from the University of Guelph’s research ethics board prior to contacting participants.

The Study 2 participants did not differ significantly from the Study 1 participants in terms of their levels of shame, self-compassion, self-forgiveness, reported difficulty of past disclosures, and attitude toward future disclosures. Fourteen interviewees reported NSSI within the past year, and 10 reported visible scarring from self-injury. Sixteen of the interviewees had disclosed their NSSI on at least one previous occasion.

**Data Collection**

Participants who consented to be contacted for a follow-up study were emailed a brief summary of the study, including the study aims, what participation would entail, and
compensation details. Interested participants contacted the research coordinator (SR) and individual interviews were arranged. Prior to commencing the interview, participants were provided with an informed consent sheet describing the study, their right to confidentiality, the limits of confidentiality, how data would be collected and stored, and their right to withdraw from the study at any time. Participants were provided with an opportunity to ask questions before offering their written consent. Interviews were conducted in a private lab space and were audio and video recorded with participant consent. The interviews ranged from 30 minutes to 50 minutes in length and were semi-structured (Appendix H). Participants were asked to talk about their experiences telling others about their self-injury, including any factors that may have made the experience particularly easy or difficult. Participants who had not disclosed to others in the past were asked to talk about reasons they had not done so. Participants were also asked whether they had any scarring as a result of self-injury and whether that had ever impacted how they relate to or interact with others. At the end of the interview, participants were provided with a debriefing sheet, which offered further information about NSSI and mental health resources in the community. Participants who were eligible to receive course credit for research participation received one credit and those who were not eligible for course credit received a $10 Starbucks gift certificate as a token of appreciation for their participation.

**Analytical Approach**

This study attempted to understand participants’ experiences disclosing their self-injury to others. In trying to access participants’ accounts of their experiences, it was understood that in reflecting on and relaying their experiences participants would have engaged in a process of interpretation and meaning making. Given the ongoing nature of some of the participants’ struggles with self-injury, it is expected this interpretive process may have occurred at multiple
points in the past as well as during the context of the interview. The author’s primary role in conducting the interviews and in coding and analyzing the data necessitates that she was situated in multiple interpretive roles from study inception to completion. As such, a process of double hermeneutics is assumed to have occurred. As participants worked to interpret and communicate their experiences, this writer was also engaged in an interpretive process aimed at understanding the stories participants shared. Although this writer has knowledge of both the empirical and clinical self-injury literature, she strived to employ a non-expert stance in conducting and analyzing the interviews, believing that each participant was the expert in the realm of his/her own experiences.

Data Analysis

Data analysis was conducted in accordance with Braun and Clarke’s (2006) guidelines to conducting a thematic analysis. Prior to beginning analysis, all of the interviews were transcribed verbatim by the principal investigator. Excerpts used to illustrate the results of this study consist of only originally transcribed testimony. During the initial phase of analysis, each transcript was read multiple times to ensure ample familiarity with the data and to identify potential codes. During these initial read-throughs, notes were made to highlight portions of the interview that seemed important or of interest. This led to the next phase of data analysis, where initial codes (meaningful groups of data) were extracted from the transcripts. These codes were noted on the individual transcripts and in a master document compiling a complete list of the emergent codes and interpretations. The third phase involved arranging the codes into potential themes. Following this, the transcripts were re-read with these themes in mind and relevant text extracts illustrating the themes were compiled into 17 tables (i.e., one for each participant). Through repeated reviews of the themes at this stage, superordinate themes began to emerge as lower-
order concepts grouped together. Themes were then reviewed and refined, ensuring there was enough data to support each theme, that the data within each theme cohered together meaningfully, and that the themes were clear and distinct from one another. At this stage, a thematic map was created to reflect the themes and their relation to one another, as well as the data set as a whole. During the final phase, the themes were further defined and refined, by identifying the essence of each theme and appropriately naming them.

Thematic analysis (TA) was chosen to analyze participant interviews for a number of reasons. Most notably, TA is a flexible approach to analysis that is not tied to a particular theoretical or epistemological position (Braun & Clarke, 2006). As described in the analytical approach section, above, the principal investigator of this study approached data analysis from a realist epistemological stance. The pan-theoretical flexibility offered by TA was, therefore compatible with the framework chosen for data analysis. In this way TA differs from other analytic methods that aim to describe patterns across qualitative data, such as Interpretive Phenomenological Analysis (IPA), which is tied to a phenomenological epistemology (Smith, Jarman, & Osborn, 1999), and Grounded Theory, which aims to generate a theory of the subject being studied (McLeod, 2001). Following Braun and Clarke’s guidelines to conducting TA in psychology helped to ensure rigour in the analysis, as did regular consultations with the investigator’s research advisor, who has extensive research and clinical experience in the area of NSSI.

Results: Study 2

While the aim of this study was to better understand participants’ experiences telling others about their self-injury, throughout the course of conducting and reviewing the interviews it became apparent that the broader social context of living with self-injury and the social
implications of disclosure were as salient for participants as the act of disclosure itself. The results of this study explored themes related to participants’ disclosure experiences as well as aspects of living with NSSI and, in particular, having to contend with the scarring that often remains. Broadly, the superordinate themes derived from participant interviews are as follows: barriers to disclosure, the role of scars, and responses to disclosure (see Figure 2 for a summary of themes and subthemes).

Figure 2. Thematic map of Study 2 results

**Barriers to Disclosure**

Two barriers to disclosure emerged as particularly salient for many of the participants: the experience of shame and concern about how their disclosure would impact others. For some participants, these experiences acted as true barriers, preventing them from telling important
others about their NSSI. For others, they made the act of disclosing emotionally distressing without preventing disclosures altogether. Each is discussed further below.

**Shame.** Shame is traditionally understood to be an intense, negative, self-conscious emotion, whereby behaviours or transgressions are seen as reflecting a defective, global, self (Lewis, 1971). It is often associated with a drive to escape or conceal deficiencies (Tangney, Miller, Flicker, & Barlow, 1996). Shame figured prominently in almost all participants’ discussions of their disclosure experiences – both as an emotional experience that prevented them from sharing their NSSI with others and as an intense emotion experienced during disclosure itself. Participant 1 described the first time she disclosed her self-injury to her parents, saying:

“At the time when I told them, I was really, really ashamed of it. Like I go through cycles where I’m really, really ashamed of the fact that I’ve done it and then when I do start up again I don’t really care so much that I’m doing it. But at the time I was really, really ashamed of it and it was really hard to tell them because I really, really wasn’t proud of it.” (P1)

For this participant, the shame she experienced regarding her self-injury was one factor that made the act of disclosing to her parents difficult. This testimony also serves to illustrate the intensity of Participant 1’s experience of shame; she emphasized being “really, really ashamed” throughout the passage and recalled “shaking uncontrollably” during the conversation with her parents.

For other participants, feeling ashamed of their self-injury prevented them from disclosing to others and led them to conceal evidence of their self-injury. In other words, their shame silenced them. Participant 3 spoke of her reluctance to tell others about her self-injury,
“I just didn’t want other people to know. I didn’t want people thinking I was that emo chick who cut herself. Like I was really embarrassed. I was very, very ashamed that I did it, and I just didn’t want people to know that I did.” (P3)

Again, the intensity of this individual’s experience of shame is evident in the emphasis she places on feeling “really embarrassed” and “very, very ashamed”. She also alluded to an assumption that others would judge her unfavourably if they knew about her self-injury – an assumption grounded in a negative internalized view of her behaviour. Indeed, she shared her concern that she would be labeled an ‘emo-chick’ which, to her, seemed to carry a pejorative connotation and would likely contribute to feelings of shame.

It is interesting to note that all participants reported experiencing feelings of shame, regardless of whether they chose to disclose their self-injury to others. The feeling was not solely elicited during the act of self-injury disclosure, but was often present when considering their self-injurious behaviour in general. While sharing NSSI experiences tended to provoke feelings of shame, many participants described the sense of shame they felt about the fact that they had engaged in NSSI. This shame was independent of the act of disclosure. Nevertheless, it was evident that feelings of shame impacted the relative difficulty of the disclosure experience. Although past research has not directly explored the experience of shame in the context of self-injury disclosure, shame has been found to associate with avoiding treatment for emotional and mental health problems (Corrigan, 2004; Hinshaw & Cicchetti, 2000) and lack of disclosure of emotional distress to friends, family, and professionals (MacDonald & Morley, 2001). This is elaborated upon further in the Discussion, below.

One aspect of Participant 3’s shame that was articulated in the above excerpt was a fear that others might regard her as a specific type of person or member of a social group with
potentially unfavourable associations (e.g., “an emo chick”) because she had self-injured. Other participants shared a similar concern. Explaining why she had not told many of her friends about her self-injury, Participant 2 shared:

“Again, it’s like the overwhelming feelings of shame. I tend to be a perfectionist, so it’s just knowing that I’m doing something that is kind of frowned upon by a lot of people and kind of has such a negative stigma attached to it. I don’t know, I didn’t want to seem like a freak, or whatever people want to call it [...] that idea of me being such a strong person will be ruined in a way.” (P2)

For this participant, the potential disruption to the way her friends thought of her (which seemed to be consistent with her preferred view of self) was a major barrier to sharing her experiences with others. She worried that her friends would see her differently or label her a “freak” if they knew that she had struggled with self-injury. This provides further insight into the deep sense of shame experienced by some of the interviewees. That Participant 2 and Participant 3 were both aware of the cultural stigma associated with self-injury and wished to protect themselves from potential negative characterizations, suggests they may have internalized the notion that people who self-injure are abnormal or “freaks”.

Other participants expressed shame related to the perceived “normalcy” of the act. Participant 13 described the embarrassment she felt when considering her NSSI, which ultimately led to her hiding her self-injury from important others in her life.

“Like I know that it’s common, but at 11 I was like ’k this isn’t normal, normal people don’t do this, happy, healthy people don’t do this, so it was kind of like it’s an embarrassing trait. People don’t want to share other embarrassing traits, so I shouldn’t share this.” (P13)
Although Participant 13 was aware of the high prevalence of NSSI, at the time she believed her NSSI distinguished her from her “normal”, “happy”, and “healthy” peers. Like Participant 13, a number of interviewees expressed feelings of shame regarding their self-injury that were not exclusively related to the act itself or the scarring that resulted, but that also reflected a fear about what their self-injury meant about them and the type of people they were. Participant 13’s description of shame may map onto the concept of characterological shame, which has been conceptualized as feeling ashamed of the sort of person one is (Andrews, Qian, & Valentine, 2002). Consistent with this view, Participant 1 shared concern about the meaning derived from her self-injury, although her focus was on the meaning conveyed through her scars:

“People have scars for any number of reasons, but I think it’s just the fact that even if they assume it’s from something else, it’s the fact that I know what they represent and I know that there is a certain amount of judgment and stigma that comes along with having scars for the reasons I have them. I think it would be something like that…like it wouldn’t be so much the fact that I have them, it’d be the fact of what they’re from.” (P1)

Here, this participant seemed to focus on a meaning behind her self-injury and her scarring that extended beyond others’ potential views of her. The concern she expressed was not tied to others knowing what her scars represented; the fact that she knew what they were from was shame inducing in itself.

**Concern for others.** Many participants expressed concern regarding the impact disclosing their NSSI would have on important others. Most often this concern manifested in a reluctance to feel like a burden to friends and family. Participant 2 expressed this reluctance succinctly, saying, “when you hear from people how many things that are bothering them, it’s
tough….you don’t want to add to their stress, in a way”. Participant 14 elaborated on her own unease with burdening others,

“I just felt people are busy enough with their own lives, people have their own problems, I just don’t want to be the burden, like you have to think about me while you think about your own problems. I’d rather let someone know, hey like I’m there for you instead of them trying to comfort me, so it was just I just didn’t want to make it seem like I needed people to, you know, always rely on them.” (P14)

While this participant identified with her historical role of being a care provider for friends, she expressed discomfort with being someone for whom others felt the need to care. This concern with burdening others seems to be related to the concept of self-perceived burden, defined as “empathic concern engendered from the impact on others of one’s illness and care needs, resulting in guilt, distress, feelings of responsibility, and diminished sense of self” (McPherson, Wilson, & Murray, 2007, p. 425). While self-perceived burden has been explored in chronically and terminally ill patients (e.g., McPherson et al.; Kowal, Wilson, McWilliams, Péloquin, & Duong, 2012), it has not been explored with individuals suffering with mental health concerns. Of course, individuals and families struggling with mental health issues often have considerable need for care and emotional support, and may also have need for more applied support as well (e.g., transport to doctors appointments). It is understandable that individuals relying on others for care would worry about the impact of their needs on important others, regardless of whether their concerns have a physical or emotional basis. As such, it is likely that self-perceived burden has relevance for mental health issues like NSSI. Participant 9 expressed a similar concern regarding burdening others:
“It was only hard because it was, I didn’t want them to be upset. Like you don’t want them to have to have the burden of having to deal with all of that too, so I think at the time it was kind of like it’s my problem not yours, so I don’t want them knowing about it because they’ll be upset and that’s one more thing that I’ll have to deal with, so it was just kind of, that was difficult because I didn’t want them to have to deal with it and have to feel that pain sort of.” (P9)

Not only was Participant 9 reluctant to feel like a burden to her family, she also expressed concern about the emotional pain they would feel as a result of learning of her self-injury and indicated that she would, in turn, feel compelled to support them. A number of interviewees shared they did not want to upset and, especially, to disappoint loved ones by telling them about their NSSI. Participant 17 shared, “the one thing that kills me is my mom and I could never tell her. I would feel awful and I know it would destroy her and she would be so upset…I know that she would be upset like she had done something wrong”. These examples suggest interviewees were most concerned about the emotional burden their NSSI (and particularly, knowledge of their NSSI) would place on friends and family, which may differentiate self-perceived burden associated with mental health concerns from self-perceived burden associated with physical health concerns. Participant 5 was also resolute in her decision to hide her NSSI from her parents, saying,

“They'd probably feel like they failed as parents and blame themselves… I went so far to protect them from finding out that, on three occasions, I gave myself stitches with a regular needle/thread, instead of seeking actual medical help when I likely needed it”.

