REVIEW

Revisiting Social Stigma in Non-suicidal Self-injury: A Narrative Review

Пересмотр социальной стигмы при несуицидальных самоповреждениях: нарративный обзор

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Review

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The article took part in the competition of scientific papers of early-career psychiatrists.

ABSTRACT

Non-suicidal self-injury (NSSI) is highly prevalent in our community. Yet, there is a significant discrepancy between the number of individuals engaging in NSSI and those who seek treatment for NSSI. This discrepancy can be due to the high social stigma associated with the behavior. The impact of NSSI stigma is significant and can impair the quality of life in the individuals engaging in NSSI, delay help-seeking, reduce access to mental health care and further fuel misinformation. Even though the symptomatology, risks, and demographics of NSSI have received attention in terms of research, there is limited literature on NSSI stigma and its consequences. With that background set, this review provides a bird's-eye view of the different levels of stigma in NSSI (public, self, and health care), associated discrimination, the various aspects of such stigmatization (NSSI-related language, physical scarring, misinformation, the media), and, finally, the collaborative clinical-outreach interventions for mitigating NSSI-associated social stigma. If NSSI is indeed recognized as a clinical disorder, future research would need to focus on these constructs of stigma and treat them with the same importance as the one given to clinical studies of intervention and symptomatology in NSSI.

АННОТАЦИЯ

Несуицидальное самоповреждающее поведение (НССП) широко распространено в нашем обществе. Тем не менее, существует значительное несоответствие в количестве людей с НССП, и тех, кто обращается за медицинской помощью в связи с этим состоянием. Такое несоответствие может быть связано с выраженной социальной стигматизацией, связанной с данным состоянием. Стигматизация НССП оказывает значительное влияние и может ухудшить качество жизни таких пациентов, отсрочить обращение за помощью, снизить доступ к психиатрической помощи и еще больше способствовать накоплению неверной информации. Несмотря на то, что симптоматике, рискам и демографическим характеристикам НССП уделялось внимание в исследованиях, литературные данные о стигматизации данного состояния и ее последствиях ограничены. Исходя из этого, данный обзор дает представление о различных уровнях стигматизации НССП (общественный, самостигматизация и медицинская помощь), связанной с данным состоянием дискриминацией, различных аспектах такой стигматизации (язык, связанный с НССП, физические повреждения, ошибочная информация,

СМИ) и, наконец, о совместных клинико-информационных мероприятиях для смягчения социальной стигматизацией НССП. Если НССП действительно будет признано клиническим расстройством, будущие исследования должны быть сосредоточены на этой концепции стигматизации и лечения с тем же значением, которое придается клиническим исследованиям вмешательств и симптоматики при НССП.

Keywords: *non-suicidal self-injury; self-harm; stigma; self-stigma; recovery*
Ключевые слова: *несуицидальное самоповреждающее поведение; самоповреждение; стигматизация; самостигматизация; выздоровление*

INTRODUCTION

Non-suicidal self-injury (NSSI) is the deliberate self-infliction of pain that involves tissue damage and is not culturally or socially sanctioned [1]. It is distinguished from behaviors where the harmful consequences are unintended (e.g., Smoking, substance use) [2] or where self-harm is not the primary intention (e.g., self-purging of Bulimia Nervosa [1]). Over the last two decades, NSSI has drawn attention from researchers and clinicians, especially since it was listed as a condition for further study in Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) [3]. Adolescents and young adults are especially vulnerable to NSSI [4], with a high prevalence rate — 7.5–46.5% in adolescents; 38.9% in university students; and 4–23% among adults [5]. Indeed, a recent meta-analysis suggests that the pooled lifetime prevalence of NSSI is 20% [6]. Recent research suggests that even though the prevalence decreases with age, individuals with NSSI are more likely to have long-term negative outcomes than individuals without NSSI [7]. Additionally, NSSI can be a potentially lethal behaviour due to the high association with suicide thoughts and behaviors [8], and early intervention would be crucial to prevent the course from becoming chronic [9, 10]. To complicate matters further, NSSI is associated with a number of psychosocial difficulties [5] and may be present even without any psychiatric diagnosis [11]. According to a recent systematic review, it is highly prevalent not only in the clinical population, but also in community samples, with 7.5 to 46.5% in adolescents and 4 to 23% in adults [5].

