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They just don't get it: a qualitative study on perceptions of anticipated self-injury stigma across generations

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Abstract

Background Non-suicidal self-injury (NSSI) is a common and serious mental health concern among young adults. It is also highly stigmatised, which can impede disclosure and recovery. To advance the literature on NSSI stigma, we explored what young adults who self-injure believe different age-groups (i.e., young adults, parents, middle-aged, and older adults) think about NSSI and people who self-injure.

Method Participants ($n = 187$) with a mean age of 19.07 (SD = 1.52) took part in an online survey and answered open-ended questions about the above beliefs. Responses were examined via reflexive thematic analysis.

Results Findings yielded three primary themes namely: *They Just Don't Get It*, *Ignorance is Bliss*, *and Willing to Lend a Helping Hand*. Overall, our results indicate that all age-groups asked about are believed to harbour stigmatising views (e.g., NSSI is selfish and attention-seeking, people who self-injure are weak and crazy). Perceptions regarding the prominence of these beliefs, however, varied across age-groups.

Conclusion Expectancy beliefs and differences in anticipated stigma across age groups may stem from prior experiences with others and may play a role in disclosure. The present findings thus have implications for research, anti-stigma initiatives, and supportive practices.

Keywords Non-suicidal self-injury, Self-harm, Stigma, Anticipated stigma, Lived experience, Qualitative

Introduction

Defined as the purposeful damage (e.g., cutting, burning) of one's body tissue with nonlethal intent, non-suicidal self-injury (NSSI) represents a widespread and serious mental health concern [1]. The behaviour is common among adolescents and young adults, with lifetime rates of 17.2% and 13.4%, respectively [2, 3]. Among young adults attending university, lifetime rates are even higher and tend to hover around 20% [3, 4]. Engagement in NSSI associates with an array of mental health difficulties (e.g., higher levels of anxiety, difficulty coping). Rates of NSSI are typically higher in clinical populations and NSSI associates with different forms of mental illness (e.g., major depression, eating disorders, borderline personality disorder) [4–7]. Given its link to heightened distress, NSSI is typically used to obtain temporary relief from difficult and often very painful emotions [see 7]. Further, researchers have found that NSSI confers suicide risk, even though it is definitionally distinct from suicide. Notably, a meta-analytic review suggests that NSSI is

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the most reliable predictor of later suicidal thinking and behaviour [8].

Owing to a steady increase in research on NSSI over the years, there have been significant advances in the understanding of the behaviour [5]. Unfortunately, however, NSSI and people who enact it remain highly stigmatised [9–12]. This is concerning, given that NSSI stigma may thwart disclosure [12, 13] and hinder recovery [10]. Until recently, efforts to empirically study NSSI stigma have been limited. Growing research, however, highlights the complexity of NSSI stigma and the need to address different stigma manifestations [12, 14, 15]. Thus, it is important to delineate the different types of NSSI stigma as research has historically examined NSSI stigma more broadly.

One form of NSSI stigma refers to public stigma [18], namely the inaccurate or derogatory attitudes and beliefs people may have about NSSI or individuals who engage in it [12, 14]. There are several examples of this in the NSSI literature, with references to people viewing NSSI negatively and people who self-injure as attention-seeking, manipulative, unstable, and weak [e.g., 12, 15, 17, 19]. When public stigma results in discrimination and other forms of poor treatment of others, this is known as enacted stigma [20]. Much like public stigma, there are also reports from research about people being treated negatively due to their engagement in NSSI [e.g., 12, 14]. Externalised forms of stigma, especially public stigma, can become internalised in the form of self-stigma [18]. Here, people apply public attitudes to themselves, with several reports from the field indicating that people who self-injure view themselves in ways congruent with existing public attitudes about people who self-injure. Examples include seeing oneself as weak, crazy, or weird [12, 19]. Finally, individuals who self-injure may experience anticipated stigma [21], which refers to the expectancy of stigmatisation from others. Importantly, anticipated stigma can be present irrespective of one's prior stigmatising experiences. In this way, although anticipated stigma may stem from one's past stigmatising experience such as being responded to negatively by a loved one, this may not always be the case [12, 15, 19]. For example, researchers have suggested that anticipated stigma may be present due to awareness of broader stigma in society (e.g., negative public attitudes) but without necessarily having been stigmatised [12, 15, 16, 22]. Compared to other forms of stigma, anticipated stigma has been less researched despite calls for such work [12, 16, 22].

Anticipated stigma and concerns about how others may react to people who self-injure are not unfounded given the many reports of negative reactions toward people who self-injure in the general public [e.g., 9] as well as in healthcare [e.g., 23, 24], and school settings [e.g., 25, 26]. A recent review of the literature indicates that rates of NSSI disclosure are low, with stigma and shame serving as major barriers [13]. When people with lived experience elect to share that they self-injure, this tends to transpire with same-age peers [13] perhaps due to a perception that same-age peers will be more accepting and understanding and thus less stigmatising. This trend is especially well-documented among young adults [e.g., 13, 27, 28]. Indeed, research indicates that younger generations - relative to older ones - typically hold less stigmatising views regarding some forms of mental illness, such as depression and anxiety [e.g., 29, 30]. In line with this, a recent study provides evidence that young adults who self-injure may view their same age peers (i.e., other young adults) as less stigmatising and more understanding of NSSI compared to other age groups [16]. However, this study did not explore how young adults who engage in NSSI perceive other age groups' views about NSSI; thus, conclusions about beliefs concerning other age groups cannot yet be drawn.