(P5)
This participant’s description of her actions as *protective* helps to illustrate a mindset that was indirectly communicated by many of the participants: that of their own needs being secondary to those of important others. That many participants were concerned their need for emotional support might burden others suggests not only a perception of their needs being less important than the needs of others, but also a sense of the *self* as being less worthy of support. Alternatively, participants’ expressed desire to protect friends and family from the “burden” of their NSSI may be interpreted as a form of shame avoidance. Perhaps Participant 5 concealed her NSSI from her parents to protect them from feeling as though “they failed as parents” and to protect herself from the shame associated with feeling like the product of their failure.

**The Role of Scars**

The majority of interviewees reported having scars from self-injury, albeit in differing locations and with varying degrees of visibility. While participants most often referred to scarring and, particularly, the social repercussions of having a visual manifestation of their distress and behaviour, they also discussed wounds and the similar role they played. Three themes emerged as particularly salient for interviewees: namely, the role of scars and wounds in initiating disclosure conversations, the way that scars (and NSSI more broadly) can help to illustrate or authenticate emotional distress in a way that language sometimes fails to do, and finally the personal and social impact of having an enduring representation of the pain they experienced.

**Initiating disclosure.** Many participants shared that they had been questioned about the nature of their self-injury wounds and scars from various people in their lives, including friends, family, and teachers. This questioning placed these individuals in the difficult position of either being forced to disclose their self-injury in the moment, having to lie about the nature of the
marks, or attempting to avoid the question entirely. Participant 4 shared her thoughts on being questioned about her scars:

“I’ve never had a situation where I’ve chosen to tell someone, other than my boyfriend, I don’t think so, because it always ends up being that everyone else can see it, so it’s never really on your terms if you have visible scarring. […] You are always caught off guard, so no time ever feels good when someone confronts you about it.” (P4)

This participant spoke about the confrontational nature of the questions she received from many peers and adults in her life. She often felt as though there was no way she could avoid answering the question in some form. At times she would tell the person inquiring that she did not want to talk about it, while other times she would feel compelled to disclose her self-injury.

When Participant 3’s sister saw marks from self-injury on her body she demanded to know what they were from. Participant 3 told her the truth, but recalled that, “I didn’t want to. I wasn’t ready for it.” When confronted in this manner, both Participant 3 and 4 felt as though they had been compelled to disclose on terms that were not their own. Other participants recalled going to great efforts to conceal their scars to prevent others from questioning them, such as not wearing short sleeves for more than a year, avoiding pool parties and trips to the beach, and creating elaborate stories to account for their scars when questioned.

Conversely, some participants found that showing their scars to others helped them to disclose what they could not effectively articulate with words. Participant 16 shared,

“Back in high school it would have been easier to just show a scar. I think when I was younger and like I was doing it, it would be easier if you didn’t have to speak. So, yeah, cause then someone else would find the words or you could figure out the words eventually.” (P16)
Scars can also mean that the decision to disclose or not remains relevant long after an individual has recovered from self-injury. Some of the interviewees spoke of grappling with continued forced and elective disclosures for years after they had ceased to self-injure. Participant 13 spoke of responding to questions about her scars years after stopping NSSI:

“The only time I’d have to bring it up is if someone saw say a scar. Then I’d try to make some sort of little deviation away from it, but then if not, I’d be like, ‘just some stuff happened, its not a big deal, I don’t do it anymore’ then it never really turns into anything big.” (P13)

While this participant had established a suitable approach to managing questions about her NSSI from friends and acquaintances, she expressed concern about the potential impact her scarring might have on future job prospects,

“If I go into a job interview and I’m wearing a t-shirt or like anything like that, a dress, anything, then that [the scars] might be the first thing they see. It might not be, but it might be, so that’s always a question.” (P13)

Participant 13 shared trepidation in the context of a larger discussion about the long-term repercussions of engaging in NSSI. Other interviewees expressed similar concern, wondering what their scars might mean for their future – both personally and professionally. Some interviewees spoke about their teaching aspirations and worried about what their scars might communicate to their students, while another participant wondered what her future children would think about her scarring from self-injury and how she might respond to questions from them. Regardless of the specific concerns, it was clear that a number of participants were preoccupied with what their scars might mean for their future.
**Authenticating distress.** While scars and wounds sometimes served to initiate unwanted disclosures for participants, at other times they helped to illustrate or even authenticate distress during a disclosure. Participant 1 recalled the first time she told her parents about her self-injury:

“I remember I like broke out in tears because they were going back and forth and my dad…my mom was talking about how oh when she was a kid she went through periods like this and it wasn’t that serious, that I’d be fine, I’d get better. And I broke down and told them that like this isn’t like me, this isn’t me, this isn’t what I want to be like and showed them and told them that I wasn’t okay basically.” (P1)

At a time when she needed her parents to understand the extent of her distress, this participant’s scars allowed her to communicate a message that she found difficult to articulate with words. Once her parents learned of her self-injury they supported her in her efforts to seek help. Along similar lines, Participant 4 recalled telling her father about her self-injury as a means of authenticating her distress:

“I just felt like he never really believed that I was depressed or that anything was wrong, he was just like, you’re fine, I’ve seen people much worse than you, or whatever, I guess. And so to make him stop I just told him that.” (P4)

Disclosing her self-injury to her father helped this participant to illustrate the extent of her distress in a way that other words had not been able to. Participant 12 spoke about using her scars to communicate her distress to others, even during times when she was not actively self-injuring,

“I guess in terms of the last couple of years, like the way my self-injury patterns, like there have been periods where it’s been really bad and periods where nothing happens, it sort of continues like that. And then there have been times when I’ve still been feeling
sad but I haven’t injured myself, so like there are still going to be marks that exist, so like scarring and stuff, and sometimes I just have to use that to explain it…. mostly just showing I guess.” (P12)

Again, this participant found that showing scars could be a powerful way of communicating her emotional distress to others. Overall, that some of the interviewees recalled instances in which they communicated their distress by disclosing their self-injury and presenting their scars may be related to the finding that poor verbal communication skills associate with NSSI (Nock, 2008). Alternatively, feelings of shame that can accompany mental health difficulties (Corrigan, 2004; Hinshaw & Cicchetti, 2000), including NSSI (Brown, Linehan, Comtois, Murray & Chapman, 2009) may make initiating a discussion to elicit support challenging. If individuals find it difficult to articulate their distress using words, displaying their scars may be an effective way to circumvent this challenge.

**Scars as an enduring representation of pain.** For some participants, having scars that remained for years after enacting NSSI served as a continued reminder of the act itself, of the emotional pain that led to or associated with their self-injury, and of the societal stigma that accompanies NSSI. As Participant 1 noted, “it wouldn’t be so much the fact that I have [scars], it’d be the fact of what they’re from.”

Participant 16 articulated what her scars represented to her and what she believed they communicated to others, saying,

“It was embarrassing when somebody saw [a scar] because like they’d be seeing your vulnerability and things you’d done that people will look down on and you don’t want people to see that. […] I didn’t want people seeing it because I guess they could see me
and my weaknesses and my fears and my stress and my struggles without me having any control over it.”

This participant emphasized her discomfort with the idea that her scars communicate messages to others that she may not want them to know, noting that her scars represent not only a stigma-laden act, but also the pain and vulnerabilities that led to the act.

Participant 13 spoke about the enduring nature of her self-injury scars and what that has meant for her:

“It’s always part of me and always will be I guess. They’re never going to go away, but yeah I guess it’s always going to be that subconscious thought, like what if someone sees it or what are they going to think if they see it.” (P13)

The idea that NSSI has become “a part of [her]” suggests that NSSI’s embodiment in the form of scars is more than just a physical consequence of self-injury, but may represent a more personal identification with the act.

Finally, Participant 4 eloquently summarized why she believes scarring fundamentally differentiates NSSI from other forms of mental illness,

“Somehow it’s just worse than depression, like it’s because it stays with you forever, like the scars and everything about it. Even if you get over depression or an eating disorder, that part of your life can be forgotten, but if you have scars or something on your arms, then it’s with you forever.” (P4)

While the idea that depression or an eating disorder can be forgotten once overcome may not be accurate for all individuals, the scarring that results from some forms of NSSI can serve as an enduring and visible reminder of the pain associated with the act. Further, the body-altering nature of scarring from NSSI may contribute to the sense that NSSI “stays with you forever” and
becomes “a part of” oneself. Beyond the reality that scars are enduring, the fact that, through scarring, NSSI can become an embodied part of those who engage in it may lead to ongoing identification with the act, contributing to the sense that NSSI is “with you forever.”

**Responses to Disclosure**

Interviewees shared numerous examples of responses they had received upon disclosing their NSSI. These responses ranged from helpful to harmful, with some disclosures leading to support and others leading to invalidation and, occasionally, anger. One of the more robust and illuminating themes to emerge from the data was that many of the interviewees’ disclosures or signs of self-injury (e.g., visible scars, wounds) were met with silence and/or subsequent avoidance of the topic. Many participants, however, were able to share at least one example of a positive disclosure experience, and these positive experiences tended to consist of understanding and acceptance on the part of the disclosure recipient.

**Silence and avoidance.** In recounting their experiences with NSSI disclosure, many participants described situations in which their disclosures were met with silence, inaction, and subsequent avoidance of the topic by others (namely, the disclosure recipient). When Participant 3’s sister discovered she was cutting herself, she ordered her to stop and threatened to tell their parents if she continued. As described by this participant,

“Um, I just felt like she didn’t want to deal with it, like it was a stop it or our parents will find out. And we just never spoke about it. I never actually got to explain or get her support. I didn’t stop, it didn’t help me stop, I just hid it better from then on because I knew how easily it could be found out. So I ended up starting to cut in other places where it would be even less visible. But that’s not helpful, being even more secretive about it.”

(P3)
Not only did Participant 3 miss out on an opportunity to discuss her distress and reasons for self-injuring with a loved one (something she had not done at that point), her sister’s threat led her to take greater efforts to hide her NSSI from others. Indeed, her sister’s response seemed to function to silence discussion of the participant’s NSSI experience. Adding support to this perspective is the fact that, at the time of this interview, Participant 3 had only disclosed her NSSI to one other person. Participant 12 shared a similar first disclosure experience:

“Um, the first time I told someone was one of my close friends, pretty soon after it happened the first time and then there was a period where nothing really happened after that, like we didn’t talk about it after that.” (P3)

Eventually, this participant sought help for her mental health struggles from her school guidance counsellor and was able to share her experiences with NSSI with a trusted adult. After this initial conversation with her guidance counselor, she was able to disclose her NSSI to other important people in her life. However, for approximately one month after first disclosing to her friend, Participant 12 did not receive support or the benefit of discussing her experiences further with this friend. The metaphorical silence and subsequent avoidance this participant’s disclosure elicited was upsetting – she recalled feeling “very stressed, and depressed, and frustrated, and just generally overwhelmed” in the month following her disclosure.

Subsequent avoidance of the topic of NSSI (both on the part of the discloser and recipient) following a disclosure conversation was an experience described by many of the study participants. For Participant 5, avoidance was characterized as a frequent response to disclosure:

“Because mostly I’ll tell people but it will never get brought back up in conversation again, just cause like, I don’t know what they’re thinking. Like they don’t want to upset
me or like it’s not like your everyday conversation. Like there’s …I think the reason why a lot of people don’t talk about it is cause it just doesn’t come up in conversation.” (P5)

While this participant offered several reasons others may not have addressed her NSSI disclosures and did not explicitly address how their avoidance of the topic impacted her, she did assert her belief that the broader societal avoidance of discussion related to NSSI leads to misperceptions and stereotypes, saying, “I think the main thing is that people don’t talk about it. And it’s where those prejudices, those ideas come from.”

