"I have some people who actually really care:" Young sexual minority women's lived experiences of non-suicidal self-injury disclosure

Lindsay A. Taliaferro,[1] Jennifer J. Muehlenkamp,[2] Dahlia Wrubluski,[1] Karli Reeves,[1] Sarah A. Job,[1] Robert D. Dvorak,[3] Eric W. Schrimshaw[1]

[1]Department of Population Health Sciences, College of Medicine, University of Central Florida, Orlando; [2]Department of Psychology, College of Arts and Sciences, University of Wisconsin-Eau Claire, [3]Department of Psychology, College of Sciences, University of Central Florida, Orlando, United States

Correspondence: Lindsay Taliaferro, Department of Population Health Sciences, College of Medicine, University of Central Florida; 6900 Lake Nona Blvd., BBS 426, Orlando, FL 32827, United States.
Tel.: 407.266.7149.
E-mail: Lindsay.Taliaferro@ucf.edu

Key words: Lesbian, gay, bisexual, queer, assigned female, NSSI.

Contributions: SJ, KR, and ES led the recruitment and enrollment of the sample. KR completed all of the individual interviews. LT, JM, and ES led the conceptualization of the paper, though all authors were involved in this process. LT, DW, and KR performed data coding and analysis. LT and ES led the writing of the introduction, methods, and results, while JM led the development of the discussion, with RD contributing significantly to the clinical implications. SJ provided substantive feedback on all sections. All authors edited and commented on the multiple versions of this manuscript.

Conflict of interest: The authors declare no potential conflict of interest, and all authors confirm accuracy.

Funding: Research reported in this publication was supported by the National Institute on Minority Health and Health Disparities of the National Institutes of Health under Award Number R01MD015896. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

Ethics approval: The Institutional Review Board at the University of Central Florida, USA approved the study procedures (IRB ID: STUDY00002361). The study conforms with the Helsinki Declaration of 1964, as revised in 2013, concerning human and animal rights.

Informed consent and consent for publication: Participants electonically signed the consent forms.

Availability of data and materials: Data are available upon reasonable request.

Received: 3 May 2024.
Accepted: 11 October 2024.

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Licensee PAGEPress, Italy
Qualitative Research in Medicine & Healthcare 2024; 8:12632
doi:10.4081/qrmh.2024.12632

ABSTRACT

Sexual minority youth are more likely to engage in Non-Suicidal Self-Injury (NSSI) than their heterosexual peers, and sexual minority women demonstrate greater risk of NSSI than their sexual minority male counterparts. However, a lack of research exists on NSSI among young sexual minority women, particularly their NSSI disclosure experiences. We used a descriptive-interpretive, qualitative design with semi-structured interviews to examine young sexual minority women's lived experiences disclosing NSSI and of others' responses to these disclosures. The sample included 65 sexual minority women aged 14-30 recruited via paid social media advertising from across the U.S. We performed an inductive thematic analysis of transcripts from 58 participants (89%) who reported a history of NSSI. Participants shared reasons for disclosure (wanting help, communicating distress) or nondisclosure (cultural stigmas), types of disclosure (accidental/involuntary, and direct/voluntary), and recipients of a disclosure (friends, partners, mental health providers, and parents). They also described responses to, and feelings after, NSSI disclosure, revealing two themes: i) Unhelpful/stigmatizing responses (based on fear, anger, and apathy) and ii) Helpful/destigmatizing responses (expressions of concern, emotional support, and alternative coping strategies). Overall, young sexual minority women's disclosure experiences were consistent with those of other populations, highlighting the need to further reduce stigma about NSSI, as well as sexual minority identities, and provide universal education promoting helpful responses to NSSI disclosure.

Introduction

Research on Non-Suicidal Self-Injury (NSSI) among sexual minority (lesbian, gay, bisexual) adolescents and young adults shows this population demonstrates greater prevalence of past-year and lifetime NSSI than their heterosexual counterparts (Batejan et al., 2015; Jackman et al. 2016; Rogers & Taliaferro, 2021; Tsypes et al., 2016). Specifically, sexual minority youth are 2.25 to 5.80 times more likely to engage in NSSI than their heterosexual peers (Rogers & Taliaferro, 2021). For example, examining data from a state Youth Risk Behavior Survey, Liu (2019) found