Understanding what young adults with lived experience of NSSI believe people from different age groups– including but not limited to other young adults– think about NSSI may help shed light on anticipated stigma and build on recent work that has exclusively looked at perceptions of other young adults (16). Such inquiry would also lay a preliminary foundation for researchers seeking to better understand anticipated stigma of NSSI and its potential role in disclosure. For example, if greater anticipated stigma is present (e.g., people see a particular age group as harbouring more negative views about NSSI), this may represent a larger barrier to disclosure. Finally, this knowledge would help advance the extant literature on NSSI stigma, specifically offering a more in-depth look at anticipated stigma which has been under-researched compared to other forms of stigma [12, 16, 22].

Current study

Following the above, the aim of the current study was to examine the beliefs of university undergraduates with lived experience of NSSI regarding what different age groups think about NSSI and people who self-injure. Specifically, we asked participants about these perceptions in relation to four age groups, namely: young adults (same age peers), middle-aged adults, older adults, and people of their parents' age. The last group was included as we did not want to assume the age of participants' parents (we discuss this further in the next section).

Method

Participants

Participants were undergraduate students recruited through an online university participant pool in Canada. To be eligible for the study, individuals had to be English-speaking and have a history of NSSI. Initial recruitment

resulted in 370 participants. Since we sought to examine differences in participant responses across generational groups, we excluded participant data ($n = 128$) if they did not respond to all the open-ended questions (noted below). In line with past research, we also narrowed the focus to participants with at least 5 lifetime instances of NSSI [31–33] and whose reported methods conforming with the official definition of NSSI [1]. For example, some participants only reported eating disordered behaviours or substance abuse, which resulted in them being excluded. This resulted in 190 participants. Lastly, we omitted data from 3 people as their text response to the open-ended questions had insufficient richness (e.g., comprised 2–3 words), resulting in a final sample size of 187. This final set of participants provided sufficient text for analysis (i.e., had at least a sentence articulating specific views and/or experiences germane to the research question).

Measures

Demographics

Participants first completed a brief demographics questionnaire (e.g., age, sex, sexual orientation, gender, ethnicity).

NSSI history

To assess NSSI history, the Inventory of Statements About Self-Injury (ISAS) [34] was used. This measure has good construct validity and test-retest reliability [34, 35], and comprises questions about people's experience with NSSI, including methods used, frequency, and recency.

Open-ended questions: cross-generational beliefs

Participants were presented with the following open-ended question asking what they thought different generations believe about self-injury and people who self-injure: *When you think about X, what kind of beliefs do you think they have about self-injury and people who self-injure? (e.g., positive/negative, supportive/unsupportive, understanding/not understanding). Please explain your answer.* Participants responded to this question four times, once for each of the following groups (denoted by X): emerging adults, middle-aged adults, older adults, and people of their parents' age. For this last group, the question was framed to reflect the age group of participants' parents. We asked participants about adults of their parents' age as we did not want to assume that their parents would fit cleanly with middle or older aged adults. We also wanted to account for the possibility that participants might view people of their parents' age differently than other age groups. We comment on this further in the discussion.

Procedure

The study protocol was reviewed and approved by the institutional review board of the lead author (Protocol #: 20-01-017). After that, the study was advertised on the website for an undergraduate participation pool. Interested participants were directed to an online consent form via Qualtrics. Upon providing informed consent, they were directed to the above questions. Although participants could take as long as they wanted to answer these questions, they had to do so in one sitting. Upon completion, participants were granted course credit; they were also debriefed and given NSSI and mental health resources (e.g. campus support services).

Analytic approach

Reflexive thematic analysis (TA) was used to explore participants' open-ended responses [36]. We chose this approach due to its flexibility and utility in inductive oriented research [36]. Moreover, it has been used productively in prior NSSI research by helping to shed light on lived experience perspectives [e.g., 37, 38, 39, 40]. When conducting our analysis, we adopted a subjectivist epistemological stance, which involves active interpretation of the studied phenomena and recognition that our subjectivity, values, assumptions, experiences, and social positionalities, shape our understandings of what participants share [41]. Commensurate with this, different interpretations in the analysis may come from different researchers. While this is the case, these differences are viewed as a strength in that they permit triangulation, integration, and synthesis across these different viewpoints [42, 43].

The nature of our epistemology (subjectivist) and use of reflexive thematic analysis necessitated reflexivity. Reflexivity was practiced in the following manner. The second author, who led the analysis, reflected on her assumptions, value set, and social positioning within the context of the analysis. In so doing, she used notetaking and met regularly with the first author to discuss and consult on the analytic process. We acknowledge that by conducting a reflexive TA in this way, our experiences, pre-existing knowledge, and positionalities may play a role in data analysis and interpretation of findings. We therefore believe it is important to state that the first author is an established researcher in the NSSI field, with vast experience working directly with individuals who self-injure, and who has personal lived experience of NSSI. The second author, who collected data and led the analysis, is a psychology student interested in NSSI. The third author is a senior researcher in the field of NSSI and mental health among youth and young adults. Finally, the fourth author is a stigma researcher with a particular interest in youth mental health.