A number of participants also expressed a belief that others had noticed signs of their NSSI, such as scars or wounds, and had chosen to remain silent rather than confront them. Participant 8 shared her sense that her family was aware of her NSSI, but chose not to ask her about it: “My family members noticed, but no one asked, no one talked about it, but definitely the faces, the you know that I know.” Participant 9 relayed a similar experience with a boyfriend, saying, “…and I had one boyfriend who did notice, I saw him look at it, but he didn’t ask so I just never said anything. And it was kind of swept under the rug.” While neither of these participants expressed they would have preferred to talk about their NSSI, other participants shared that not openly discussing their self-injury with family who had noticed signs of their NSSI was upsetting.

Participant 4 believed her father had noticed her self-injury scars, yet had declined to ask her about them. She conveyed that having a conversation about her self-injury with him would have been her preferred outcome:

“Um, I think if he had known it would have been better if he had approached me about it. Like it’s a bit more confrontational and like, but I think I would have dealt with it better. Because he must have known, he must have, like there is no way he couldn’t have
noticed, so it was just kind of like…I mean he was probably waiting for me to come to him, but if you need to have the conversation, sooner [is better].” (P4)

In this way, NSSI (and the shame associated with it) seems to silence not only individuals with a history of NSSI, but also friends and family members who may not know how to broach the topic or may not want to believe their loved one is hurting him/herself. Participant 13 expressed a similar sentiment; however, she, importantly, linked her family’s silence to her subsequent reluctance to disclose her NSSI to others in her life:

“Actually the defining moment when I didn’t want to tell anyone at all ever about it and I almost felt like people didn’t care and that was because one morning I’d done it the night before and there was probably 4 or 5 marks on my arm and I went downstairs into the kitchen with a t-shirt on. My dad and my mom and my little sister were all in the kitchen and part of me knows that they saw it, but they didn’t say anything […] And the whole fact that they almost like, like obviously it’s not that they didn’t care, but that’s how it translated to me. Obviously it put them in an awkward situation cause they didn’t want to bring it up or talk about it, which made me be like this is bad, this is awkward, like people, it’s not a good thing to talk about, it’s not something people want to know, like you shouldn’t be doing it, but just don’t like share with anyone so […] but I feel like if they would have maybe noticed and like helped me through or whatever, as corny as that sounds, then it might be easier to talk about in the future.” (P13)

This participant struggled with what it meant that her family did not address her injuries – at times suggesting that they had noticed her injuries but had failed to begin a conversation about it and at other times insinuating that they had not noticed. Notably, she articulated an assumption
that other participants had implied but not stated explicitly: that NSSI is so subversive that it cannot be discussed.

**Understanding and acceptance.** The majority of interviewees had disclosed to at least one other person prior to the interview. Of those who had undertaken multiple disclosures, most were able to recall at least one positive disclosure experience. Disclosure recipients who facilitated positive experiences seemed to cultivate an environment of understanding, empathy, and acceptance. Participant 15 explained what made her positive disclosure experience so helpful:

“They were good at listening and like just letting me explain it. They didn’t try to like refer back to their circumstances, like they weren’t like oh I’ve felt, like they didn’t try to completely understand it and I remember like I think both of those circumstances, they explicitly said, I can’t completely understand where you’re coming from, because I’m not in that… but like that they could sympathize and that they would also be there if they needed to be and if there was anything that they could do to help, that they would be there.” (P15)

Participant 7 described her most positive disclosure experience thusly: “I think her just being comforting with it, not just like distancing herself or even just saying okay I get it, but having an open conversation about it that is more accepting for sure.” For many participants, including Participant 7, the willingness of disclosure recipients to discuss NSSI openly and without judgment helped to make the disclosure experience a positive one. Participant 1 expressed a similar sentiment, saying,

“I think a lot of it was the fact that there was no …it wasn’t like a question of why I was doing it, what do we have to do for help, just when I told her she was just emotionally
there for me I guess, which made it a little more positive, just to have her give me a hug and cry with me, and just let me know that she felt for me. Then later on there was talk of what happened, but the initial in the moment, it was nice to just have the emotional support, instead of looking at it objectively, or how to solve it. It was just feeling it, you know what I mean?” (P1)

This participant highlighted how meaningful it was to receive an empathic response from her friend, one that was accepting of the situation rather than motivated to solve it immediately. The accepting nature of the responses described by participants coheres with what has been recommended by experts in the study of NSSI. Walsh (2006) emphasized the import of attending to people’s NSSI and associated emotional experiences with a low-key, validating, and calm demeanor. It has also been suggested that approaching conversations about NSSI with a respectful curiosity and genuine desire to understand the individual’s experiences is helpful (Kettlewell, 1999).

**Discussion: Study 2**

The present study initially set out to better understand the nature of NSSI disclosure. To date, limited research has explored the disclosure experience, despite the fact that research suggests a third of young adults who self-injure tell no one about it (Whitlock et al., 2006a) and many may not be receiving support or the opportunity to find relief through disclosure (Nixon, Cloutier, & Jansson, 2008; Zivin et al., 2009). Furthermore, there is ample evidence to suggest that disclosure about distressing material in general has therapeutic properties (e.g., Frattaroli, 2006; Lyubormirsky, Sousa, & Dickerhoof, 2006). As such, it was important to explore the experience of telling (directly and indirectly) or deciding not to tell others about self-injury from the perspective of young people who had experienced it first hand. For the individuals who took
part in this study, disclosing NSSI was often not a straightforward act, and at times was not even a decision that they had made and initiated themselves. Many of the participants spoke of the continued relevance of the disclosure experience, regardless of the length of time that had elapsed since they had last self-injured. Three superordinate themes were extracted from participant interviews: barriers to disclosure, the roles of scars, and responses to disclosure. Within each superordinate theme, two to three subthemes were extracted and interpreted (see Figure 2).

Barriers to Disclosure

Two barriers to disclosure emerged from participant interviews: the experience of shame and concern regarding the impact of disclosure on important others. It is interesting to note the intersection of self and other in these subthemes. While feelings about the self and self-worth are certainly at the core of shame, concern about judgment from others (and the resultant shame one might experience) often accompanies shame, and was described by a number of participants in this study. Invariably, participants’ feelings about the self colour their interpretations and expectations of how others think of and relate to them. Participants’ concern for the impact their disclosure might have on others was also both self- and other-focused. While a number of participants expressed a desire to protect their friends and family from knowledge of their NSSI, the primacy of their concern for others’ needs (potentially at the expense of their own) communicated a sense of self (e.g., needs, feelings, and worth) that was subordinate to others.

Shame. Many participants identified feeling intensely ashamed of their NSSI and of themselves for engaging in it as being either a barrier to disclosure or increasing the difficulty of the experience. The shame they felt was, in effect, silencing. Past research has found a relation between shame and self-injury (Brown et al., 2009), with heightened characterological shame
(i.e., feeling ashamed of one’s personal habits, personal ability, or the sort of person one is),
behavioural shame (i.e., shame about doing something wrong), and bodily shame (i.e., feeling
ashamed of one’s body or any part of it) all associating with self-injury enactment (Gilbert et al.,
2010). Although past research has not directly examined the role of shame in the disclosure of
self-injury, the link between shame and non-disclosure to professionals and important others is
well-established in the clinical literature (e.g., Hook & Andrews, 2005; MacDonald & Morley,
2001). In a sample of young women suffering from eating disorders (a group that is at-risk for
self-injurious behaviour; Paul, Schroeter, Dahme, & Nutzinger, 2002), non-disclosure in
treatment was associated with higher levels of characterological shame (Swan & Andrews,
2003), suggesting that shame about the type of person one is may impair one’s ability to disclose.
Similarly, shame-proneness was found to be the most frequently reported reason for non-
disclosure in therapy in a sample of men and women who had received treatment for depression
(Hook & Andrews). The fact that shame was such a central experience for the participants in this
study, coupled with the established link between shame and non-disclosure in the general mental
health literature (Hook & Andrews; MacDonald & Morley; Swan & Andrews), suggests that
shame may be a barrier to disclosure for other young adults with current or past experiences with
self-injury.

**Concern for others.** Participants also reported concealing their NSSI due to concern
regarding how knowledge of their self-injury would impact important others in their life. Many
who expressed this concern shared that they did not want to burden their friends and family, with
some communicating their preference for providing support to others rather than being the
recipient of it. Self-perceived burden (SPB) is a construct that has been studied in patients
suffering from chronic illness or pain, and those receiving end-of-life care (McPherson et al.,
TALKING ABOUT NON-SUICIDAL SELF-INJURY

2007; Kowal, Wilson, McWilliams, Péloquin, & Duong, 2012), and entails empathic concern regarding the impact of one’s illness and care needs on others. A study exploring SPB among patients receiving end-of-life care found that participants expressed concern for the physical, social, and emotional burdens placed on their caregivers (McPherson et al.). Given that participants in the present study mainly expressed concern for the emotional burden knowledge of their NSSI would have on important others, there may be important parallels between the self-perceived burden and emotional concern expressed by physically ill patients with that expressed (or avoided) by individuals contending with NSSI. End-of-life patients expressed concern regarding the emotional burdens they perceived their caregivers to face, including the added stresses associated with caregiving, the strain of remaining vigilant over the patient’s wellbeing, and concern regarding the distress created for the family as a whole (McPherson et al.). Participants in McPherson et al.’s study also described a willingness to conceal their own needs in order to protect their caregivers from further emotional strain, much like participants in the present study opted to conceal evidence of their NSSI from important others to avoid burdening or upsetting them. The emotional implications found for individuals who experience SPB include feelings of guilt and regret regarding the hardships endured by others (McPherson et al.).

SPB is analogous to the construct of perceived burdensomeness, a precursor to serious suicidality according to the Interpersonal-Psychological Theory of Suicidal Behavior (Joiner, 2005). Perceived burdensomeness is the “perception that one is a burden on loved ones” (Van Orden, Lynam, Hollar, & Joiner, 2006, p. 457) and involves a sense that loved ones would be better off if the burdensome individual was gone. Perceived burdensomeness is an important predictor of suicidal behaviour, and studies have found it to offer unique predictive value above and beyond hopelessness, a robust predictor of suicidality (Van Orden et al.). The Interpersonal-
Psychological Theory of Suicidal Behaviour has been proposed as one explanation for the increased risk of suicide among individuals who engage in NSSI (Joiner, Robeiro, & Silva, 2012). As such, the concern about burdening others expressed by participants in this study indicates further research investigating NSSI and the role of self-perceived burden and/or perceived burdensomeness is warranted.

As noted above, participants’ expressed concern for others’ needs at the (potential) expense of their own needs suggests something about participants’ sense of their own worth and worthiness. Participants who described not wanting to burden their loved ones with their emotional needs may not have felt adequate or worthy of others’ care and support.

**The Role of Scars**

Although scars seemed to be somewhat of a liability for many participants in this study, in the sense that they often elicited unwanted questioning and, at times, forced unwanted disclosures, they also served to authenticate distress in the face of emotional invalidation. In this way, NSSI scars played a complex and multifaceted role for individuals in this study, both in the context of disclosing self-injury and in the more general context of living with evidence of current or past NSSI in a social and stigma-laden world.

**Initiating disclosure.** Many participants shared their experiences being questioned about wounds and scars from NSSI. Participants communicated the dilemma they faced in responding to this line of questioning (namely, deciding whether to disclose their self-injury, avoid the question entirely, or present a cover story to account for their marks). Approaches to handling scar or wound-related questioning were previously explored in Hodgson’s (2004) examination of NSSI stigma management techniques. Hodgson noted that many study participants chose to concoct a cover story when unexpectedly confronted about the origin of their cuts or scars. These
cover stories tended to consist of activities or interactions that could credibly result in an injury (e.g., “I was scratched by a cat”). This is one method of managing when and with whom NSSI disclosures occur. An alternate method of maintaining control over disclosures entails hiding wounds and scars by wearing clothes and accessories that cover-up those marks, referred to as “passing” by Hodgson and endorsed by participants in the current study. In her expansive study of self-injurious behaviour, Chandler (2010) explored the decision to hide or reveal NSSI scars, noting that for many of her participants, the decision to reveal their NSSI scars was more accurately described as the decision to stop hiding their scars. Much like the participants in the present study, Chandler found that those who ceased to hide their scars encountered questions and comments about the nature of their scarring, thereby having to decide whether to disclose or relay a cover story. While scar-initiated disclosure is not a novel or surprising phenomenon, the emotional consequences of feeling compelled to disclose a sensitive mental health concern like NSSI have been rarely discussed in the literature.