12-month prevalence rates of NSSI across different survey years between 2005 and 2017 ranging from 38.1% to 53.0% for sexual minority youth, compared to 10.8% to 20.4% for heterosexual youth. Within the limited research with sexual minority young people, large studies examining differences between men and women consistently found higher risk of NSSI among sexual minority women, compared to sexual minority men (Guo et al., 2023; Jackman et al., 2016). However, to our knowledge, only two studies have focused on NSSI among populations of sexual minority women (Alexander & Clare, 2004; Zaki et al., 2017). Zaki et al. (2017) examined help-seeking behavior through a quantitative cross-sectional survey among a sample of sexual minority and heterosexual women with a history of NSSI recruited from Internet self-injury discussion forums. They found that all groups reported relying primarily on friends for support, but heterosexual women and girls were more likely to seek support from a mental health professional, compared to their sexual minority counterparts. Whereas Alexander and Clare (2004) conducted a small (N=14) qualitative study with lesbian and bisexual women who engaged in repetitive self-injury to explore factors associated with development of and engagement in NSSI, particularly factors related to participants' sexual identities. Findings showed that "feeling different" was strongly associated with engagement in NSSI for sexual minority women, and many participants faced negative and invalidating responses from healthcare professionals upon NSSI disclosure. Thus, limited research has examined unique experiences of adolescent and young adult sexual minority women who engage in NSSI.

One critically understudied aspect of NSSI among adolescent and young adult women, and particularly sexual minority women, involves their experiences with NSSI disclosure and responses of others to NSSI disclosure or discovery. Although young people may fear disclosing NSSI due to others' stigmatization of the behavior and misinterpretation of NSSI as a suicide attempt, disclosure can facilitate help-seeking, social support, and self-advocacy (Burke et al., 2019; Hasking et al., 2015; Mirichlis et al., 2022; Rosenrot & Lewis, 2020). To our knowledge, only Burke et al. (2021) have examined the disclosure of self-injurious thoughts and behaviors among sexual and gender minority youth. The investigators compared disclosure of self-injurious thoughts and behaviors between sexual and gender minority youth and heterosexual and cisgender youth using quantitative surveys, and they found few differences in disclosure patterns (i.e., to whom they disclosed) across the groups. One notable finding involved barriers to disclosing this behavior to a therapist. Sexual and gender minority youth were more likely than their heterosexual and cisgender peers to *not* disclose their self-injurious thoughts and behaviors to a therapist due to concern the therapist would share this information with a parent (gender minority youth specifically) and/or information regarding their self-injurious thoughts and behaviors would worry a parent (Burke et al., 2021). The authors speculate that sexual and gender minority youth may feel particularly concerned about negatively impacting relationships with their parents after a disclosure of self-injurious thoughts and behaviors (Burke et al., 2021). However, they did not explore reasons for this finding. Still, research demonstrating the tenuous or strained relationships some sexual and gender minority youth share with their parents related to their sexual/gender identities supports the researchers' proposition (Bouris et al., 2010; Newcomb et al., 2019). Given the lack of research on NSSI disclosure experiences among sexual minority youth, investigators have called for research with this population to better understand unique challenges they may experience disclosing NSSI as a population encountering significant societal stigma and associated minority stressors (Simone & Hamza, 2020).

Qualitative research yielding in-depth narrative data represents the preferred approach for investigating understudied phenomena (Creswell & Creswell, 2018; Creswell & Poth, 2024), such as disclosure experiences, especially among understudied populations (Creswell & Poth, 2024), including young sexual minority women. However, to our knowledge, researchers have only conducted four qualitative studies regarding NSSI with sexual or gender minority populations, and none of these studies examined NSSI disclosure experiences (Alexander & Clare, 2004; DiStefano, 2008; Jackman et al., 2018; Scourfield et al., 2008). Further, only two qualitative studies have examined NSSI disclosure experiences among young people (Rosenrot & Lewis, 2020; Simone et al., 2023), and these studies included relatively small samples (N~20) of college students. Thus, we lack nuanced understanding of young sexual minority women's experiences of disclosing their NSSI to others and their perceptions of helpful and unhelpful responses to such disclosures.

In the current study, we addressed calls for research on NSSI disclosure experiences among at-risk underrepresented populations such as sexual minority youth (Simone & Hamza, 2020), and qualitative research on self-injurious thoughts and behaviors with this population (Scourfield et al., 2008). Specifically, we explored NSSI disclosure experiences among young sexual minority women, a population who demonstrates increased risk for engaging in NSSI, by conducting a qualitative investigation to glean in-depth understanding of experiences related to NSSI disclosure. One research question guided the current analysis: What are young sexual minority women's lived experiences of disclosing NSSI and of others' responses to these disclosures?