We used an inductive approach in the analysis guided by the steps of Braun and Clarke [36]. This involved the

second author familiarizing herself with the data by reading and re-reading participants' responses (Step 1). Salient features of the data (i.e., of relevance to the research question) were documented and informed initial codes (Step 2). At this stage, the first and second authors met to discuss the initial codes and organized them as tentative themes, or recurring patterns of meaning with relevance to the research question. In addition to their relevance to our research question, these initial themes were informed based on their frequency and the language used by participants (e.g., strongly worded statements, expressions of strong emotion, mention of direct personal experience).

From here, the preliminary themes were organised via colour-coding (Step 3). The first two authors then met again to discuss and clarify the themes (Step 4). Next, all authors reviewed the themes until consensus was met; this resulted in the final themes presented in the results below (Step 5). Finally, extracts were selected from the data to represent the final set of themes (Step 6). All quotes presented are verbatim in line with reporting recommendations for thematic analysis [36].

Results

Participant demographics and NSSI history

Participants were aged 18 to 25 (M = 19.07, SD = 1.52), with 164 being females (87.7%) and 23 individuals reporting their sex as male or intersex (12.3%). Regarding sexual orientation, most (n = 128) identified as heterosexual and then bisexual (n = 41), with 18 individuals indicating other sexual orientations (e.g., lesbian, queer, pansexual). Most identified as women 163 (87.2%), with 21 (11.2%) identifying as men. The majority of participants also reported being White/European (n = 140; 74.9%) with the remaining individuals being South Asian (n = 11; 5.9%), Southeast Asian (n = 8; 4.3%), or reporting other ethnicities (n = 28; 14.9%). Demographic information is summarised in Table 1. The mean age for NSSI onset

Table 1 Summarized demographic information and NSSI history by NSSI method and number of lifetime instances of prior NSSI (Mean and standard Deviation)

Demographics		***n* (%)**
Sex		
Female		164 (87.7)
Male or Intersex		23 (12.3)
Gender Identification		
Woman		163 (87.2)
Man/gender-diverse		22 (11.7)
Sexual Orientation		
Heterosexual		128 (68.4)
Bisexual		41 (21.9)
Other sexual orientations		18 (9.6)
Ethnicity		
White/European		140 (74.9)
South Asian (Indian, Sir Lankan)		11 (5.9)
Southeast Asian (Chinese, Japanese, Korean, Vietnamese, Cambodian, Filipino)		8 (4.3)
Other Ethnicities		28 (14.8)
NSSI Method	**n (%)**	**Lifetime NSSI Mean (SD)**
Cutting	128 (68.4)	46.45 (72.90)
Interfering with Wound Healing (e.g., picking scabs)	124 (66.3)	184.60 (266.24)
Pinching	122 (65.2)	60.98 (86.99)
Banging or Hitting Self	115 (61.5)	58.20 (116.41)
Severe Scratching	114 (61)	111.82 (218.70)
Biting	86 (46)	57.79 (98.91)
Burning	45 (24.1)	11.09 (16.67)
Hair Pulling	97 (51.9)	99.11 (234.95)
Rubbing Skin Against Rough Surface	48 (25.7)	28.88 (41.89)
Sticking Self with Needles	31 (16.6)	30.45 (58.11)
Swallowing Dangerous Substances	28 (15)	20.21 (41.61)
Carving	17 (9.1)	8.18 (11.91)
Not Listed	6 (3.2)	160 (199.47)

Note: We combined some demographic groups (e.g., sex, ethnicity) when there were low cell sizes. This was done to protect participant anonymity and to adhere to recommendations from our research ethics board

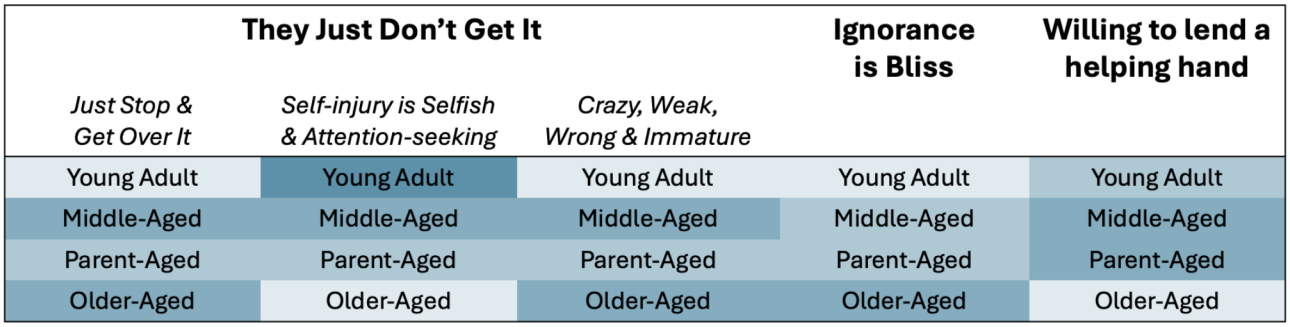

Fig. 1 Thematic map outlining the three themes related to people's views on how generations perceive NSSI and those who engage in it, their descriptions, and overall prominence, with darker shades indicating themes being more prominent within the data

across participants was 13.49 years (SD = 2.83). Although a range of NSSI methods were reported, most indicated using cutting (36.9%), interfering with wound healing (15%), banging or hitting self (10.7%), and pinching (10.7%) as a primary method. Participants' NSSI histories are also summarised in Table 1.