Retaining control over personal information is an important aspect of the disclosure experience; indeed, research has found that men are more likely to avoid self-disclosure to avoid a loss of control (Rosenfeld, 1979). That many individuals in the current study felt unable to dictate with whom they shared their history of NSSI is concerning and further research investigating the psychosocial consequences of other-initiated disclosures is warranted. As Participant 4 shared, “I’ve never had a situation where I’ve chosen to tell someone […] it’s never really on your terms if you have visible scarring […] no time ever feels good when someone confronts you about it”. Beyond the fact that it is uncomfortable and potentially upsetting to disclose sensitive information on someone else’s terms, sharing personal information is not an invariably positive experience and an individual’s disclosure-related goals may relate to the
outcome of the disclosure. The Disclosure Process Model (Chaudoir & Fisher, 2010) proposes that individuals who endorse avoidance-focused goals (e.g., to avoid social rejection or interpersonal conflict) may have more difficulty deciding when to disclose and may choose less direct methods of disclosure, such as e-mail (Chaudoir & Fisher). Researchers have also found that individuals who choose to disclose personal information yet are sensitive to the possibility of social rejection are more likely to experience negative consequences as a result of their disclosure (Cole, Kemeny, & Taylor, 1997). If individuals’ disclosure aims and social sensitivities impact the disclosure experience, it is important to consider the consequences of other-initiated disclosures, which do not take into consideration the discloser’s goals.

In fact, there is empirical evidence to suggest that unwanted disclosures negatively impact the discloser. Specifically, in one study, participants who were unexpectedly asked to disclose their history of mental illness prior to completing an intellectual test performed worse than those who were not asked to disclose (Quinn, Kahng, & Crocker, 2004). Given that negative consequences may result from unexpected disclosures and participants in the present study reported negative emotional reactions when compelled to disclose speaks to the importance of further research on the emotional correlates of scar- and wound-initiated NSSI disclosure.

By virtue of their long lasting and, in some cases, permanent nature, individuals who have scarring from NSSI may have to manage questions about their scars long after they first appeared. For some individuals, this means having to contend with other-initiated disclosures years after they have ceased to self-injure. A number of participants noted concerns about the long-term consequences of their scarring from NSSI, including how it might impact future job prospects, how they would explain their scars to their children, and the emotional toll of having to repeatedly disclose to others (e.g., intimate partners). While the research literature has largely
not addressed the long-term consequences of scarring, Chandler (2010) noted that some of her interviewees pursued tattoos and scar minimization procedures as a way to cover up and, in the case of tattooing, distract from and decorate the skin. The long-term emotional consequences of NSSI scars will be discussed further below, however this represents an area of research suitable for further study.

**Authenticating distress.** A number of participants described experiencing parental invalidation in response to their distress, whereby their emotional experiences were trivialized and the extent of their distress was diminished. While emotional invalidation in the family environment is an experience that has been found to associate with self-injury (Sim, Adrian, Zeman, Cassano, & Friedrich, 2009; You & Leung, 2012), the use of scars to both authenticate distress and disclose self-injury in such an environment has not been explored empirically.

The concept of self-injury as a signal of distress, however, is not unique. The social signaling hypothesis proposes that people use self-injury to signal their distress when milder forms of communication, such as talking, have been ineffective at communicating their distress and eliciting help (Nock, 2008). According to Nock, people tend to escalate the intensity of their mode of communication or behaviour when their message has not effectively achieved the desired response. Escalated behaviours both increase the likelihood the message will be communicated and increase the “cost” or risk to the signaler (Nock, 2008). For example, speaking is a low cost and low intensity form of communication. If ineffective, a person may escalate to yelling or crying, behaviours that are both more intense and require greater (emotional and physical) resources on the part of the individual. Behaviours that are still higher in their intensity (and cost), such as NSSI, may be enacted when weaker signals have not elicited the desired response. Behaviours that bring about the desired response will be reinforced and
strenthened over time (Nock, 2008). Clearly, not all people will choose to enact NSSI when weaker signals, such as talking or yelling, have been ineffective; however, there is research to support that youth who do engage in NSSI have verbal deficits that may impair their ability to communicate effectively. Specifically, studies have found poorer verbal fluency (i.e., word generation) amongst individuals who self-injure (Photos & Nock, 2006), as well as deficits in emotional expression (Gratz, 2006). Further, the families of individuals who engage in NSSI show higher levels of hostility and criticism (Wedig & Nock, 2007), which may associate with problems receiving or responding to milder forms of communication.

The idea of self-injury serving as a social signal is perhaps best illustrated by Marilee Strong’s (1998) description of self-injury as a “bright red scream”. This description illustrates that, for some, NSSI is both the physical manifestation of emotional pain and a way to communicate the extent of this pain to others. While the social signaling hypothesis helps us to understand the etiology of self-injury for some individuals, it may also help us to understand why some youth who self-injure choose to present the injuries or scars resulting from their self-injury when words fail to adequately communicate their emotional distress. Not only is the act itself a more intense and costly signal of distress, the presentation of the physical damage resulting from NSSI underscores some participants’ predilection for behavioural rather than verbal communication.

**Scars as an enduring representation of pain.** Scars also seemed to serve as an enduring reminder or representation of some participants’ NSSI and, by extension, the emotional pain that associated with it. While past research has not thoroughly examined the psychosocial repercussions of having a continued reminder of difficult times, Chandler’s (2010) qualitative look at self-injury supports the notion that scars can serve as a painful reminder of a difficult
period in one’s life. A young adult in Chandler’s sample noted that his scars remind him of a
time and place that “wasn’t very nice” (Chandler, p.118). For some participants in the present
study, the social implications of long-term scarring seemed to be most pertinent. For instance,
when Participant 16 said, “It was embarrassing when somebody saw [a scar] because like they’d
be seeing your vulnerability and things you’d done that people will look down on and you don’t
want people to see that”, she emphasized the message her scars communicated about her pain
and experiences to others.

Interestingly, the language used by some participants to describe their NSSI and scars
from NSSI (e.g., “it’s always part of me […] they’re never going to go away”) suggested a
degree of identification with NSSI that warrants further empirical attention. Of course, scarring
represents a permanent alteration of the skin; as such, scars from NSSI do literally become a part
of those that bear them. However, some participants indicated that the permanence of their scars
meant that NSSI had become a “part of [them]” or would “stay with [them] forever”. While past
research has rarely explored the relation between scarring from NSSI and identity, the act of
identifying with NSSI has been the focus of some research and theory. In particular, a number of
qualitative studies have explored what it means to identify as a “self-injurer” (Baker & Lewis,
2013; Breen, Lewis, & Sutherland, 2013; York, 2014). Breen and colleagues (2013) explored
accounts of NSSI on personal websites and found that many authors spoke of NSSI as a source
of self-identification – something that made them unique and an individual. York (2014) found
that participants in her dissertation study explicitly identified as “self-injurers” or “cutters”, yet
believed that their appearance and persona did not correspond to the societal perception of
someone who self-injures. Though beyond the scope of this paper, it is useful to note that given
the limited and somewhat pejorative stereotypes that are often associated with NSSI (e.g.,
“emo”, “goth”) it is not surprising that youth who do not identify with such groups wish to distance themselves from that association.

Unlike the participants of the research referenced above, the current study participants did not explicitly refer to themselves as “self-injurers”; rather, their language suggested a more implicit identification with the behaviour (e.g., “it’s always part of me”). The implicit identification hypothesis proposes that individuals develop implicit associations or identifications with various behaviours, which in turn predicts whether they will engage in said behaviour (Greenwald, Poehlman, Uhlmann, & Banaji, 2009). Nock (2010) hypothesized that an implicit association or identification with NSSI may lead individuals to choose NSSI as a regulatory strategy rather than alternate coping strategies. Indeed, research has found that those with a history of NSSI hold more favourable attitudes toward self-injury and implicitly identify with the behaviour compared with matched controls (Nock & Banaji, 2007). Given that participants in the present study were those with past or current history of NSSI, it is difficult to assess what led them to choose NSSI as a regulatory strategy; however, it is possible that identifying with NSSI led them to continue to use NSSI as a regulatory strategy, at least for some time.

While participants spoke of NSSI using the language of identification, they did not describe a favourable association with the act. Participant 4 shared her belief that NSSI is “worse than depression, like it’s because it stays with you forever, like the scars and everything about it”. Past research exploring NSSI and identity development has found that, for some, NSSI offers an appealing way to define the self and one’s individuality (Breen et al., 2013). While the relationship between NSSI and identity is likely a complex one that differs from individual to individual, it may be that individuals who are actively engaging in NSSI find the personal
association more appealing than those who have recovered. The fact that scars initiate disclosure, may be used to authenticate distress or disclose NSSI when words fail, and have continued relevance even after recovery from NSSI underscores the need to prepare potential NSSI disclosure recipients by disseminating information on effective responses to disclosure.

**Responses to Disclosure**

Most interviewees were able to share at least one positive disclosure experience and one they deemed negative or difficult. While many different disclosure responses were shared, the most robust themes involved responses to disclosures characterized by silence and avoidance and responses that were described as being understanding and accepting.

**Silence and avoidance.** The silence surrounding mental illness in general has been well documented. One only has to look to recent mental health awareness campaigns, such as Bell’s “Let’s Talk”, which was designed explicitly to stimulate discourse about mental illness, to appreciate that silence has been the status quo when it comes to issues of mental health. The assumption behind this, and other, mental health campaigns is that sharing one’s distress with others will jumpstart a conversation and, hopefully, lead one to seek more formal avenues of help. Unfortunately, a number of participants in the present study found that their efforts to disclose their current or past NSSI were met with silence and/or subsequent avoidance of the topic.

The experience of encountering silence in response to NSSI disclosure and/or discovery has been explored in past qualitative research examining NSSI. Chandler (2010) shared that some participants in her dissertation study noted growing up in supportive families yet described familial atmospheres that were silencing or silent, particularly in response to emotional issues.
For instance, in a scenario similar to the one Participant 8 in the present study described (see p. 78), a young man relayed his belief that his family knew about his self-injury (“Obviously everybody’s seen it”, p.192) and did not address it (Chandler). In other cases, participants described situations where family members may not have known about their NSSI because the familial environment did not support communication about emotions (Chandler).

Silence in response to evidence of NSSI and direct disclosure was an issue in the context of both family and peer relationships in the present study. In the familial context, participants tended to share stories of parental “counterfeit secrecy” (e.g., situations in which a person suspects another’s NSSI yet does not wish to acknowledge or confirm their suspicions; Hodgson, 2004), whereby parents may have seen evidence of NSSI or even asked questions about the nature of their child’s wounds, but chose to remain silent or believe the cover story that was provided. In the context of peer relationships, however, participants most often shared stories of disclosures that were met with subsequent avoidance of the topic. This finding is consistent with participant narratives explored in Chandler’s (2010) dissertation work. Although Chandler’s work did not focus directly on NSSI disclosures, participants in her study shared stories of social contacts ignoring signs of their NSSI, such as visible wounds or scars. We know from the general self-harm literature (self-harm being a broader category under which NSSI is subsumed, but may also include overdosing and suicidal behaviour) that youth who harm themselves report fewer people with whom they can share bothersome information and experiences compared to their peers (Evans, Hawton, & Rodham, 2005). It is, therefore, troubling that participants who manage to disclose their experiences with NSSI to friends and family may not be receiving the social support they seek.
In keeping with the social signaling hypothesis (Nock, 2008) discussed above, if NSSI is used to signal distress when weaker signals have been unsuccessful, the implications of continued silence in response to that distress may be particularly problematic. It is possible that not receiving the desired response to a signal of distress (i.e., NSSI) may lead to further escalation of the behaviour (e.g., more serious or more frequent acts of self-injury). Silent or avoidant responses may also communicate that NSSI is an act that is so bad or shameful that it cannot be discussed, potentially perpetuating a cycle of shame and promoting further silence.

We also know from the disclosure literature that unsupportive or rejecting responses to disclosure can lead to increased psychological distress (Chaudoir & Fisher, 2010) and may even predict worse psychological outcomes than not disclosing in the first place (Ullman, 2010). Further research into the impact of silent and/or avoidant responses to NSSI disclosure may help to better understand the implications of this type of response.

Finally, beyond the fact that silent or avoidant responses to disclosures can be upsetting and counterproductive, single disclosure experiences may shape the likelihood of future disclosures (Chaudoir & Fisher, 2010). According to the Disclosure Process Model (DPM; Chaudoir & Fisher) a feedback loop exists within disclosure experiences, such that positive disclosure experiences promote openness and may increase the likelihood of subsequent disclosures, while negative disclosure experiences promote concealment and may decrease the likelihood of subsequent disclosures. If youth who disclose to their friends and families are met with silence and a lack of support, they may be less willing to initiate other disclosure conversations, potentially impacting the likelihood of seeking help or support. In fact, a number of interviewees from the present study explicitly stated that negative disclosure experiences had silenced them.
Given the evidence that single disclosure experiences may impact future disclosure trajectories, it is important to not only understand what negative disclosure experiences and responses look like, but also to explore positive disclosure experiences and responses. If we know what responses young adults find helpful, we can share this information with parents, teachers, youth, and other important stakeholders.