Materials and Methods

Study design

We used a descriptive-interpretive qualitative design (Elliott & Timulak, 2005, 2021) with semi-structured individual interviews. Data were collected in 2023-2024 as part of a larger national, U.S. longitudinal, mixed-methods research study on suicide prevention among young sexual minority women and nonbinary individuals assigned female at birth. Inclusion criteria for the larger study required participants: i) currently identify as a cisgender woman, identify as transgender woman, or identify as genderqueer/non-binary and also report being assigned female at birth, ii) identify as lesbian or bisexual, or report sexual attractions toward a woman in the past year, iii) be aged 14 to 30 (18 or older in Florida), iv) report currently living in the U.S. or its territories, v) be sufficiently fluent in English to complete the survey in English, and vi) have Internet access and provide a telephone or mobile number. Further, sampling quotas sought to obtain equal numbers of lesbian and bisexual women and were used to ensure racial/ethnic diversity (a minimum of 25% Black, 25% Hispanic/Latine, 10% Asian). The Institutional Review Board at the University of Central Florida, USA approved the study procedures (IRB ID: STUDY00002361).

Study team

The study team included individuals of diverse sexual and gender identities. The study investigators' educational backgrounds included doctoral degrees in public health, social psy-

chology, and clinical psychology. All study staff interacting with participants were assigned female at birth, and most also held diverse sexual identities. Two study staff members conducted interviews. The primary interviewer, who conducted most interviews (n = 52), was a trained master's-prepared anthropologist who identified as a non-Hispanic White bisexual genderfluid non-binary person. The second interviewer had bachelor's degrees in psychology-clinical track and political science and identified as a non-Hispanic Black bisexual non-binary person.

Recruitment, participants, and data collection

Recruitment occurred through paid social media advertising on Facebook, Instagram, Snapchat, and Twitter (X). Potential participants who clicked on the online study advertisements were taken to a Qualtrics webpage containing study and consent information and an eligibility screening questionnaire. We used multiple fraud detection procedures when reviewing online screeners (e.g., blocking bots and multiple surveys from the same IP address, verifying locations of IP addresses, utilizing Qualtrics' built-in fraud detection). Those deemed eligible were immediately notified at the end of the screening survey and given further information about the study purpose and demands. Those interested in participating were asked to provide a first name, an email address, and a telephone number. Study staff contacted respondents who screened eligible to complete a brief telephone survey. After providing verbal assent, respondents were asked questions to obtain additional information, re-confirm eligibility, and detect potential fraudulent respondents. After they were deemed eligible for the study based on the online and telephone screeners, participants were verbally presented with the consent document, and they provided verbal consent. Here are the procedures for procuring consent, as noted above in the correction to the wording about obtaining written consent, which is not possible for a national study. Roughly 10% of survey participants were selected for an interview after completing the baseline survey. Interview participants were asked to provide verbal consent again at the beginning of the interview phone call after being reminded about the details of the interview. The IRB approved a waiver of parental consent for participants under age 18 (except in the state of Florida where such waivers are prohibited by state law) to participate in the study, consistent with recommendations for low-risk research with sexual and gender minority youth due to risks associated with "outing" participants to parents or guardians (Cwinn et al., 2021; Mustanski, 2011; Newcomb et al., 2016; Schrager et al., 2019; Smith & Schwartz, 2019). We incorporated many suicide risk protection best practice procedures within this study, including for those completing an individual interview (Hom et al., 2017; Nock et al., 2021; Schatten et al., 2020).

As part of the aims of the study, participants invited to complete an interview had to report a non-zero level of suicidal ideation during the past four months on the baseline survey and report a developmental transition (e.g., entered high school, entered college from high school, entered the workforce from college) during the previous 12 months. The study interview sample included 65 participants. Within this study sample, 58 participants (89%) reported engaging in NSSI at some point in their lives and represented the analytic sample. Participants in the analytic sample were aged 14 to 30 (M = 21.1 years, SD = 3.7 years) and racially and ethnically diverse: 29% Hispanic/Latine (any race), 21% Black, 19% Asian, and 31% White (see Table 1). These participants came from 24 different states across the U.S.

Individual interviews were conducted using an in-depth, semi-structured interview guide developed through a review of relevant existing literature and discussion among the study team. Prior to data collection, 10 members of the study population pretested the interview guide, and study staff incorporated their feedback into the final guide. The guide featured open-ended questions about experiences of suicidal ideation and behavior, minority stressors, sexual identity, feelings of entrapment, developmental transitions, and social connectedness (topics related to the theoretical model tested in the larger longitudinal study), as well as experiences of NSSI (topic of the current analysis). Telephone interviews lasted one hour and 14 minutes to three hours and 17 minutes (M = 1 hour and 58 minutes), were audio-recorded, and were transcribed verbatim by a professional transcription company. Thirteen percent of transcripts were checked for quality control. At the completion of an interview, participants were emailed a $50 Amazon e-gift card code. The interview guide did not include explicit questions regarding NSSI disclosure experiences. However, participants often spontaneously described disclosure experiences in response to two interview questions, which helped guide the current analysis: i) If other people have noticed you hurting yourself or have seen the effects, how do they react?; and ii) How does this make you feel?