Literature shows a wide discrepancy between the prevalence of NSSI in the general population and the number of people who seek formal help, such as from a hospital [12]. This significant gap suggests that the majority of individuals who engage in self-harm either refrain from help-seeking or are not receiving adequate care. One of the prime reasons for this significant discrepancy could be that NSSI is a highly stigmatized behavior [13]. Stigma refers to negative views towards a group and the resultant attitudes towards the group, when it is viewed as inferior to the societal norms, and stigma is very relevant in the context of mental health problems [14, 15].

Individuals engage in NSSI due to the wide range of interpersonal and intrapersonal functions that it serves, including emotion regulation, avoidance of psychological pain, or to seek physical sensation [16–19]. Due to the wide scope of its functions [18] and its self-reinforcing nature [20], individuals who self-injure are often reluctant to stop the behavior and there is a certain amount of ambivalence involved in the recovery process [21]. This ambivalence for recovery, along with the perceived stigma, makes individuals' engagement in NSSI high in secrecy and privacy [22, 23], thus creating reluctance in individuals for initiating the support-seeking process, or even delaying it.

SEARCH STRATEGY

This review specifically focuses on NSSI-related stigma, various attributes related to the same and its impact on individuals who engage in self-injury. Since there is limited literature in this area, an all-inclusive search was conducted in major databases (GOOGLE SCHOLAR, PSYCHINFO, PUBMED, PUBMED CENTRAL). The keywords **Non-suicidal, non-suicidal self-injury, NSSI, self-injury, non-suicidal self-harm, self-harm together** with **stigma, marginalization, labelling, and stigmatization** were used in various permutations and combinations. All original articles, case reports, case series, viewpoints and commentaries related to stigma, correlates of stigma, consequences of stigma, and management of stigma in NSSI were included. Since this is a descriptive review, the search strategy was not more inclusive and not very systematic. The authors decided to go for a 'narrative approach', since content is very limited and niched in the study area. Relevant search information was synthesized

and presented under appropriate sub-headings. The discussion also includes stigma-mitigating strategies which may enable more help-seeking and more positive responses to disclosure.

NSSI RELATED STIGMA: VARIOUS SHADES

Why is NSSI stigmatized?

NSSI is highly stigmatized, as it involves self-infliction of tissue damage and, thereby, violates the basic social expectation of self-preservation or avoidance of pain [24]. Thus, NSSI is viewed not only as pathological, but also as a voluntarily chosen socially deviant behavior [25], resulting in the associated stigma. Additionally, NSSI being self-inflicted, or volitional, is perceived to be high in controllability [13]. Extant literature on stigma suggests that the greater the controllability of a behaviour the more stigmatising it is, as society blames individuals and holds them responsible for recovery [15]. For instance, a substance use disorder, or a behaviorally generated physical illness, such as lung cancer caused by years of smoking, would be associated with greater stigma than an illness perceived to not be in one's control, such as Dementia or Post Traumatic Stress Disorder (PTSD) [26]. NSSI may also be the result of chronic perceived stress, which implies varied understanding including unconscious motives of avoidance [16, 17]. This perceived controllability of NSSI and, thereby, the responsibility for the origin of the disorder leads to higher stigma, reduced willingness to help, and more negative responses [27].

Language and NSSI stigma

Language plays a special role in further stigmatizing NSSI. While stereotypes such as "*attention seeking*" and "*calculating*" and *"manipulative*" create misconceptions about NSSI, thereby encouraging hostile attitudes from others, even seemingly innocuous labels such as "*cutters*" or "*self-injurers*" can exacerbate stigma and imply homogeneity for individuals who self-injure [28]. Treating individuals with such homogeneity is misleading, because individuals who self-injure have varied experiences of NSSI and this type of language further dehumanizes and undermines the right to be treated individually [29] and creates the possibility of discounting lived experiences. Hasking and Boyes [29], thereby, propose that, given the importance of language in influencing societal attitudes, modifying the language in discussing NSSI would be crucial in destigmatizing NSSI and creating a societal shift in related discourses.