Reflexive thematic analysis

Three principal themes were generated with regard to participants' beliefs about how different generations view NSSI and individuals who self-injure; the first theme has three subthemes. Figure 1 depicts themes based on prominence in each age-group (denoted by colour shade). A description of themes is presented in detail below.

Theme one: they just don't get it

Participants shared the perception that all age-groups do not understand NSSI and its complexity (e.g., its reasons, the difficulty inherent in stopping NSSI). They also expressed that people who self-injure are viewed in a negative manner. Based on our analysis, participants' beliefs about others' attitudes towards NSSI and people who self-injure manifested across three subthemes, namely: *Just Stop and Get Over It*, *Self-injury is Selfish and Attention-Seeking*, and *Crazy, Weak, Wrong, and Immature.*

Just stop and get over it

Here, participants shared their belief that people fail to comprehend what NSSI involves (e.g., what underpins it, its motives) and, as such, have a superficial understanding of the behaviour and people's NSSI-related experiences. Although this belief was observed across all generations, it was most pronounced for the middle- and older-age groups. For example, one person wrote that:

> *"I think middle-aged adults know that they should be supportive and Understanding but might sometimes feel inside like it's all a charade and that these things will just go away." (Participant 39, female, age 18 years).*

Along these lines, some participants believed that when people do not understand NSSI, they correspondingly underestimate how difficult it is to stop as highlighted by the following participant:

> *"I think that people who have experienced self-injury know the struggle, And would be both positive and supportive. However, I find that most. People who haven't experienced anything like this tend to ask "why don't you just stop?" I think they want to be positive but they don't have the right understanding. I can't just stop." (Participant 40, female, age 18 years).*

At times, people shared these views when reflecting on their personal experiences, much like the following response:

> *"My dad was a bit more uneasy about it, asking me "why would you want to do this to yourself" and saying things like "you need to stop right now".It was all coming from a place of love, but it felt a bit diminishing and shameful." (Participant 63, female, age 19 years).*

In some cases, participants expressed their perception that others– and perhaps in particular, adults - view NSSI as being circumscribed to childhood and adolescence. In other words, they shared a view that adults consider NSSI as primarily enacted by young people and that the behaviour is 'grown out of' over time. They went on to convey that when these views are held, this contributes to adults not taking NSSI seriously as it is deemed a trend or fad. Indeed, one participant shared that:

> *"A lot of people when they hit adult age and have been through self-harm Seem to say they grew out of it when they matured. This simply they View the act of self-harming as Non concerning and something children grow out of." (Participant 158, female, age 19 years)..*

In sum, many participants believed that people of all ages do not appreciate the complex nature of NSSI. This may be especially the case in terms of their view of how adults view NSSI. This perceived lack of understanding was thought to result in others diminishing, and at times even trivialising, the very real difficulty people often have in stopping NSSI.

Self-injury is selfish and attention-seeking

Participants also expressed their view that other people render NSSI as attention-seeking and selfish in nature. By and large, this belief seemed to apply to other emerging adults. There were, however, some exceptions such as the following participant's response:

> *"A lot of time I think adults will think that people who self injure are being selfish or doing it for attention, which simply is not the case in most." "They see it as a selfish act because it doesn't just affect the individual but the people around them too." (Participant 96, female, age 18 years)..*

The beliefs participants shared in relation to this theme pertained to why people self-injure; often, this was with reference to the behaviour being enacted to garner attention. Unlike the above subtheme, which mentioned why people self-injure and how difficult it is to stop self-injuring, the beliefs expressed within the current subtheme do not mention others' views about how difficult it can be to stop NSSI.

With respect to participants' beliefs about other emerging adults view NSSI, they at times mentioned that rendering NSSI as attention-seeking is an assumption that does not align with the reasons for NSSI. For instance, one participant wrote that:

> *"I think that emerging adults have more of a negative beliefs towards people self-injure as they think that individuals are doing it to themselves to get attention from others, but that May not be their reason. They are always quick to jump to conclusions." (Participant 76, female, age 19 years)..*

In other instances, participants noted that when other emerging adults hold these beliefs, it can result in demeaning and even mocking NSSI and people who self-injure, as evidenced in the following excerpt:

> *"I believe that they think that it is for attention. An example that I can think of that supports this belief is when I went to breakfast with some friends after we wrote our final exam. One of my friends picked up a knife and mimicked cutting his wrists while saying "hey i'm seeking Attention"." (Participant 38, female, age 18 years)..*

Some added to this belief by highlighting how they thought this was inappropriate and rude to people who engage in NSSI:

> *"I think some see it as a way for younger individuals to get attention, which is incredibly offensive." (Participant 20, female, age 18 years).*

As is evident within these passages, participants believe others to be misunderstanding about why people self-injure and contend that this contributes to inaccurate and even hurtful conclusions about why it is engaged in and what the behaviour represents.