**Understanding and acceptance.** The disclosure responses deemed helpful by participants in the present study are in line with recommendations made by experts in the study of NSSI. Participants described responses that were understanding, empathic, and accepting. Guidelines for therapist responses to NSSI disclosures emphasize the importance of responding empathically and without judgment (Klonsky, Muehlenkamp, Lewis, & Walsh, 2011). Similarly, in his seminal text on treating self-injury, Walsh (2006) emphasized the importance of attending to people’s NSSI and associated emotional experiences with a low-key, validating, and calm demeanor. Participant responses were also consistent with suggestions drawn from participant comments in a study exploring the role of disclosure and support in NSSI cessation (Pietrusza, Rothenberg, & Whitlock, 2011). That participants’ disclosure experiences and preferences echoed expert opinion and extant research is both validating and encouraging.

While it is important to understand and promote the aspects of NSSI disclosure responses that young adults have found helpful, we know from the broader disclosure literature that supportive responses to personal disclosures have been found to positively impact discloser wellbeing (Chaudoir & Fisher, 2010). For instance, participants who shared the thoughts and feelings that were elicited by stressful stimuli (i.e., images of the Holocaust) with a supportive confidant experienced fewer intrusive thoughts about the stimuli (Lepore, Ragan, & Jones, 2000). In fact, the beneficial results of disclosing to a supportive confidant hold even when the
disclosure is imaginal, as reported by Rodriguez & Kelly (2006) in a study where participants were asked to disclose a personal secret to an imagined accepting or non-accepting confidant. Further, as noted above, positive disclosure experiences may impact the likelihood of future disclosure experiences (Chaudoir & Fisher). While this has not been investigated in the context of NSSI disclose, positive, supportive disclosure events have been found to predict the likelihood of subsequent disclosure of HIV/AIDS (Chaudoir, 2009).

Thus, the literature clearly supports the finding that disclosure recipient reactions are a significant factor in shaping the disclosure experience; however, it is important to note that different disclosure characteristics have been found to elicit different confidant responses (Chaudoir & Fisher, 2010). For instance, disclosures characterized by greater depth (i.e., contain more private or intimate information) have been found to associate with greater liking on the part of the disclosure recipient (Collins & Miller, 1994), which in turn may elicit more positive responses. It is, therefore, important to investigate both the characteristics of the disclosure as well as the response elicited. NSSI disclosures are a transactional event. While it is essential to understand the disclosure experience from the perspective of the discloser, a future research endeavor will be to examine the NSSI disclosure process from a transactional perspective.

**Clinical and Conceptual Implications**

This study sought to understand the process of disclosing NSSI from the perspective of young adults who had disclosed to others as well as those who elected not to do as such. Participants shared their experiences of disclosure and through an examination of their accounts key factors were collated and interpreted. An important thread running throughout participants’ stories was the experience of shame. Shame was implicated as a barrier to NSSI disclosure for many participants; however, it also seemed to relate to another barrier to disclosure described by
participants: not wanting to burden or upset others by disclosing their NSSI. Underlying shame is a sense of the self as not being good or worthy enough (Lewis, 2003). For those participants who were unwilling to burden others with their need for support, it is possible that feelings of shame impacted their sense of deservedness. Shame seemed to not only affect individuals’ willingness to share difficult aspects of their experience, such as NSSI, but also individuals’ sense of their needs being important and worthy of support. Further, the results of this study suggest that disclosure recipients’ responses to disclosure may further increase NSSI-related shame.

Participants in this study described silence and avoidance as common responses to NSSI disclosure or discovery. By not talking about NSSI once it’s been disclosed, recipients may be communicating that NSSI is so bad or subversive that it cannot be discussed, thereby inadvertently increasing feelings of shame and, perhaps, decreasing the likelihood and/or increasing the difficulty of future disclosures. This cycle of shame in relation to NSSI disclosure represents an important avenue for future research.

The prominent role of NSSI-related scarring in participants’ disclosure experiences (and in their lives more broadly) has important clinical implications. Many clinical guidelines for assessing and treating NSSI do not directly address scars and yet it may be important to help individuals process the beliefs and feelings they have about their scars, as well as thoughts surrounding the decision to conceal or not conceal their scars from NSSI. An individual’s choice not to conceal their scars may be a positive step toward self-acceptance, however the potential for forced disclosures may be heightened among individuals with scarring that is visible to others. As such, an important role for clinicians working with youth with scars from self-injury may be to prepare them for the possibility of being questioned about the nature of their scars and help them to decide how they would like to handle such inquiries. It may be helpful for youth to
consider the interpersonal boundaries they would like to set and practice various ways of responding to questions and comments about their scars in the context of a safe, therapeutic relationship. Efforts to reduce feelings of shame associated with NSSI and scarring from NSSI may also help individuals feel equipped for future disclosure experiences. As noted elsewhere in this paper, compassion-focused therapy (CFT; Gilbert, 2009) may be a useful treatment approach to help clients build acceptance of their scars and relate to themselves more compassionately, while diminishing feelings of shame (Kelly, Zuroff, & Shapira, 2009).

The intensity of the experience of shame described by individuals in this study underscores the importance of efforts to reduce the stigma associated with self-injury, as well as efforts to implement universal awareness and prevention programs to create social climates that are accepting of and prepared for self-injury disclosures. Given the shame associated with self-injury and the associated difficulties talking about it with others, it is important that individuals who are more likely to be the recipient of disclosures (e.g., friends, family members, teachers, therapists, and doctors; Nixon et al., 2008) understand the nature of the behaviour and feel prepared to respond to self-injury disclosures sensitively and effectively. Furthermore, if awareness programs are successful in reducing stigma associated with self-injury, youth who have struggled with self-injury may be more inclined to share their experiences. One such program that has shown effectiveness in school settings is The Signs of Self-Injury Program (Muehlenkamp, Walsh, & McDade, 2010). Although all participants in the present study were university students, most had first disclosed their NSSI in primary or secondary school, and so it is particularly important that youth and school professionals are well-equipped to handle NSSI disclosures. Informational outreach programs, such as the Self-injury Outreach & Support (SiOS) initiative led by Dr. Stephen Lewis and Dr. Nancy Heath (http://www.sioutreach.org),
offer an alternate way to reach members of the public who self-injure or know someone who does. SiOS, for instance, provides information and resources on help-seeking and recovery form NSSI, as well as helpful ways of responding to disclosures or discoveries of NSSI for various parties who may be involved (e.g., friends, parents, school professionals, medical professionals, etc.).

**Limitations and Future Directions**

The study findings and conclusions may be limited by the small size and homogeneity of the sample. This study was originally proposed as a follow-up to a larger study conducted through the psychology participant pool. As such, participants were drawn from a relatively homogeneous population of undergraduate psychology students, the majority of whom are females. While homogeneity is a sampling strategy employed in qualitative research (Patton, 1990) to ensure a comprehensive understanding of the phenomena of interest, future studies investigating the nature of the self-injury disclosure experience would benefit from recruiting a more balanced ratio of male and female participants and including participants from more diverse cultural, ethnic, and socio-economic backgrounds. Alternatively, future qualitative research may focus on participants from specific cultural, ethnic, religious, or socioeconomic backgrounds in order to elucidate differences in disclosure processes. It will also be important to hear about the disclosure experiences of individuals from varying age cohorts.

Further, disclosure is typically an interactive process involving at least two parties. While it is important to examine the disclosure experience from the perspective of youth who have disclosed, future research should explore the dyadic process of NSSI disclosure as well as examine the experience from the perspective of the disclosure recipient. Another potential limitation is the fact that this study relied on retrospective accounts of disclosure experiences.
While some participants recounted disclosures that had occurred in the recent past, others shared experiences that had occurred years ago. Accounts would have therefore been subject to participants’ memory and potential errors or biases in recall. Finally, due to the timing of data collection and analysis, it was not possible to invite participants back in to share study findings with them and incorporate their feedback into this paper. Ideally, we would have liked to have the opportunity to do so.

**General Discussion and Conclusions**

The goal of this dissertation was to explore the act of disclosure to important others among individuals who have engaged in NSSI. Two studies were conducted to accomplish this aim. The first study explored the relation between shame, self-compassion, self-forgiveness, and NSSI disclosure variables, including the ease, difficulty, and number of past disclosure experiences, as well as attitudes toward future NSSI disclosure possibilities. It also examined the role of perceived visible scarring from NSSI in the context of disclosure. Overall, findings underscored the role of shame and scarring on NSSI disclosure. The majority of respondents (72%) reported visible scarring from NSSI. Of those, more than half shared that others had both noticed and commented on their scarring in the past. Perceived visible scarring uniquely predicted the number of past disclosure recipient groups: participants with perceived visible scarring reported having disclosed to a greater number of disclosure recipient groups (e.g., friends, mother, romantic partner, etc.). This higher number of disclosure experiences may be related to greater difficulty concealing signs of NSSI and more questions from concerned or interested others. Together, shame and perceived visible scarring predicted more difficult past disclosure experiences, suggesting that individuals who experience greater shame (and, likely, a greater desire to conceal their NSSI), but who are compelled to disclose due to the presence of
scarring, may experience disclosures as being more difficult. Shame alone uniquely predicted more negative attitudes toward future disclosures (i.e., reported lower likelihood of disclosing in the future and higher anticipated difficulty of potential disclosure experiences). Given the demonstrated association between shame and NSSI (Brown et al., 2009; Gilbert et al., 2010), as well as shame’s association with the concealment of emotional distress (MacDonald & Morley, 2001) and mental illness (Corrigan, 2004), it is understandable that shame would associate with a reluctance to disclose NSSI to others.

The second study sought to understand the process of NSSI disclosure from the perspective of young adults who had disclosed their self-injury to others in the past as well as those who had elected not to do so. Individual interviews were conducted with 17 young adults recruited from Study 1 and themes were drawn from interview transcripts using Braun and Clark’s (2006) guidelines for thematic analysis. Superordinate themes included: (1) barriers to disclosure, (2) the role of scars in disclosure and, more generally, as a person living with a history of NSSI, and (3) responses to NSSI disclosure. Two major barriers to disclosure were reported by interviewees: the experience of shame and concern for the impact the disclosure would have on important others. Interviewees described shame and concern for others both as true barriers to disclosure, meaning it prevented them from telling others about their NSSI, and as factors that made the act of disclosure more difficult. In terms of the role of scars, many interviewees spoke about the nature of their scars from NSSI and the impact they had on their lives. It was apparent that NSSI scars often play a multifaceted and emotionally laden role in the lives of those who bear them. Visible scars often prompted questions from others and, at times, led to NSSI disclosure. For some, scars were used as a social signal, helping to communicate and authenticate the extent of their distress. Scars also served as an enduring representation of some
participants’ NSSI and, by extension, the emotional pain that associated with it. Some participants expressed that the permanence of scars meant that NSSI remained with them for years after recovery. For some, this ongoing reminder of NSSI seemed to contribute to an implicit identification with self-injury. Finally, potential responses to NSSI disclosure are many; however, participants in the present study most frequently shared examples of two broad responses – silence and/or subsequent avoidance of the topic of NSSI and, on the more helpful end of the spectrum, understanding and acceptance.

The findings from this dissertation highlighted the role that feelings of shame play in the process of NSSI disclosure. Shame was shown to act as a barrier to disclosure – it predicted more difficult disclosure experiences and reluctance to participate in future disclosures. Underlying feelings of shame may have also contributed to some participants’ expressed reluctance to burden others with disclosure of their NSSI. Further, some participants shared that signs of NSSI were ignored by important others in their life (e.g., parents and siblings) and a commonly cited response to disclosure was avoidance of further talk of NSSI. These types of responses are likely to promote feelings of shame, in that they imply that NSSI is so bad that it cannot be discussed. The results also underscored the challenges associated with having physical evidence of a history of NSSI in the form of visible scars or marks. In the context of disclosure, visible scarring predicted disclosure to a larger number of recipient groups (i.e., friends, parents, siblings, etc.) and participants in Study 2 spoke of being questioned about their scars by concerned and interested others. While scarring sometimes helped to prompt supportive discussions about NSSI, in other circumstances it led participants to disclose on terms that were not their own, or else concoct a cover story or diversion. Feelings of shame were also linked to scarring from
NSSI. As one participant noted, visible scars can communicate much about a person’s pain and vulnerability to others.

Finally, it is important to acknowledge that an assumption underlying the study of NSSI disclosure is that it is somehow important or necessary for NSSI recovery. As noted in the introduction, preliminary research shows that some people recover from NSSI without seeking help or even without telling anyone (Pietrusza, 2010). We also know, however, that this is not the case for everyone – many adolescents and young adults choose to disclose their NSSI for various reasons, including for the purpose of seeking help or support. Furthermore, as mentioned above, others with signs of current or past NSSI may be placed in situations where the decision to disclose is not entirely their own. Given that youth do disclose their NSSI for a number of reasons and the nature of responses to disclosures has been shown to be important for the wellbeing of the discloser, it follows that developing a good understanding of NSSI disclosure conversations, including factors that facilitate and discourage disclosure, is valuable. As such, the continued exploration of helpful and harmful NSSI disclosure experiences remains an important goal for future research.