Physical scarring and NSSI

NSSI stigma is further complicated because of the associated phenomena of scarring. Most individuals engaging in NSSI or having a history of NSSI carry at least one permanent or long-lasting and even visible scar [30], as a result of cut, scratches or burns marks from NSSI [31]. The visibility of the scars also increases the potential risk of being stigmatized by others [32]. These scars reduce the concealability of NSSI, thereby further increasing the possibility of experiencing stigma, even for individuals who stop self-injuring but continue to have scars [13]. A recent study by Burke et al. [33] indicated the presence of strong explicit and implicit negative biases towards NSSI scars when compared to tattoos or for non-intentional disfigurements. Besides increasing the risk of public stigma, scars are also associated with individuals' own feelings of anger, disgust, shame, and self-stigma [31]. Another recent study by Burke et al. [34] indicated that among individuals with a history of NSSI scarring, almost eighty percent engaged in scar concealment practices from others, and almost sixty-four percent engaged in concealment of these scars even from self. The study findings also demonstrated that the degree of scar concealment practices from others and from self was associated with a higher frequency of NSSI urges, greater anxiety, and depression symptomatology and higher degree of negative scar-related cognitions. Indeed, accepting one's scars, and thereby navigating the associated stigma and shame, plays an important role in any recovery from NSSI [35]. We could speculate that speaking about scars (in a safe non-judgemental environment) can reduce self-stigma and perhaps foster scar acceptance, which in turn can contribute to recovery.

The media and NSSI

It is perhaps especially important to examine the role of the media in NSSI knowledge and stigma. Both the language used in the media, as well as the information shared, can impact stigmatized views and stereotypes of mental health issues and mental illness [36, 37], and, thereby, the role of the media cannot be discounted [13]. NSSI is often portrayed in ways that justify engagement in NSSI or makes recovery seem impossible [38–40], thereby stigmatizing NSSI further. An accurate and

responsible media portrayal of NSSI is important, as it may act as a source of accurate information and can even play a protective role, by encouraging recovery [41]. *Secret Cutting (Painful Secrets)* (2000), *28 Days* (2000), *Thirteen* (2003), *Cut: Teens and Self-injury* (2018), etc. are some of the movies and documentaries that depict acts and conversations about NSSI. While the detailed discussion about media portrayals of NSSI is beyond the scope of this paper, Trewavas et al. [40] provide a detailed overview of representations of NSSI in motion pictures. NSSI has generally been correlated with substance abuse, adverse childhood experiences, and psychiatric illness while often being portrayed as covert and habitual. These depictions were often detailed and sensationalized. Mostly, the movies were criticized for showing inaccurate relationships of NSSI with suicide and poor availability of mental health care, which could have been shown to fuel hopeful narratives of recovery, highlight the availability of help and, thereby, promote help-seeking.

LEVELS OF STIGMA

Ahmedani [15] suggests that to gain a holistic understanding of how stigma manifests itself socially, it is important to look at its different levels. These levels are not hierarchical but rather represent the different overlapping fields of social stigma. We examine three levels of stigma in terms of stereotypes, prejudice, and discrimination specific to NSSI.

Public stigma

Public or social stigma is the stigma prevalent in the members of the general public, most often encountered from teachers, parents, and peers. Extant literature suggests that there are negative biases on NSSI, widely prevalent in the society, along with stereotyping of individuals who engage in NSSI as attention seekers, manipulative, fragile [42, 43], or is associated with other misconceptions (such as NSSI is prevalent only in teenagers, or in individuals having a gothic lifestyle; *see* study by Kapur and Gask [44], which explores attitudes towards self-harm, including NSSI and suicide). The negative biases and stereotypes result in lesser willingness to help and lack of sympathy, or even negative emotional reactions, such as anger toward individuals who engage in NSSI [45]. This social stigma runs parallel to structural barriers, including lack of knowledge resources or policies for the management of NSSI, as seen in research in school settings [46], and needs to be addressed. NSSI stigma also surfaces during disclosure to parents, teachers, peers, or trusted adults. Responses to disclosure often reflect negative emotional reactions, such as shock, disgust, and even avoidance or misconceptions of attention-seeking and manipulation [47–49]. The public stigma has far-reaching consequences, including internalization by people with lived experience, which manifests itself as self-stigma [48]. These consequences are discussed in the subsequent sections.

Self-stigma

Though there is an intuitive expectation that possession of knowledge and lived experience of the psychiatric disorder would act as protection against self-stigma, research demonstrates that there is significant self-stigma involved in psychiatric disorders and that individuals engaging in NSSI also conform to this pattern [50]. Self-stigma manifests itself in individuals who engage in NSSI in the form of shame and embarrassment regarding their self-injurious behavior, the relapses in recovery, as well as self-injurious thoughts and urges. Research also suggests that many individuals who engage in NSSI experience shame and disgust toward the NSSI scars [32]. Thus, NSSI is associated with significant self-stigma, which further hinders the process of recovery, as recovery entails the acceptance of self, acceptance of scars, and normalization of NSSI thoughts and urges [35].