Crazy, weak, wrong, and immature

Finally, participants believed that people hold an array of other stigmatising and pejorative views toward individuals with lived experience of NSSI, including that they are unstable, incapable, and deviant. These perceptions were present across all age groups asked about, but appeared to be most evident in relation to the middle- and older-age groups, as articulated by the following response:

> *"Very generally speaking, I think that older adults take a slightly less supportive, less Understanding stance. I think they believe that people who self-harm May be lazy, or unable to deal with life's challenges; like they almost see it as a weakness and use it to judge character." (Participant 132, female, age 18 years).*

Participants also believed that older adults see NSSI as a juvenile way to manage life stressors. Along these lines, one participant wrote that:

> *"they [older adults] believe that there are more responsible and mature ways to deal with personal issues." (Participant 103, female, age 18 years)..*

Indeed, there seemed to be a belief across some of our participants that other older adults draw comparisons between their own (older) generation and younger generations. Consequently, they look down upon individuals who self-injure and see them as less capable, and thus unable to cope. This was conveyed in the response below:

> *"They can't grasp the fact why someone would self harm. They think their generation was stronger and more resiliant. I know a 45 Year old man who thinks our generation is too weak and sensitive and a huge disappointment to society." (Participant 44, female, age 18 years)..*

All in all, responses comprising this subtheme point to perceptions among participants as well as personal anecdotes suggesting that other people view individuals who engage in NSSI in a negative light– often in a way that reduces the behaviour of NSSI as a less mature and weaker form of stress management. This, in turn, was believed to play a role in how older generations view individuals who self-injure in more negative and hurtful manners.

Theme two: ignorance is bliss

Several participants held the view that other individuals are uncomfortable with NSSI and, as a result, would rather not face it. Even though participants endorsed these perceptions across all generations, they seemed most relevant in reference to their beliefs about older adults, as shown below:

> *"I think that older adults are also quite negative and misunderstanding about self-injury. Older adults are probably more likely to just dismiss the fact that people self-injure altogether, and would think that it is much less common than it actually is." (Participant 33, female, age 21 years)..*

At times, participants seemed to attribute ignorance and misunderstanding about NSSI to an unconscious avoidance or fear of the behaviour, which they believed contributed to older adults not knowing how to respond to someone who self-injures, or how to offer help:

> *"Maybe unconsciously, people are afraid of those who self harm because they cannot understand it, and don't know what they should do after seeing it." (Participant 13, female, age 20 years).*

In other instances, this was tied to a belief that older adults have inadequate knowledge or literacy about NSSI, as with the following extract:

> *"I think they are uncomfortable with the subject and don't have the tools to discuss or help with mental illness and self-harm. I think it's just what they've learned and don't yet know another way." (Participant 133, female, age 18 years).*

As with other responses, participants sometimes referenced personal experience and implied that people may be willingly ignorant. For instance, one participant expressed that *"Personally, my parents chose to pretend it wasn't happening at all."* (Participant 119, female, age 20 years) Another individual shared a similar sentiment also making reference to their parents, writing that:

> *"My parents feel as if they ignore it, it will go away. For example, they sent me to a naturopath instead of a medical doctor because they didn't believe it was a real problem and would be cured by vitamin D suppliments." (Participant 91, female, age 18 years).*

As can be seen above, several participants contended that other older adults and people of their parents' age are often uncomfortable with NSSI. This was believed to be the case for a variety of reasons, with participants seeing these age groups being both unintentionally and intentionally ignorant about NSSI and thus avoidant of people who self-injure. As with other themes, part of what seems to shape some of these beliefs are participants' own past experience.

Theme three: willing to lend a helping hand

In contrast to the above themes, at least some participants believed that other individuals– including adults, who they often saw as not understanding NSSI - could be non-judgemental, and that they genuinely wanted to understand people's experiences of NSSI and offer support. These views were present in responses across each generational group but were most pronounced when participants were asked about the middle- and parent-age groups. Seemingly fuelling these beliefs were participants personal experiences with their own parents. Illustrating this was the following participant:

> *"I think these adults are very supportive and understanding. I told my parents about my cutting and they did not judge me at all. They just wanted to help me in any way they could, and make sure that I got the help I needed." (Participant 1, female, age 21 years).*

These beliefs appear to present a dichotomy. Sometimes parents and others are seen as unhelpful (e.g., ignorant), as in the prior theme. Yet in other instances, others (including parents) are seen as supportive, as in the current theme. This diversity in beliefs about other individuals is likely the product of several factors. Of note, it seems that for several participants, their prior interactions with their parents concerning NSSI played a role in shaping their beliefs about how middle and parent-aged individuals view NSSI. In line with participant beliefs about some parents and middle-aged adults being supportive, participants thought that this can stem from a willingness to help even when these others view NSSI as risky. In other words, participants seemed to think that when middle-aged adults and parents have a desire to help, this may supersede any concurrent views that might situate NSSI as a negative and undesirable behaviour. For example, one participant shared:

> *"I think a lot of beliefs are negative, however they try to be supporting and understanding. They often think that self-injury is a very bad dangerous, and destructive habit (which it is), however they often want to help stop it." (Participant 125, female, age 23 years).*

At times, views of support were also believed to come from others potentially seeing that NSSI is used to cope. Thus, participants seemed to believe that when others situate NSSI in a broader context, it can foster greater support and an openness to understand people's NSSI experience. This is shown in the following participant's perspective:

> *"I think some people have supportive thoughts on self injury as they understand it may help cope with many larger issues going on in one's life." (Participant 125, female, age 23 years).*

In some cases, participants highlighted their belief about how support from others can be expressed tangibly and manifest from optimism that people can stop NSSI; here, they placed emphasis on active listening and patience.

> *"They have a lot of belief that I can stop and can get better. They make sure I'm okay and willing to listen and understand why I'm doing what I'm doing. They discourage me, obviously, but understand that it's not easy. They make sure that I know I'm loved and that I have their support." (Participant 2, female, age 19 years).*

Taken together, the above responses offer a distinctly different set of beliefs and experiences versus those that are more negatively valenced. Oftentimes, their personal experience, including how their own parents responded to them, seems to play a role in shaping these beliefs. As discussed in the section below, some of what participants shared in this regard may have implications relevant to supporting people who self-injure. Indeed, participants' responses offered insight into what they found to be helpful when their NSSI became known by others.

Discussion

To advance the growing literature on NSSI stigma, we sought to understand what young adults with lived experience of NSSI believe different age groups think about NSSI. Specifically, these beliefs were explored across emerging adults, middle-aged adults, older adults, and people of their parents' age. Overall, participants seem to think that people from *all* these age groups do not understand NSSI and adopt negative views about the behaviour and people who engage in it. Many of these beliefs are akin to those reported in the extant stigma literature, including but not limited to viewing NSSI as attention-seeking and rendering people who self-injure 'crazy' [e.g., 12, 14, 15, 17]. The current findings add to the literature by suggesting the relevance of these views in the context of *anticipated* stigma [12, 16, 22]. Indeed, if others are seen as having stigmatising views about NSSI, it may foster an expectation that they are unable to appropriately or supportively respond to individuals who self-injure. Adding support to this possibility were anecdotes from several participants, who cited specific experiences from their own lives. It is conceivable that personal experiences with stigma may therefore provoke or even exacerbate people's level of anticipated stigma and thus the kinds of reactions people expect from others about NSSI. Similar reports have been made elsewhere [16]. These findings also suggest that many of the common stereotypes of NSSI (e.g., seeing it as attention-seeking [15–17]) continue to play a role in the lives of people who engage in the behaviour– in this case, in the context of anticipated stigma. We comment on ways to combat stigma in our Implications section.

In all, participants believed that each of the age groups held stigmatising views, however there were differences in their prominence. Of note, young adults (who do not self-injure) were seen as less likely to think that people could simply 'get over' NSSI (Just Stop & Get Over It), to refer to individuals who self-injure pejoratively (Crazy, Weak, Wrong, & Immature), or to want to ignore and avoid NSSI and people who self-injure (Ignorance is Bliss). These beliefs build on findings from a recent study, which suggest that young adults in general may be perceived as less stigmatising than older age groups [16]. Although we did not explore disclosure in our study, these findings might indicate a preference to share NSSI with same-age peers, which has been documented in the broader literature [13, 27, 28]. Other factors within this age group, however, should be considered before more concrete conclusions are made, such as the nature of these relationships (e.g., peer-support groups versus friendships). In line with this, recent findings suggest that the nature and quality of relationships factor into decisions to disclose NSSI [44]. Nevertheless, examining the role that expectancy beliefs have in disclosure contexts would be beneficial. For example, this could involve investigating the extent to which people who self-injure believe that disclosure recipients consider NSSI as a behaviour that is easy to stop. This could be done alongside asking individuals with lived experience of NSSI how this might factor into their willingness to disclose. As cited elsewhere, there are myriad factors that go into the decision to disclose NSSI [44, 45]. Accounting for expectancy beliefs across different age groups might help

understand whether and how age-related factors plays into people's decision to disclose NSSI and to whom.

Our participants thought that older generations were more likely to hold negative views about NSSI. This may have relevance when considering the parents of emerging adults. For instance, if emerging adults think their parents will view NSSI negatively, they may be reluctant to reach out to them for support. How parents have previously reacted to NSSI may also be relevant as several participants reflected on their own experiences with their parents in what they shared. Participants' beliefs about older generations may also have relevance when considering the composition of our sample – namely, young adults attending university. Indeed, middle and older-aged adults are often in a range of support roles for students on university campuses (e.g., as administrators, faculty, healthcare providers) and people in such roles have been identified as essential to supporting students who self-injure [4]. If older generations – including those in support roles on campuses – are seen as less supportive and understanding when it comes to NSSI, such beliefs may lessen the chances of NSSI disclosure beyond what may already exist given the potential power differential in these contexts.