**Future Directions**

Although numerous recommendations for future NSSI disclosure research have been proposed in previous sections of this dissertation, a few broader recommendations based on this dissertation’s findings warrant further emphasis. Recent research has underscored the role of shame in NSSI (VanDerhei et al., 2013; Schoenleber et al., 2014), including the potential shame regulating functions of NSSI (Schoenleber et al.). The results of this dissertation expand the understanding of shame in the context of NSSI by suggesting that shame serves as a key barrier to the disclosure of NSSI. Future research should investigate the efficacy of interventions
targeting shame in the treatment of NSSI and in NSSI education and awareness initiatives. Tangney and Dearing’s (2011) summary of clinician approaches to identifying and managing shame in the therapeutic context offers numerous techniques for addressing shame therapeutically. Incorporating shame-related material – for example, the promotion of responses to NSSI disclosure that mitigate feelings of shame – into broader NSSI education programs is another potential direction for future NSSI research.

Self-compassion has been proposed as a remedy for feelings of shame (Gilbert, 2005; Tangney & Dearing, 2011). While self-compassion was not found to play a central role in the disclosure processes examined in this dissertation, that does not mean it is does not warrant further investigation, particularly with respect to its role in the reduction of shame. Future research should examine the efficacy of compassion-focused therapy, which has been proposed as a promising treatment approach for NSSI (Van Vliet & Kalnins, 2011). In addition, fear of self-compassion, a related construct that focuses on resistance to treating oneself compassionately, has been found to associate with poor treatment outcomes for individuals with eating disorders (Kelly et al., 2013). This represents another important area for future research investigating the role of shame and self-compassion in NSSI pathology and recovery.

Finally, scarring is a salient outcome of many forms of NSSI, and the short- and long-term implications of scarring have been somewhat overlooked in the NSSI literature to date. This is surprising given the myriad potential social and personal consequences of visible scarring from NSSI. While this dissertation project focused on some of the challenges associated with having visible scars, both in the context of disclosing NSSI and in the broader context of having a lasting reminder of painful experiences, there are many potential aspects of NSSI scarring that warrant further exploration. For example, a number of participants’ expressed concerns about the
long-term impact their scars would have on their professional and personal lives. Future research may investigate the extent to which these fears are grounded in reality by talking to adults and young adults about any personal and professional challenges they have faced as a result of their history of NSSI.

**Final Thoughts**

A growing body of research produced over the past few decades has contributed immensely to our clinical and conceptual understanding of NSSI. Self-injury has also been explored in popular films, television series, and songs, and has been discussed in the mainstream media (Picard, 2011). Despite the increased empirical, media, and cultural attention that has been paid to NSSI, self-injury remains a difficult subject to talk about. While shame certainly seems to impede the disclosure process, research and theory show that silence can heighten feelings of shame. To interrupt this potential cycle of shame, it is important to encourage healthy and supportive NSSI disclosure exchanges. This dissertation aimed to develop a better understanding of the disclosure process, including identifying factors that facilitate and hinder NSSI disclosure conversations. Despite the difficult disclosure experiences many participants in this study shared, it is encouraging that the majority of interviewees in Study 2 were able to recall at least one supportive and accepting response to their disclosure of self-injury. Hopefully the knowledge derived from these and other disclosure studies will contribute to fostering an environment in which conversations about NSSI are greeted with increased understanding and acceptance, such that youth who are struggling with self-injury do not have to struggle alone.
References


Shaffer, D., & Jacobson, C. (2009, December 1). Proposal to the DSM-V childhood disorder and mood disorder work groups to include non-suicidal self-injury (NSSI) as a DSM-V disorder. Retrieved from:  
http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=443


CONSENT TO PARTICIPATE IN RESEARCH

The identification of barriers to self-injury disclosure

You are asked to participate in a research study conducted by Dr. Stephen Lewis and Shaina Rosenrot, MA (PhD Student), from the Department of Psychology at the University of Guelph.

If you have any questions or concerns about the research, please feel free to contact Dr. Lewis by phone: 519.824.4120 (x53299) or by email: stephen.lewis@uoguelph.ca. You may also contact Shaina Rosenrot (srosenro@uoguelph.ca)

PURPOSE OF THE STUDY

The main purpose of this study is to learn more about how people talk to others about their self-injury, including the factors that may facilitate or prevent someone from telling others about their self-injury. Another goal of this study is to understand the impact scarring from self-injury may have on self-injury disclosure and relationships with others.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

How the study is designed.
The study is designed in a way that allows the researchers to study the relations between various experiences, psychological symptoms and self-injury at the same time. To carry out this research, we are asking you to fill out questionnaires on the Internet. The website that the questions are on is secure and you will not be asked for your name or other information that can match who you are with what you say. In this way, your answers to all questions on the study website are completely confidential. At the end of the survey, you will be asked whether you would like to be contacted for a follow-up study. Your response to this question does not obligate you in any way to participate in the follow-up study and you can decline to participate at any time.

What you will be asked to do:
Each person who takes part in the study will be asked to complete several different questionnaires. These ask about aspects of self-injury, past experiencing telling others about self-injury, individual traits that may (or may not) interfere with talking to others about self-injury. When we refer to self-injury, we mean any behaviour that people use to hurt themselves on purpose for any reason. Each questionnaire is briefly described below.

The first set of questionnaires will ask you about how you typically act toward yourself during difficult times. The second asks you about your experience with self-conscious or embarrassed feelings. The third and fourth questionnaires ask about self-forgiveness, meaning whether you tend to forgive yourself for actions you may feel badly about after the fact. The fifth questionnaire asks about various aspects of self-injury (e.g., when you first and last self-injured). The next questionnaire asks about whether you have told anyone about your self-injury and how easy or difficult that was. The final questionnaire asks you whether you have any scarring from self-injury and whether you have any concerns about your scarring.

How long does the study take?
In total, all of the questionnaires should not take you more than about 60 minutes to complete. However, you may take as long as you like, as long as the entire study is completed in one sitting. There is no time limit and you will not be asked to stop if you have not finished a questionnaire so please feel free to take your time.

Important information about taking part in the study:
Before participating it is important that you know that taking part in the study is completely voluntary. This means that you do not have to take part in the study if you do not feel like it. This also means that you have the choice to not answer any question on any of the questionnaires. This can be for any reason and there is no penalty for choosing to not answer a question. Finally, if you choose to take part, you may stop participating at any time and for any reason. If you do agree to take part in the study, you will be asked to email Shaina Rosenrot (srosenro@uoguelph.ca).
Please feel free to ask Shaina any questions you have about the study. You may also contact Dr. Lewis (stephen.lewis@uoguelph.ca) to answer questions or address any concerns you may have. You may also ask questions throughout the study or even after the study is finished if you like.

When contacting Shaina to indicate that you want to take part in the study, please use your University of Guelph email account. You will not receive a reply from other email accounts (e.g., gmail, hotmail, yahoo). If you agree to take part in the study and wish to receive a username and password to access the questionnaires for the study, please copy and paste the following statement in your email:

‘I have read the information provided for the study ‘The identification of barriers to NSSI disclosure’ as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.’

Once you email Shaina and indicate that you agree to take part in the study (by pasting the statement above into your email), you will be sent your own unique username and password. The unique username and password will be yours and yours only. This means that only you will have
access to your questions and that others will not have access to your answers. By completing the questionnaires online, you can also fill out the questionnaires at a time that is convenient for you.

Answers to questions will be kept confidential. By completing the questionnaires online, you can keep your data confidential. This means, that your individual answers to questions will not be linked to any identifying information. You can also do the questionnaires in the privacy of your home or at another location where you feel comfortable.

**POTENTIAL RISKS AND DISCOMFORTS**

Some participants may find some of the questions about self-injury difficult or upsetting to answer. Although there is no documented evidence that answering these types of questions increases the risk for thinking about self-injury or actually hurting yourself, we cannot guarantee that this will not happen. Therefore, you may choose to not take part in this study if you would not like to answer questions about self-injury. If you experience any discomfort when taking part in the study you are encouraged to contact your family doctor or the researchers (contact information is provided, below). You may also contact the University of Guelph Counselling Centre. There contact information is as follows:

Counselling Services  
University Centre - Level 3 South  
University of Guelph  
Guelph, ON N1G 2W1  
Phone: (519) 824-4120 ext. 53244  
Fax: (519) 824-9689  
Website: [http://www.counselling.uoguelph.ca/counselling/](http://www.counselling.uoguelph.ca/counselling/)

If, at any point, you feel as though you want to hurt yourself, you are encouraged to contact a local crisis line, call 911 or go to your local Emergency Department. This information can be found below.

Local crisis line in Guelph (this is a free, confidential service available 24 hours a day, 7 days a week):  
1-877-822-0140 OR 519-821-0140  
Local distress line if you are feeling upset (this is a free, confidential service available 24 hours a day, 7 days a week):  
1-888-821-3760 OR 519-821-3760

Here is the location of the local emergency department in Guelph (Guelph General Hospital):  
Guelph General Hospital  
115 Delhi St.  
Guelph, Ontario  
N1E 4J4
If you would like to learn more about self-injury and how to get help for self-injury, or if you are seeking a supportive online community, these websites may be helpful:

www.sioutreach.org
www.recoveryourlife.com

*Please note that this information will also be provided on the website at all times. Therefore, there will be a “help-box” on every webpage of the website where you can access this information.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

There is no direct benefit to you by participating in this study. However, what we learn from participants may be of benefit to others. For instance, findings from the study may help us to better understand and treat self-injury. Additionally, findings from this study will help us to understand why some people seek help for self-injury by telling friends, family, or professionals about it but others do not. In this way, we will be able to find ways to encourage people to talk to others about their self-injury, get help and make sure people know where to go for help. This information will also help to educate mental health professionals about important ways to help those who have hurt themselves. Finally, findings from this study can help to improve people’s knowledge about self-injury and help others to understand how to react to and work with others who tell them about their self-injury.

PAYMENT FOR PARTICIPATION

While everyone who takes part in the study will be asked to volunteer their time, compensation will be offered in two ways. First, for those people in the Psychology Participant Pool, you will receive 1 credit point (i.e., 1 credit point per hour of participation or part thereof) toward your final grade in applicable undergraduate psychology courses.

If you are not a part of the Psychology Participant Pool or wish to take part in this study but not receive credit points, your email will be entered into a draw to win an iPod nano (valued at $129). The draw for the iPod nano will take place after the study is over and the winner will be contacted by email. Chances of winning will depend on the number of people who participate in the study. We expect that approximately 50 people will be eligible for the draw.

In addition to this, everyone who takes part will have the chance to hear about the results of the study. A summary of all findings will be put on the study webpage via a link, which allows you to access a secure webpage. On this webpage will be the main findings of the study.

In all cases, only group data will be presented and no one’s individual data will ever be presented as we want to ensure everyone’s confidentiality and privacy.

CONFIDENTIALITY
Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study.

All data collected in this study will be treated with the strictest of confidence. This means that we will never share your data with anyone else. To ensure confidentiality, each person who takes part in the study will be given a unique username and password. This is used to access the online questionnaires. At no point will participants be asked to give their name or other identifying information (e.g., name, address) while on the website.

Website link: https://ssl7.sentex.ca/westresearch_secure_cgi/rws5.pl?FORM=rosenrot

To further ensure the confidentiality of data collection, upon completion of the survey participants will not be able to return to earlier questions to view or alter their responses. This ensures that participants’ responses remain confidential and that others who may have access to a shared computer will not be able to view the survey. Further, all questionnaires will be administered on a secure server and upon completion of all questionnaires all individual accounts will be closed so that no one can see what answers were given for each question. The server on which the website is located is dedicated to these types of surveys and all content and handling of data is in compliance with the Personal Information Protection and Electronic Documents Act (PIPEDA).

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may exercise the option of removing your data from the study. You may also refuse to answer any questions you don’t want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise that warrant doing so.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Research Ethics Coordinator
University of Guelph
437 University Centre
Guelph, ON N1G 2W1

Telephone: (519) 824-4120, ext. 56606
E-mail: sauld@uoguelph.ca
Fax: (519) 821-5236
ELECTRONIC SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

Please paste the statement below (in quotations) in an email from your University of Guelph email account to the graduate coordinator of this study, Shaina Rosenrot (srosenro@uoguelph.ca).

“I have read the information provided for the study “The identification of barriers to NSSI disclosure” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.”
Appendix B

Brief Demographics Questionnaire

Please indicate your sex:   Male ○   Female ○

Please indicate your age (in years): __________

Please indicate your ethnicity: __________
Appendix C

Inventory of Statements About Self-injury (ISAS; Klonsky & Glenn, 2009) – Section I.