Health worker stigma

The attitude of health professionals towards patients, including stigmatization, can influence the quality of health care offered. For instance, extant literature suggests that health professionals may perceive self-injurious behavior to be manipulative and, in such instances, may spend less time with such individuals, and may also be less willing to help [27, 51]. Even mental health professionals are not exempt from harboring such negative views, albeit, less so than other medical health professionals, perhaps due to some knowledge and training [52, 53]. Such negative views amongst mental health professionals often manifest themselves in the form of an urge to "fix" clients that may materialize in a form of coercive action meant to stop the self-injurious behavior, including premature or ill-conceived safety contracts [24]. Therapists may be tempted to prioritize stopping the self-injurious behavior prematurely, before the client is ready [24], or might

inadvertently use labels in therapy such as "*attention seeking disorder*" or *"maladaptive coping*" [23, 54], while sharing the diagnosis or formulation in an attempt to simplify the experience. This is quite plausible, given that therapists and other mental health professionals often feel incompetent in treating self-injurious behavior [55]. Additionally, disclosure of self-injury may evoke strong emotions in therapists, which might bring forth the need to separate themselves from clients who self-injure, and also bring forth latent judgements [48], which can manifest itself in the form of stigma.

Thus, social stigma for NSSI happens at three distinct levels. To capture the holistic understanding of NSSI stigma at these three levels it is important to understand the stereotypes (negative views about a group) and prejudice (negative emotional reactions congruent with belief or negative views) and the discriminatory practices at these three levels. The actions of discrimination from others are termed as enacted stigma, and these experiences of enacted stigma are often anticipated by the stigmatized group, resulting in actions taken from the anticipated stigma. Thus, discriminatory practices are behavioral responses to prejudice and may involve both enacted stigma as well as actions taken from anticipated stigma. Table 1 describes the stereotypes, prejudices, and discriminatory actions present at the three distinct levels of social stigma.

IMPACT OF STIGMA

The impact of stigma on NSSI can be multifold, the foremost of which is that it acts as a barrier in the help-seeking process or even discussion of NSSI [56, 57]. Additionally, stigma may also lead the individual to not adhere to the suggested treatment or drop out of treatment [15, 58]. Indeed, extant literature suggests that individuals who self-injure are often reluctant to seek help or support due to the stigma associated with NSSI, or, in other words, stigma is a barrier to help-seeking [59, 60]. Stigma from health professionals can also lead to unhelpful therapy experiences, such as feeling judged or misunderstood [23, 48], that can cause individuals to discontinue treatment or stop any further discloses [56, 57]. It can also lead the individual to internalize shame and stigma and potentially create more isolation and alienation for the individual [56]. Indeed, individuals who self-injure are often aware of the stigma associated with NSSI and this awareness often evokes fear of the negative impact of the stigma, such as labeling, misunderstandings, and judgement [48]. The fear of being stigmatized not only impedes help-seeking, but can also drive the individual to go to extreme lengths to hide their self-injury, maintain a social facade to ensure privacy, such as hiding scars or being untruthful about the origin of NSSI scars, or self-injuring in areas not easily visible [23, 48, 61].

Table 1. Stereotype, prejudice, discrimination for NSSI at different levels of social stigma

	Levels of stigma		
	Public stigma	**Self-stigma**	**Health professional stigma**
Stereotype negative views about a group	Seeing individuals who self-injure: • dangerous • attention seeking • fragile character • suicidal (even when the individual is not)	Seeing self as: • weak • incompetent	Seeing individuals who self-injure: • manipulative • attention seeking • suicidal (even when the individual is not)
Prejudice negative emotional reactions congruent with belief	Anger, disgust	Low self-worth, low self-efficacy, shame	Anger, disgust, reduced empathy
Discrimination behavioural response to prejudice	Enacted stigma taking forms of: • avoidance • rejection • withdrawal	Actions taken because of anticipated stigma: • not seeking help • concealing scars from self and others • not disclosing self-injury in treatment • avoiding social gatherings and • losing opportunities in fear of rejection or intrusive questions • discontinuing treatment	Enacted stigma taking the form of: • reduced willingness to help • coercing clients to stop NSSI before client is ready • referrals to others • refusing same treatment (e.g., refusing analgesia) • putting someone who is engaging in self-injury on suicide watch or forcing the individual to admit to being suicidal even when they are not

Additionally, stigma experiences also lead to ambivalence toward not only disclosing NSSI, but also the recovery process [21].