Based on what participants shared, it may be that young adults are seen as more understanding when it comes to NSSI; some of our prior research indicates that young adults perceive a cultural shift in that younger generations are deemed less stigmatising when it comes to NSSI and mental health challenges [15, 16]. Other researchers have likewise indicated that younger generations may be less stigmatising regarding broader mental health difficulties [29, 30]. These views might therefore account for why participants considered older age groups as not appreciating the difficulty inherent in NSSI recovery (e.g., Just Stop & Get Over It) and to harbour more negative views about individuals who engage in NSSI (Crazy, Weak, Wrong & Immature*).*

Even though young adults were seen as more understanding about NSSI, participants appeared to believe that this age group was most inclined (versus other groups) to consider NSSI as selfish and attention-seeking. Thinking that NSSI is attention-seeking is a widely cited misconception about why people self-injure [e.g., 12, 15, 17], but one that is debunked by robust evidence [for a review see 7]. Participants might see same age peers as potentially more accepting and understanding regarding NSSI, however they also may not see them as immune from stigma and/or having a fulsome understanding about why people self-injure. Similar reports have been made elsewhere [16]. Viewing peers as not being immune from stigma may have contributed to why many people nonetheless remain cautious about sharing NSSI with others. The set of beliefs our participants expressed in relation to other young adults is also concerning given our sample composition. Across many universities, students are often encouraged to utilise peer-based support initiatives, which can involve disclosing mental health challenges and obtaining support from fellow students. Indeed, a recent position paper highlights the role that all university stakeholders can play in supporting students who self-injure; this includes fellow students in informal and more formal (e.g., student support networks) contexts [4]. If other young adults (in this case, students) are believed to hold stigmatising views about NSSI, such services and opportunities for support may go unused.

Importantly, participants expressed their beliefs that people can nonetheless be supportive (Willing to Lend a Helping Hand), despite elements of anticipated stigma seemingly being present across each age group asked about. Often, these beliefs were held in relation to middle-aged adults – primarily, people of their parents' age. When sharing their beliefs about these individuals being potentially supportive, young adults in our study pointed to the centrality of non-judgmental responses and a willingness to listen and offer help. As with some of the other responses participants shared, they often drew on personal experiences - typically referring to their parents (e.g., discussing how their parents were supportive). Thus, participants shared that parents can be both unsupportive (e.g., as with the theme Ignorance is Bliss) and supportive (e.g., as with the theme Willing to Lend a Helping Hand). These discrepant beliefs may very well reflect the nature of people's past negative and positive experiences. As discussed earlier, one's prior stigmatising experiences may shape one's expectancy beliefs about how others view NSSI. The same might therefore apply to positive experiences. That is, people who have been responded to supportively in the past may believe that others may respond supportively in the future; if this is the case, it might indicate a lesser degree of anticipated stigma. Future work on anticipated stigma should thus account for a range of past NSSI disclosure experiences.

The content of the anecdotes and experiences that were seen as positive aligns with recent person-centered guidelines, which underscore the importance of responding to people who self-injure compassionately, without judgement, and with a willingness to listen and understand their unique experience [see 5, 46]. Indeed, efforts to collaboratively create and disseminate resources in this regard would likely be helpful in minimising inappropriate or unhelpful responding. These kinds of efforts could go a long way on college campuses and would help address calls from the field to ensure that all stakeholders on campuses are equipped to respond appropriately to students who self-injure [4].

Limitations and future directions

Our sample was deliberately composed of young undergraduates attending university as this group has been shown to report high rates of NSSI [e.g., 3, 4]. Participants in our study indeed reported relatively high rates of NSSI across the different methods assessed. This is not uncommon when studying NSSI amongst university students [see 6 for a review]. In the future, it may be useful to explore anticipated stigma as well as other forms of stigma (e.g., self-stigma), while also accounting for different NSSI histories. For instance, people with more frequent or medically severe NSSI may experience more enacted stigma from others (e.g., due to the potential for NSSI to be more visible or to require medical aid) or perhaps more self-stigma (e.g., more shame due to scarring from more severe injuries); there is merit in exploring these and other possibilities in future studies. With respect to our findings, some of the beliefs participants shared (e.g., concern that others see people who self-injure as 'crazy') may very well be held by other groups (e.g., clinical populations, adolescents) which would align with some prior work [e.g., 14, 19]; future research should explore the extent to which this is the case. Another limitation is the relative homogeneity of the sample, and the lack of stratified analysis. Most of our participants identified as White, female, and heterosexual; future research should stratify groups to explore the beliefs of demographic groups not well represented in the present study including, men, people who identify as transgender or nonbinary, and ethnic minorities. This is especially important considering the paucity of NSSI research involving more racially and gender diverse groups.

Methodologically, we asked people with lived experience of NSSI about their beliefs concerning other age groups' views of NSSI. On the one hand, this helps to garner insight into potentially relevant aspects of anticipated stigma. On the other hand, our findings reflect what participants believe, and their beliefs may or may not align with the actual views of the age groups asked about. Caution is therefore needed when making inferences about the views of others and further research is needed to explore such perspectives. Further, we used an open-ended question that allowed participants to share their personal views in their own words. Given the design of the study, however, we had no opportunity to follow-up on what they shared. This would have been fruitful and interview-based studies are recommended for future research in this area. For example, by asking follow-up questions, we could inquire about the role of participants' beliefs in NSSI disclosure contexts.