This questionnaire asks about a variety of self-harm behaviors. Please only endorse a behavior if you have done it intentionally (i.e., on purpose) and without suicidal intent (i.e., not for suicidal reasons).

1. Please estimate the number of times in your life you have intentionally (i.e., on purpose) performed each type of non-suicidal self-harm (e.g., 0, 10, 100, 500):

   Cutting ____  Severe Scratching ____
   Biting ____  Banging or Hitting Self ____
   Burning ____  Interfering w/ Wound Healing ____
     (e.g., picking scabs)
   Carving ____  Rubbing Skin Against Rough Surface ____
   Pinching ____  Sticking Self w/ Needles ____
   Pulling Hair ____  Swallowing Dangerous Substances ____
   Other ________________, ________________

******************************************************************************
**********************
Important: If you have performed one or more of the behaviors listed above, please complete the final part of this questionnaire. If you have not performed any of the behaviors listed above, you are done with this particular questionnaire and should continue to the next.
******************************************************************************
**********************

2. If you feel that you have a main form of self-harm, please circle the behavior(s) on the first page above that you consider to be your main form of self-harm.

3. At what age did you:

   First harm yourself? ____________  Most recently harm yourself? ____________
   (approximate date – month/date/year)
4. Do you experience physical pain during self-harm?

Please circle a choice:  YES  SOMETHING NO

5. When you self-harm, are you alone?

Please circle a choice:  YES  SOMETHING NO

6. Typically, how much time elapses from the time you have the urge to self-harm until you act on the urge?

Please circle a choice:

< 1 hour   1 - 3 hours   3 - 6 hours

6 - 12 hours   12 - 24 hours   > 1 day

7. Do/did you want to stop self-harming?

Please circle a choice:  YES  NO
Appendix D

Self-Compassion Scale (SCS; Neff, 2003a)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

<table>
<thead>
<tr>
<th>Almost never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Almost always</th>
<th>5</th>
</tr>
</thead>
</table>

1. I’m disapproving and judgmental about my own flaws and inadequacies.
2. When I’m feeling down I tend to obsess and fixate on everything that’s wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I’m feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I’m down and out, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I’m intolerant and impatient towards those aspects of my personality I don't like.
12. When I’m going through a very hard time, I give myself the caring and tenderness I need.
13. When I’m feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens I try to take a balanced view of the situation.
15. I try to see my failings as part of the human condition.
16. When I see aspects of myself that I don’t like, I get down on myself.

17. When I fail at something important to me I try to keep things in perspective.

18. When I’m really struggling, I tend to feel like other people must be having an easier
time of it.

19. I’m kind to myself when I’m experiencing suffering.

20. When something upsets me I get carried away with my feelings.

21. I can be a bit cold-hearted towards myself when I’m experiencing suffering.

22. When I’m feeling down I try to approach my feelings with curiosity and openness.

23. I’m tolerant of my own flaws and inadequacies.

24. When something painful happens I tend to blow the incident out of proportion.

25. When I fail at something that's important to me, I tend to feel alone in my failure.

26. I try to be understanding and patient towards those aspects of my personality I don't
like.
Appendix E

Heartland Forgiveness Scale – Forgiveness of Self subscale (HFS; Thompson et al., 2005)

In the course of our lives negative things may occur because of our own actions, the actions of others, or circumstances beyond our control. For some time after these events, we may have negative thoughts or feelings about ourselves. Think about how you typically respond to such negative events. Next to each of the following items write the number (from the 7-point scale below) that best describes how you typically respond to the type of negative situation described. There are no right or wrong answers. Please be as open as possible in your answers.

1                     2                     3                     4                     5                     6                     7
Almost Always            More Often            More Often            Almost Always
False of Me              False of Me              True of Me              True of Me

____ 1. Although I feel bad at first when I mess up, over time I can give myself some slack.
____ 2. I hold grudges against myself for negative things I’ve done.
____ 3. Learning from bad things that I’ve done helps me get over them.
____ 4. It is really hard for me to accept myself once I’ve messed up.
____ 5. With time I am understanding of myself for mistakes I’ve made.
____ 6. I don’t stop criticizing myself for negative things I’ve felt, thought, said, or done.
Appendix F

Experience of Shame Scale (ESS; Andrews et al., 2002)

Everybody at times can feel embarrassed, self-conscious, or ashamed. These questions are about such feelings if they have occurred at any time in the past year. There are no ‘right’ or ‘wrong’ answers. Please indicate the response that applies to you with a tick.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Very much</td>
</tr>
</tbody>
</table>

1. Have you felt ashamed of any of your personal habits?
2. Have you worried about what other people think of any of your personal habits?
3. Have you tried to cover up or conceal any of your personal habits?
4. Have you felt ashamed of your manner with others?
5. Have you worried about what other people think of your manner with others?
6. Have you avoided people because of your manner?
7. Have you felt ashamed of the sort of person you are?
8. Have you worried about what other people think of the sort of person you are?
9. Have you tried to conceal from others the sort of person you are?
10. Have you felt ashamed of your ability to do things?
11. Have you worried about what other people think of your ability to do things?
12. Have you avoided people because of your inability to do things?
13. Do you feel ashamed when you do something wrong?
14. Have you worried about what other people think of you when you do something wrong?
15. Have you tried to cover up or conceal things you felt ashamed of having done?
16. Have you felt ashamed when you said something stupid?
17. Have you worried about what other people think of you when you said something stupid?

18. Have you avoided contact with anyone who knew you said something stupid?

19. Have you felt ashamed when you failed at something which was important to you?

20. Have you worried about what other people think of you when you fail?

21. Have you avoided people who have seen you fail?

22. Have you felt ashamed of your body or any part of it?

23. Have you worried about what other people think of your appearance?

24. Have you avoided looking at yourself in the mirror?

25. Have you wanted to hide or conceal your body or any part of it?
Appendix G

NSSI Disclosure Questionnaire

Have you ever told anyone about your self-injury?

___ YES
___ NO

If yes, who did you FIRST tell? Please select as many options that apply:

___ Mother
___ Father
___ Friend
___ Sibling
___ Romantic partner
___ Teacher
___ Guidance counsellor
___ Mental Health Professional (e.g., psychologist, social worker, psychiatrist)
___ Medical Doctor
___ Anonymous Internet interaction (e.g., chat room with non-identifying screen name)
___ Non-anonymous Internet interaction (e.g., facebook, email, personal blog)
___ Other family member
___ Other (open text box)

Who ELSE have you told? Please select as many options that apply:

___ Mother
___Father
___Friend
___Sibling
___Romantic partner
___Teacher
___Guidance counsellor
___Mental Health Professional (e.g., psychologist, social worker, psychiatrist)
___Medical Doctor
___Anonymous Internet interaction (e.g., chat room with non-identifying screen name)
___Non-anonymous Internet interaction (e.g., facebook, email, personal blog)
___Other family member
___Other (open text box)

Thinking about the FIRST time you told someone about your self-injury, how difficult did you find it?

1 2 3 4 5 6 7

No difficulty at all Somewhat difficult Very difficult The most difficult thing I’ve ever done

In general, have subsequent disclosures of your self-injury been easier or more difficult?

1 2 3 4 5 6 7

Much Easier A little easier A little more difficult Much more difficult
Thinking of the most difficult time you had telling someone about your self-injury, how difficult did you find it?

1 2 3 4 5 6 7
No difficulty Somewhat difficult Moderately difficult The most difficult thing I’ve ever done
at all

Please describe what happened to make it difficult: (Text box)

At the time, did the person(s) you told about your self-injury respond to you in the way you expected?

1 2 3 4 5 6 7
Not at all Somewhat as expected Pretty much as expected Completely as expected
as expected

At the time, how did the person(s) respond to you telling them about your self-injury?

1 2 3 4 5 6 7
Not supportive Somewhat supportive Moderately supportive Incredibly supportive
at all

Thinking of the easiest time you had telling someone about your self-injury, how difficult did you find it?

1 2 3 4 5 6 7
No difficulty Somewhat difficult Moderately difficult The most difficult thing I’ve ever done
at all
Please describe the factors that helped to make it easier: (Text box)

At the time, did the person(s) you told about your self-injury respond to you in the way you expected?

1                      2                     3                     4                     5                     6                     7
Not at all as expected Somewhat as expected Pretty much as expected Completely as expected

At the time, how did the person(s) respond to you telling them about your self-injury?

1                      2                     3                     4                     5                     6                     7
Not supportive at all Somewhat supportive Moderately supportive Incredibly supportive

Thinking about possible future disclosures, how easy or difficult would it be for you to tell someone else about your self-injury?

1                      2                     3                     4                     5                     6                     7
No difficulty at all Somewhat difficult Very difficult The most difficult thing I’ve ever done

How likely is it that you will tell someone else about your self-injury?

1                      2                     3                     4                     5                     6                     7
Not at all likely Unlikely Likely Completely certain
If the participant has not told anyone about their self-injury and answered ‘no’ to the first question of the survey (‘Have you ever told anyone about your self-injury?’), they will be automatically ‘jumped’ to the questions below:

If you have not told anyone about your self-injury, who would be the FIRST person you would choose to tell?

___ Mother
___ Father
___ Friend
___ Sibling
___ Romantic partner
___ Teacher
___ Guidance counsellor
___ Mental Health Professional (e.g., psychologist, social worker, psychiatrist)
___ Medical Doctor
___ Anonymous Internet interaction (e.g., chat room with non-identifying screen name)
___ Non-anonymous Internet interaction (e.g., facebook, email, personal blog)
___ Other family member
___ Other (open text box)

If you were to tell this person, how easy or difficult do you think it would be?

1                         2                      3                      4                        5                      6                       7
No difficulty at all       Somewhat difficult           Moderately difficult          The most difficult thing I’ve ever done
Appendix H

Scar Severity and Location Questions

Do you have any visible scarring as a result of self-injury?
___Yes
___No

Have other people noticed your scarring?
___Yes
___No

Have other people commented on your scarring?
___Yes
___No

How concerned are you about your scarring from self-injury?

1                2                3                4                5                6                7
Not concerned  Somewhat concerned  Moderately concerned  Extremely concerned

If you have concerns about your scarring, please describe your main concerns: (Text box)
Where on your body do you have scarring from self-injury? Please select as many options as apply:

___ Left hand
___ Inner left forearm (from wrist to elbow)
___ Outer left forearm (from wrist to elbow)
___ Upper left arm (from elbow to shoulder)
___ Right hand
___ Inner right forearm (from wrist to elbow)
___ Outer right forearm (from wrist to elbow)
___ Upper right arm (from elbow to shoulder)
___ Chest
___ Scalp
___ Neck
___ Face
___ Groin
___ Genitals
___ Buttocks
___ Upper left leg (from hip to knee)
___ Lower left leg (from knee to ankle)
___ Left foot
___ Upper right leg (from hip to knee)
___ Lower right leg (from knee to ankle)
___ Right foot
Where on your body do you have the most scarring from self-injury? Please select only the one that best applies:

___ Left hand
___ Inner left forearm (from wrist to elbow)
___ Outer left forearm (from wrist to elbow)
___ Upper left arm (from elbow to shoulder)
___ Right hand
___ Inner right forearm (from wrist to elbow)
___ Outer right forearm (from wrist to elbow)
___ Upper right arm (from elbow to shoulder)
___ Chest
___ Scalp
___ Neck
___ Face
___ Groin
___ Genitals
___ Buttocks
___ Upper left leg (from hip to knee)
___ Lower left leg (from knee to ankle)
___ Left foot
___ Upper right leg (from hip to knee)
___Lower right leg  (from knee to ankle)

___Right foot

___Other (text box)

___Not applicable

Participants will be prompted to skip the following question if they have no scarring and have indicated N/A to the previous two items.

Thinking of the place on your body where your scarring is the worst, please rate the severity of your scarring from self-injury:

1  2  3  4  5  6  7

Minor  Moderate  Severe

Thinking of the place on your body where your scarring is the worst, please estimate the proportion of surface area the scarring takes up:

0 %  10 %  20 %  30 %  40 %  50 %  60 %  70 %  80 %  90 %  100 %

(Use slider to indicate proportion of surface area covered with scarring)
Appendix I

Study 1 Debriefing Form

**Debriefing Package**

**Project Title:** Identifying barriers to self-injury disclosure

Thank you for your time and support in participating in this study. The purpose of this research is to examine self-injury in a sample of university students. In particular, we are interested in understanding the various factors that may facilitate or impede the disclosure of self-injury to others.

Self-injury is an important and common behaviour among adolescents and young adults. A recent study of self-injury in University students found that about 17% of students have hurt themselves on purpose in the past, with some studies suggesting that rates are even higher than this. Furthermore, self-injury is often a secretive behaviour – research suggests that a third of university students who self-injure tell no one about it. This project will help us gain a better understanding of why self-injury may be difficult to talk about, with the overarching hope of informing the development of programs to promote the safe and effective disclosure of self-injury.