Moreover, internalization of stigma can lead to diminished self-efficacy, reduced self-esteem, and diminished hope for one's future [58, 62]. Indeed, individuals who engage in self-injury report lower self-esteem and self-efficacy than people without a history of self-injury [63]. Lower self-efficacy and self-esteem can lead to demoralization of the individual, and that ultimately leads to the "why try effect," where individuals give up on pursuing social opportunities [58, 64]. Indeed, NSSI (scar related stigma) has been reported to increase social isolation [61]. Individuals engaging in NSSI also report apprehension as regards their career prospects [48], and they often avoid social activities such as going to the beach or even swimming [61]. Thus, NSSI stigma has a far-reaching impact on an individual's social and personal life, which highlights the importance of reducing NSSI-related stigma. Indeed, misinformation and negative views and biases about NSSI lead to a vicious cycle where these stereotypes are internalized, hobbling help-seeking, increasing isolation, and possibly helping perpetuate the NSSI behavior and narrowing the chances for recovery.

UNDERSTANDING NSSI STIGMA

Assessment of stigma plays a very important role in understanding NSSI. Assessment of stigma can serve as an initial step before introducing interventions to mitigate public stigma and health worker stigma, including even self-stigma.

In the clinical setting, an individual's experiences of NSSI stigma can be assessed through an exploration of enacted stigma (experiences of prejudice and discrimination), as well as their actions based on anticipated stigma (expectation of prejudice and discrimination) [13]. Self-stigma plays a central role in influencing help-seeking, as well as clinical engagement, and it can be assessed in the clinical settings through an exploration of one's beliefs about self-harm, the affective experiences associated with NSSI (such as anger, disgust and shame), and the individuals willingness to discuss NSSI experiences [65]. The assessment should also include scar concealment practices and scar-related cognitions, as it may shed further light on the experience of stigma and shame that individual's experience [34]. This exploration of stigma associated with scars is especially relevant, because scars can have long-term implications even for individuals who have stopped self-injuring, as they continue to carry a physical reminder of past self-injury [13]. Additionally, in a recent study it has been suggested that personalized assessments and feedback interventions can be effective tools in the reduction of NSSI. Min et al. [65] found that individuals engaging in NSSI underestimate whether others would understand the reasons for engaging in NSSI, but people without a history of NSSI would still understand why individuals engaging in NSSI do so, suggesting that such an assessment and feedback loop may be utilized in Personalized feedback interventions to reduce the shame associated with NSSI. This type of intervention may reduce self-stigma and also promote help-seeking and disclosure of NSSI.

It would also be important to understand the explicit and implicit biases and negative attitudes toward NSSI among key stakeholders who may be approached for support by individuals engaging in NSSI. These stakeholders, like general health professionals, teachers, and guidance counsellors, are among the other resources likely to be approached [57]. The Self-Harm Antipathy Scale [67] developed to assess attitudes among health professionals towards self-harm can be modified to assess attitudes towards NSSI, specifically. Another tool, the Self-injury Stigma Scale (SISS), based on the model of self-stigma has been recently developed and validated [68]. Understanding these attitudes (implicit and explicit) would be helpful in specifically designing interventions that directly address these stigmatizing views.

The next step in understanding stigma is conceptualizing it. One of the ways to conceptualize NSSI stigma could be through the framework suggested by Staniland et al. [13]. Staniland and colleagues propose conceptualizing stigma along six constructs, in the context of NSSI from the six stigma constructs suggested by Jones et al. [69]. The framework examines public stigma, self-stigma, enacted stigma, and anticipated stigma along the six stigma constructs of origin, course, peril, disruptiveness, concealability, and aesthetics. This framework allows us to understand the distinctive facets within a single experience of stigma. Understanding and addressing these specific constructs could prove to be efficacious in stigma reduction in the therapeutic settings, as well as provide direction for future research.

This study highlights the multifaceted nature of NSSI stigma, and acquiring a holistic understanding of NSSI stigma may be crucial in facilitating help-seeking and

recovery from NSSI. It is, therefore, important to understand the various layers and depth of stigma experiences through assessments and conceptualize the different features of the experience.