Also related to the questions asked, we did not specify the age-range for the groups we asked about. Participants could therefore interpret these groups in their own way. Looking ahead, researchers could consider specifying age ranges to determine whether people's beliefs vary on this basis; interview-based studies could permit follow-up about how people interpret different age categories if an age-range is not specified. There may also be utility in asking about personal relationships in conjunction with broader age-based categories. For example, questions could inquire about people's own parents or friends versus particular age-groups (e.g., other young adults, middle-aged adults). Recent research indeed suggests that the quality of the relationship plays a role in disclosure likelihood [44].

Finally, we recognise that our findings reflect what participants believe to be true regarding the age groups asked about; the extent to which people these generations hold stigmatising views and how these vary between each age-group should be explored in future research. Although these are participants' views and not independent measurements of how other age groups think about NSSI and people who self-injure, these perceptions likely guide young adults thinking (e.g., that they will be stigmatised) and actions (e.g., concealing NSSI). Looking ahead, it will be important account for the roles that different forms of stigma (e.g., past stigmatising experiences, self-stigma, anticipation of stigma) play in the context of disclosure reluctance and other outcomes (e.g., thwarted recovery efforts).

Implications

With NSSI literature indicating that disclosure reluctance is largely due to stigma, our findings implicate the potential role of anticipated stigma. It is conceivable that the kinds of beliefs shared by our participants hinder disclosure and thus possibly support obtainment. If so, anti-stigma efforts may benefit from being multi-pronged in an effort to maximise their effectiveness. Singular approaches that address just one kind of stigma (e.g., efforts to reduce public stigma via psychoeducation) may be limited. The use of participatory-based approaches has been identified as a promising way to address multiple forms of NSSI stigma (e.g., self and public stigma) in tandem [5, 47]. The extent to which they can impact anticipated sigma, however, remains unknown. Future work may thus be needed to determine the extent to which these approaches aid in reducing various stigma forms.

Hearing directly from people who have 'been there' is likely important for individuals who have lived experience of NSSI. Not only did our participants seem to share a sentiment that only people who self-injure can fully understand NSSI, but evidence suggests that hearing others' NSSI experiences can have a positive impact for people with a history of NSSI [48]. One means to share other people's lived experience may be through social media given its salience as a communication channel for

individuals who self-injure [see 49, 50]. For example, YouTube, has been implicated as potentially potent means of advocacy for NSSI [51]. Given the nature of our sample (young adults attending university), these approaches may hold particular appeal.

Finally, stigma has not been explicitly emphasised in clinical recommendations when working with clients who self-injure, until recently [see 6]. Findings from this study add to the growing literature on NSSI stigma, suggesting the aspect of anticipated stigma (along with other forms of stigma) may need to be on the radar of clinicians when working with clients who self-injure. For example, clinicians could inquire about a client's willingness and comfort in sharing about their NSSI and about any prior stigmatising experience they encountered. Doing so would better position them in supporting clients when stigma is germane to their experience and thus in fostering NSSI recovery. Recently published person-centred approaches may help facilitate this process as they situate the person who self-injures as an expert in their own right, while acknowledging the difficulty tied to talking about and stopping NSSI – difficulty often stemming from stigma [5, 46]. These approaches are also grounded in what our participants said was helpful to them – namely, being non-judgmental, compassionate, and willing to understand one's unique experience.

Conclusion

Growing efforts have focused on understanding the stigmatisation of NSSI. The current study adds to this literature by highlighting the potential role of anticipated stigma and related expectancy beliefs in what may make it easier for people who self-injure to share their experiences with same-age peers versus other age groups. Looking ahead, more work is needed to understand the stigma tied to NSSI across different age groups. In doing so, the field will be better equipped to work toward reducing stigma and fostering disclosure among people who can benefit from the support of others.

Author contributions

SPL: funding acquisition, study conception & design, project administration, data collection, supervision (analysis), writing (Introduction, Discussion), review & editing of manuscript drafts. GALL: data collection, analysis, writing (Method, Results), review & editing of manuscript drafts. NLH: funding acquisition, study conception & design, review & editing of manuscript drafts. RW: funding acquisition, study conception & design, review & editing of manuscript drafts. All authors read and approved the final manuscript.

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Data availability

Given the private and qualitative nature of the data collected, we are unable to share data. Queries can be directed to the corresponding author.

Declarations

Ethical approval and consent to participate

This study received ethics clearance from the University of Guelph and adhered to the Declaration of Helsinki. Ethical Approval Reference Number: 20-01-017.

Consent to participate

Prior to beginning the study, informed consent was obtained from all participants. This occurred through provision of a comprehensive online informed consent document outlining the study's aims and what participants' roles would involve. Participants were debriefed and provided supportive resources at the study's conclusion.

Consent for publication

As part of the informed consent process, participants were informed that their responses to questions may be published in peer-reviewed outlets.

Competing interests

The authors declare no competing interests.

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