If you feel distressed by the content of any of the questionnaires, please contact your family doctor, Dr. Lewis, or the crisis hotlines outlined below. If you would like more information about sources of support for self-injury, we have provided you with a list of resources on the next page. If you feel your rights as a participant in research have been violated during the course of this project, you may contact the Research Ethics Officer at the University of Guelph at 519.824.4120 (x53299). This project has been reviewed and received ethics clearance through the Office of Research Ethics Broad, University of Guelph.

Thank you again for your time. Your participation in this study is greatly appreciated and is essential for advancing our knowledge of this important issue.

If you have any questions or concerns, please feel free to contact any of the researchers.

**Dr. Stephen Lewis**  
Assistant Professor  
University of Guelph  
519.824.4120 (x53299)

**Shaina Rosenrot, MA**  
Ph.D. Student  
University of Guelph  
srosenro@uoguelph.ca
If you are feeling distressed, struggling with self-injury, or other mental health difficulties, please contact a service provider.

University of Guelph Counselling Services  
University Centre - Level 3 South  
Phone: (519) 824-4120 ext. 53244

Guelph General Hospital (Emergency Department)  
115 Delhi St, Guelph, Ontario  
519 837-6420

For more information about self-injury, please consult the following:

Scientific Papers:  

Books:  

Online:  
http://www.crpsib.com/
CONSENT TO PARTICIPATE IN RESEARCH

The identification of barriers to self-injury disclosure

You are asked to participate in a research study conducted by Dr. Stephen Lewis and Shaina Rosenrot, MA (PhD Candidate), from the Department of Psychology at the University of Guelph.

If you have any questions or concerns about the research, please feel free to contact Dr. Lewis by phone: 519.824.4120 (x53299) or by email: stephen.lewis@uoguelph.ca. You may also contact Shaina Rosenrot (srosenro@uoguelph.ca)

PURPOSE OF THE STUDY

The main purpose of this study is to learn more about how people talk to others about their self-injury, including the factors that may facilitate or prevent someone from telling others about their self-injury. Another goal of this study is to understand the impact scarring from self-injury may have on self-injury disclosure and relationships with others.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

How the study is designed.
This research project aims to explore an aspect of self-injury that is not well understood – how people tell others about their self-injury. For this reason, the study was designed to allow the researchers to learn about self-injury disclosure directly from those who have either already experienced what it is like to talk about their self-injury with others or from those who have been unable to do so for various reasons. This study will be conducted using a semi-structured interview format; this means that while the interviewer will have some pre-determined questions to ask that will guide the conversation, much of the content of the interview will depend on how the participant tells their story. In other words, the interview will not follow a strict question-and-answer format. The interviews will be video-recorded to allow the interviewer to engage in the conversation without taking notes, however the content of the video will remain strictly confidential and will only be viewed by the interviewer and the principal investigator, Dr. Stephen Lewis.
What you will be asked to do:
Each person who takes part in the study will be asked to participate in a one-on-one video-recorded interview. The interview aims to better understand what it is like to talk to others about experiences with self-injury and will ask a series of open-ended and follow-up questions to that end. When we refer to self-injury, we mean any behaviour that people use to hurt themselves on purpose without suicidal intent.

How long does the study take?
In total, the entire interview process will not take more than 40 minutes to complete, however 60 minutes will be allotted in case additional time is needed.

Important information about taking part in the study:
Before participating it is important that you know that taking part in the study is completely voluntary. This means that you do not have to take part in the study if you do not feel like it. This also means that you have the choice to not answer any question or request that the interview move on from the current topic at any point. This can be for any reason and there is no penalty for choosing to not answer a question. Finally, if you choose to take part, you may stop participating at any time and for any reason and will not be penalized in any way.

Please feel free to ask Shaina any questions you have about the study. You may also contact Dr. Lewis (stephen.lewis@uoguelph.ca) to answer questions or address any concerns you may have. You may also ask questions throughout the study or even after the study is finished if you like.

Answers to questions will be kept confidential.
All of your data will be held in the strictest of confidence and your individual responses will not be linked to any identifying information. All data from this study will be stored in a locked cabinet in a locked office in Mackinnon Extension.

POTENTIAL RISKS AND DISCOMFORTS

Some participants may find talking about self-injury difficult or upsetting to answer. Although there is no documented evidence that talking about self-injury increases the risk for thinking about self-injury or actually hurting yourself, we cannot guarantee that this will not happen. Therefore, you may choose to not take part in this study if you would not like to talk about your experiences telling others about your self-injury. If you experience any discomfort when taking part in the study you are encouraged to let the interviewer know that you are uncomfortable and would like to stop the interview. If you feel distressed following the study, you are also encouraged to contact your family doctor. You may also contact the University of Guelph Counselling Centre. Their contact information is as follows:

Counselling Services
University Centre - Level 3 South
University of Guelph
Guelph, ON N1G 2W1
Phone: (519) 824-4120 ext. 53244
Fax: (519) 824-9689
Website:  http://www.counselling.uoguelph.ca/counselling/

If, at any time, you feel as though you want to hurt yourself, you are encouraged to contact a local crisis line, call 911 or go to your local Emergency Department. This information can be found below.

Local crisis line in Guelph (this is a free, confidential service available 24 hours a day, 7 days a week):
1-877-822-0140 OR 519-821-0140

Local distress line if you are feeling upset (this is a free, confidential service available 24 hours a day, 7 days a week):
1-888-821-3760 OR 519-821-3760

Here is the location of the local emergency department in Guelph (Guelph General Hospital):
Guelph General Hospital
115 Delhi St.
Guelph, Ontario
N1E 4J4

If you would like to learn more about self-injury and how to get help for self-injury, or if you are seeking a supportive online community, these websites may be helpful:

www.sioutreach.org
www.recoveryourlife.com

**POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY**

Apart from a modest monetary token of appreciation for your participation, there is no direct benefit to you by participating in this study. However, what we learn from participants may be of benefit to others. For instance, findings from the study may help us to better understand and treat self-injury. Additionally, findings from this study will help us to understand why some people seek help for self-injury by telling friends, family, or professionals about it but others do not. In this way, we will be able to find ways to encourage people to talk to others about their self-injury, get help and make sure people know where to go for help. This information will also help to educate mental health professionals about important ways to help those who have hurt themselves. Finally, findings from this study can help to improve people’s knowledge about self-injury and help others to understand how to react to and work with others who tell them about their self-injury.

**PAYMENT FOR PARTICIPATION**

While everyone who takes part in the study will be asked to volunteer their time, compensation will be offered in two ways. First, for those eligible for course credit, you will receive 1 credit point (i.e., 1 credit point per hour of participation or part thereof) toward your final grade in applicable undergraduate psychology courses.
If you are not a part of the Psychology Participant Pool or wish to take part in this study but not receive credit points, you will receive a Starbucks gift card valued at $10 as a token of appreciation for volunteering your time.

In addition to this, everyone who takes part will have the chance to hear about the results of the study. A summary of all findings will be put on the study webpage via a link, which allows you to access a secure webpage. On this webpage will be the main findings/trends of the study.

In all cases, only group data will be presented and no one’s individual data will ever be presented, as we want to ensure everyone’s confidentiality and privacy.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study.

All data collected in this study will be treated with the strictest of confidence. This means that we will never share your data with anyone else. To ensure confidentiality, each person who takes part in the study will be assigned a unique username, which will be used to identify your data (i.e., your data will not be linked to your name or email address). All data from this study will be stored in a locked cabinet in a locked office in Mackinnon Extension.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may exercise the option of removing your data from the study. You may also refuse to answer any questions you don’t want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise that warrant doing so.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Research Ethics Coordinator
University of Guelph
437 University Centre
Guelph, ON N1G 2W1

Telephone: (519) 824-4120, ext. 56606
E-mail: sauld@uoguelph.ca
Fax: (519) 821-5236

Signature ___________________________________________ Date ________________________________
Appendix K

Study 2 Semi-Structured Interview Questions

The following are the anchor questions that will be asked in every interview. Individual interviews will vary depending on how respondents answer the open-ended questions. Additional questions may be required to either follow-up on something a participant has said or redirect the conversation as needed.

Disclosure:

“Self-injury is a very personal and sensitive topic for many and it is common for people to find it difficult to talk to others about their experiences with self-injury. So, even if you have been able to talk to someone about your self-injury before, I realize that it is may be difficult to talk about it here today. I appreciate your willingness to participate and recognize that it may not be an easy thing to do. “

“I’m going to be asking you several questions to get a sense of what your experiences telling others about your self-injury have been like. Please let me know if you need to take a break at any time or if you begin to feel like talking about it is too much and would like to end the interview. “

“To begin, have you told anyone about your self-injury?”

For participants who have disclosed to someone:

“Can you recall the most difficult experience you’ve had telling someone about your self-injury? Can you walk me through what that experience was like? “

Follow-up questions:

“What made it so difficult?”
“Can you recall how you were feeling in the moment?”
“Did you initiate the disclosure or were you confronted about it?”
“Were there any factors in particular that made it difficult?”
“Can you think of anything that might have made it easier?”

“Have you had an experience telling someone about your self-injury that you would describe as being positive? What helped to make it a positive experience?”

For participants who have not disclosed to anyone:

“What do you think has prevented you from telling others about your self-injury?”
“What might make it easier for you to tell someone about your self-injury?”
Impact of scarring:

“Sometimes when people self-injure they have visible scars that remain after the fact, has this been a concern for you?”

*If scarring is a concern:*

“You mention that your scars have been a concern, has scarring ever played a role in how you interact with or relate to other people?”

*Follow-up questions:*

  “Have people ever treated you differently because of your scars?”
  “Has anyone ever asked you about your scars? If yes, how did you respond?”
  “Has scarring ever made it difficult to tell others about your self-injury?”
  “Has scarring ever made it easier to tell others about your self-injury?”

“Just as scarring may impact the way you relate to others, it sometimes also makes it difficult to enter a romantic relationship, especially if you have had difficulty telling others about your self-injury. Has your self-injury impacted your romantic life in any way?”

*Follow-up questions:*

  “Have concerns about your scars from self-injury impacted your desire to be in a romantic relationship?”
  “Have you found that you have avoided romantic relationships over concerns about your self-injury?”
  “Have you found that you have avoided romantic relationships over concerns about your scarring from self-injury?”
  “Have you ever self-injured while you were in a romantic relationship?”

*Potential follow-up questions:*

  “If yes, did you tell your partner about your self-injury?”
  “If no, do you think your partner was aware of your self-injury?”
  “Did you make an effort to conceal any scarring/wounds from your partner?”

“Thank you very much for taking part in this study, if you have any questions or would like an update on the progress of the study please do not hesitate to contact us. If you are feeling at all distressed and would like to speak with someone, we would be happy to put you in contact with counselling services.”

*All participants will be provided with a debriefing packet that includes NSSI resources and counseling and crisis line information.*
Appendix L

Study 2 Debriefing Form

Debriefing Package

*Identifying barriers to self-injury disclosure*

Thank you for your time and support in participating in this study. The purpose of this research is to examine self-injury disclosure in a sample of university students. In particular, we are interested in understanding the various factors that may facilitate or impede the disclosure of self-injury to others.

Self-injury is an important and common behaviour among adolescents and young adults. A recent study of self-injury in University students found that about 17% of students have hurt themselves on purpose in the past, with some studies suggesting that rates are even higher than this. Furthermore, self-injury is often a secretive behaviour – research suggests that a third of university students who self-injure tell no one about it. This project will help us gain a better understanding of why self-injury may be difficult to talk about, with the overarching hope of informing the development of programs to promote the safe and effective disclosure of self-injury.

If you feel distressed by the content of any of the questionnaires, please contact your family doctor, Dr. Lewis, or the crisis hotlines outlined below. If you would like more information about sources of support for self-injury, we have provided you with a list of resources on the next page. If you feel your rights as a participant in research have been violated during the course of this project, you may contact the Research Ethics Officer at the University of Guelph at 519.824.4120 (x53299). This project has been reviewed and received ethics clearance through the Office of Research Ethics Broad, University of Guelph.

*Thank you again for your time. Your participation in this study is greatly appreciated and is essential for advancing our knowledge of this important issue.*

*If you have any questions or concerns, please feel free to contact any of the researchers.*

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University of Guelph  
519.824.4120 (x53299)

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University of Guelph  
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HELP-SEEKING RESOURCES

If you are feeling distressed, struggling with self-injury, or other mental health difficulties, please contact a service provider.

University of Guelph Counselling Services
University Centre - Level 3 South
Phone: (519) 824-4120 ext. 53244

Guelph General Hospital (Emergency Department)
115 Delhi St, Guelph, Ontario
519 837-6420

For more information about self-injury, please consult the following:

Scientific Papers:

Books:

Online:
www.sioutreach.org
http://www.crpsib.com/
www.recoveryourlife.com