REDUCING STIGMA: SUGGESTED INTERVENTIONS

Addressing and mitigating stigma becomes imperative to facilitate help-seeking and to facilitate the process of recovery from NSSI. Fostering empowerment of the individual is key to addressing stigma, especially self-stigma [62], and it has the added advantage of contributing to recovery. Indeed, acceptance of past NSSI, acceptance of scars, developing alternative methods to respond to NSSI, urges, and fostering psychological wellbeing are not only crucial to the process of recovery from NSSI [35], but can also empower the person, thereby reducing self-stigma. Thus, reducing stigma and recovery from NSSI appear to be closely aligned.

The de-stigmatization of NSSI warrants interventions at several levels and settings, such as the individual, the media, public, healthcare system. We discuss several methods that can be used to tackle public stigma, as well as self-stigma, both through outreach efforts and in the clinical setting. Such strategies have been further summarized in Table 2. Indeed, much of the outreach efforts are directed toward reducing public stigma, while certain strategies in clinical settings are focused on reducing the self-stigma experienced by individuals and facilitating recovery.

Outreach efforts to reduce stigma

Contact and education have been identified as effective means to reduce public stigma [70, 71]. This implies that mental health literacy with regards to NSSI and contact with individuals who engage in NSSI would be effective means to reduce NSSI stigma. Interventions that promote support-seeking and educate the public, such as psychoeducation programs, multimedia interventions, peer training interventions and outreach programs, have been well developed and validated for common mental health problems [72], but need to be designed specifically for NSSI. Indeed, a recent study found that a prevention program modified to include a psychoeducation module on NSSI could encourage support-seeking in individuals engaging in NSSI and also that it had no iatrogenic effects on others [73], therefore allaying the fears of contagion in NSSI. Such education programs have also been found to increase the willingness to help individuals engaging in NSSI and reduce rejection and avoidance responses to disclosure [47]. Another recent study found that educational intervention designed to increase overall understanding of self-harm reduced negative attitudes towards individuals who self-harm significantly among

Table 2. Multi-level strategies to reduce stigma related to NSSI

Outreach efforts to reduce stigma
Psychoeducation models, specific to NSSI, tailored for different groups.
Responsible reporting of NSSI by media.
Social media and internet-based services.
Peer support network (especially with individuals having lived experience).
Inclusion of lived experience accounts in education models and interventions.
Reduction of stigma in clinical settings
Detailed understanding and assessment of NSSI stigma experiences (enacted stigma, anticipated stigma, self-stigma, scar-related stigma experiences).
Acknowledging a therapist's negative biases toward NSSI and resolving them.
Using appropriate language to describe and discuss NSSI with clients.
Gaining a person-centered understanding of NSSI (Lewis & Hasking, 2021).
Therapeutic interventions: • using Cognitive behavioral strategies to reduce self-stigma and challenge negative biases, • using Compassion based approaches to reduce shame and internalized stigma, • fostering acceptance of past engagement with NSSI, • fostering scar acceptance, especially with a culture-based understanding of the value of scars as a predictor of scar acceptance. (for example: one way to look at scars is 'physical difference' rather than 'physical deformity'; in certain socio-cultural norms, like tattoos, scars are considered to be physical imprint of past memories and pain; further some belief that scars add value to their physique by making them aware how they navigated painful challenges in life that led to resilience, hope and healing [59,61,63])

health professionals [74]. This implies that community education models may not only prove beneficial in terms of reducing stigma, but also encourage support-seeking, and that they make positive disclosure experiences more likely. These programs should therefore be tailored to the different confidante groups, such as peers, parents, teachers, among others [47, 75], and future research should focus on exploring the effectiveness of different formats of such education programs, such as school-based seminars, or web-based formats [76].

Much of the stigma that exists is due to a failure to include NSSI in the list of disorders, which in turn leads to lack of awareness and the lack of structural resources such as policies specific to NSSI. Most mental health programs and policies include suicides and suicidal attempts, but NSSI is not clearly mentioned [4]. As the authors are from India, we provide the example of the Mental Healthcare Act (MHCA) 2017, which decriminalized suicide and advocated for the rehabilitation and treatment of suicide-survivors. It was a long-overdue welcome approach. However, throughout the Act, there has been no mention or a discourse related to NSSI. There is a prevailing view among many researchers and clinicians that NSSI needs to be recognized as a distinct disorder in DSM 5 [11, 77, 78], which could lead to better treatment options. Indeed, in the context of stigma, it has been argued that if NSSI gains the status of a disorder, it will not only validate the experience of NSSI for individuals, but also encourage treatment-seeking for NSSI, and potentially reduce stigma. The ambiguity surrounding NSSI as a concept reduces help-seeking and awareness, and limits management options [13]. According to the perspectives of individuals with a lived experience of self-injury, this could mean legitimizing NSSI as a mental health concern, possibly bringing about a reduction in misconceptions regarding NSSI, and thereby a shift in public attitude towards NSSI [79]. Inclusive practices could gradually lead to a recognition of NSSI in settings such as schools and colleges and result in standard guidelines and recommendations for the treatment of NSSI for counsellors. However, another view holds that inclusion of NSSI as a disorder could further stigmatize the behavior. Regardless of the status of NSSI as a disorder, Lewis et al. [79] emphasize the need to reduce stigma through increased awareness of NSSI, improved understanding of NSSI, and lessening the shame and isolation that affect individuals who self-injure, while suggesting participatory-based approaches to achieve that goal. Participatory-based approaches lead to empowerment and a lending of voice to individuals with lived experiences They also lead to improved understanding of the experiences, thereby, reducing stigma [62, 80].

One such participatory-based approach would be incorporating peer support workers in health services [62], especially ones with a lived experience of self-injury. Such peer networks would be helpful in a low- or middle-income country (such as India), where resources are limited but social networks are strong [65]. Extant literature suggests that there is a natural inclination to approach people who have gone through similar experiences for support [62], which could increase support-seeking without the fear of being stigmatized. Involving people with lived experiences in peer support capacity could also mean providing non-discriminatory and non-judgmental services that would go a long way in reducing the NSSI stigma prevalent in health services [65]. Inclusion of voices with a lived experience and perceived unmet needs in both interventions and policies is imperative.

Mental health literacy programs that encourage help-seeking could also include accounts of the lived experiences of individuals who are in recovery. Access to such resources has been known to reduce isolation, provide a person with the language needed to describe their own experiences, as well as instil hope for recovery [81]. Such accounts could reduce both public stigma and self-stigma, as well as encourage individuals to seek professional help [62]. An example of such an intervention would be the "In Our Own Voice Program" in the United States, which was developed by the National Alliance on Mental Illness and contains testimonials from individuals with mental illness. It was found to reduce both public stigma and self-stigma, as well as advance a narrative of recovery and hope [82–84]. This could be an example of a reduction of stigma through contact. Indeed, a recent study found that conversations and group sessions with other individuals with a lived experience of NSSI could help individuals feel hopeful and feel a sense of belonging [56].

Another effective platform for outreach and the reduction of stigma for self-harm would be social media [65]. Given the salience of social media and online platforms for NSSI [85], Internet-based services can possibly be a proximal step to seeking face-to-face help [86]. Indeed, Internet-based services could provide information

and guidance, reduce isolation, facilitate help-seeking and access, and also ensure privacy [87]. Social media platforms and Internet services can also be utilized to reduce stigma, whereby people with mental health difficulties are able to share their experiences in public online spaces and challenge public stigma [88]. Therefore, social media would also be an effective platform for reducing NSSI stigma. The media could be another platform for the reduction of NSSI stigma. Responsible reporting on NSSI, by using appropriate language and abiding by certain recommended guidelines to report on NSSI, could be effective in dispelling myths and misconceptions regarding NSSI and help in shifting public perception of NSSI [29, 41].

Reduction of stigma in clinical settings

Stigma has several implications for clinical services and the therapeutic setting as well. It is important for mental health care providers to acknowledge and understand the self-stigma that individuals who engage in NSSI may experience and provide a supportive environment in which to disclose and (or) discuss their NSSI experience [50]. This calls for a detailed understanding and assessment of the stigma experienced by the individual, which has been discussed in detail in an earlier section.

Disclosure in a supportive environment could lead to owning and acceptance of one's stigmatized identity, which itself could reduce self-stigma [62, 89]. Thus, fostering disclosure through a supportive environment would be crucial in the clinical and therapeutic settings.

Additionally, given that health care workers could also harbor negative biases towards NSSI, it is important to not reinforce the negative biases the individual engaging in NSSI may hold against NSSI or against themselves (in the context of NSSI). Thus, health care workers also need to be mindful of the language used to describe or discuss NSSI. Clinicians, mental health professionals, and allied health professionals are taught to discuss mental illness in a non-stigmatizing way, and this should also apply to the language and discourses surrounding NSSI [29]. Moreover, health professionals should refrain from using terms or labels such as "self-injurers" or "cutters" in clinical services as well as in published work [28]. Instead, using a person-centered understanding of NSSI [90] and respectful language that is deemed appropriate by individuals with a lived experience of self-injury is recommended [91]. In line with this, it is also important for mental health care providers to be aware of and tackle their own negative biases and misconceptions regarding NSSI and individuals who self-injure that may affect their work [50].

Additionally, in a therapeutic setting, self-stigma regarding self-harm can influence the degree of an individual's investment in therapy [65]. Therefore, it is critical to address the beliefs about self-injury, along with beliefs about one self that would be important in understanding how self-stigma can influence the recovery process. Knowledge of self and NSSI influence support-seeking and, thereby, plays a role in recovery. This indicates that therapeutic approaches that explore and address these cognitions, such as Cognitive behavior therapy approaches, may be beneficial [92]. Cognitive Behavioral strategies have been particularly recommended to address self-stigma [62]. Shame, embarrassment, and other effects associated with internalized stigma also need to be addressed in therapy, as it may influence NSSI experience, support-seeking, investment in treatment and would, thereby, also impact the process of recovery [59]. This indicates that approaches that address shame in the therapeutic context, such as suggestions by Tangney and Dearing [93] or compassion-focused therapy for NSSI [94], could prove to be potentially beneficial. Fostering scar acceptance through scar-specific treatment (such as cognitive restructuring for scar-specific dysfunctional beliefs, gradual exposure to aversive memories associated with scars, and building of tolerance for these distressing experiences) would be important in addressing the scar-related stigma, as well as the recovery process [34].

MOVING FORWARD: FUTURE DIRECTIONS FOR RESEARCH

While the amount of NSSI research has increased in the past decade, research into NSSI stigma is still in nascent stages and does not receive the same importance given to clinical studies. Indeed, much of the NSSI stigma experiences have emerged as part of other research work, limited in scope and ancillary [13]. This review has highlighted several areas that need further research. Phenomenological approaches to the study of stigma may shed light on the lived experiences of individuals' experiences of NSSI stigma. Moreover, stigma experiences may be further complicated, with added layers of being discriminated against for being part of minority groups.

Future research can focus on an area that is representative of such experiences. Additionally, research also needs to be specific on the way NSSI is defined and distinguished from self-harm. Most research has been focused on self-harm, which could mean both suicidal behavior as well as NSSI. To work on NSSI stigma, the definition of NSSI needs to be clearly demarcated from self-harm. Future research could focus on developing standardized assessments that examine NSSI stigma for self-harm, including scar concealment practices, scar cognition, and other anticipated stigma practices. Assessments that also look at public stigma, both explicit and implicit, also need to be developed through further research. Another area that needs further research is the development of stigma reduction interventions and examining the utility of these programs. NSSI stigma has many implications for treatment and interventions and needs to receive as much importance as clinical studies.

A discussion related to NSSI, and related stigma, will be incomplete without mentioning the added risk posed by the ongoing Coronavirus (COVID-19) pandemic. Studies have shown an increased prevalence of NSSI mainly among adolescents [95] and females [96]. The history of NSSI, internalizing symptoms, perceived stress, family conflicts, and adverse personal experiences during the pandemic were the main risks. The issues of personality and virtual environment, related risk factors, and self-esteem-enhancing strategies were highlighted as useful [95]. The stigma related to NSSI can compound the social stigma of the pandemic and lead to a compounded vulnerability, impeding health care access and help-seeking. While many of these factors are still being explored, empirical research is warranted in order to further understand the bi-directional relationship between disasters such as COVID-19 and NSSI behavior.

CONCLUSION

This review brings forth the multidimensional aspects that needs to be considered when talking about the NSSI stigma. The impact of the stigma can be significant, as it severely affects the help-seeking experiences of individuals, as well as their treatment experiences, and also plays a significant role in the recovery process and treatment outcomes. Addressing this stigma is beneficial both for managing and accessing support for NSSI. The reduction of stigma would also require a holistic approach, involving outreach efforts at multiple levels, clinical interventions, as well as the involvement of primary healthcare. Given the detrimental effects of NSSI stigma, and how highly stigmatized NSSI is, this review highlighted the fact that if NSSI is indeed recognized as a clinical disorder, future research would need to focus on these constructs and treat with a level of importance similar to the one given to clinical studies of intervention and symptomatology in NSSI.

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