Data analysis

We conducted an inductive thematic analysis of the transcribed interviews largely following the Boyatzis (1998) approach, which includes multiple team members in the analysis to increase validity in the development of the coding scheme as well as reliability in the application of codes. We analyzed the NSSI data using Dedoose to organize the transcribed interviews, highlight text relevant to NSSI, and select representative quotes. To begin, one author (who also conducted the interviews) read each transcript to identify all sections of the

Table 1. Analytic sample demographics.

	N (or *M*)	% (or SD)
Sexual identity		
Lesbian	30	52
Bisexual/Pansexual	18	31
Queer	7	12
Gay	2	3
Sapphic	1	2
Gender Identity		
Cisgender woman/girl	39	67
Non-binary/Genderfluid AFAB	15	26
Queer/Femme	4	7
Race/Ethnicity		
Hispanic/Latine (any race)	17	29
Asian	11	19
Black	12	21
White	18	31
Educational Attainment		
Completed college	26	45
Currently in college	20	34
Completed high school, no college	3	5
Currently in high school	9	16
Age		
14-30 years	21.1	3.7

AFAB, Assigned Female at Birth.

interviews in which NSSI was discussed. Consistent with the Boyatzis (1998) method, multiple study team members were involved in the analysis of the data to build reliability and consensus in the resulting analysis and findings. The full authorship team then met to discuss the NSSI data and refine the research questions to focus specifically on the lived experience of disclosure. With input from the first author, two authors then re-read the extracted interview material about NSSI and coded data related to four areas: i) reasons for disclosure/ nondisclosure, ii) types or nature of disclosure, iii) recipients of disclosure, and iv) nature of responses to disclosure. These three authors then met regularly to build a consensus regarding the findings within each of these four areas, extract quotes that represent the most common findings, and draft the results. All authors then provided feedback on the results as presented and approved the final version.

Results

Although our interview questions did not specifically ask why, how, or to whom participants disclosed their NSSI, some participants naturally shared this experience when describing others' responses. Thus, we present results related to participants' reasons for disclosure or nondisclosure, types of disclosure (i.e., accidental/involuntary and direct/ voluntary), and recipients of a disclosure (i.e., friends, partners, mental health professionals, and parents) based on spontaneous descriptions of these topics. Then, we present results for themes regarding responses to and feelings after NSSI disclosure. Specifically, we describe unhelpful responses based on fear, anger, or apathy that often led to negative feelings, and helpful responses demonstrating concern, emotional support, and/or offers of alternative coping strategies that often led to positive feelings.

Disclosure experiences

Reasons for disclosure or nondisclosure

The only reasons participants shared for voluntarily disclosing self-injury involved wanting help from and communicating distress to others. For example, a 15-year-old, Persian bisexual female[1] told her school counselor because they "just wanted someone to care." Other participants described their NSSI as a "cry for help":

> I would describe it as a cry for help hoping that my mom and dad would pick up, but they never did unless I explicitly told them. I was just looking for support in a time where people weren't able to or decided not to support me. (16-year-old, Latine lesbian non-binary person)

> My mom was super upset when she found out. She confiscated all of my seam rippers. I think that was probably what I wanted 'cause, when I was doing it back then, like at age 13, it was definitely partially a cry for help. (18-year-old, White pansexual genderfluid person)

Similarly, a participant described NSSI as a visible way to communicate their emotional pain with hope of obtaining understanding from others:

> It was a way to release, I guess, the pain I felt, in a way that was visible, so people would tune in—or not tune in, but people would understand how I was feeling, 'cause I had hid it from my parents for as long as I could. (25-year-old, Black Hispanic sapphic female)

Still, some participants expressed fear of disclosing NSSI based on cultural norms related to communicating about mental health issues and/or responses to their sexual identity. Specifically, they described cultural expectations associated with concealing rather than sharing emotional pain and concerns related to discussing their sexual identity:

> I think that's a very prevalent thing in South Asian communities of your struggles are behind closed doors, and this feeling of the only person you can rely on is yourself or that the people around you shouldn't see the ways that you're suffering. (17-year-old, South Asian lesbian non-binary person)

> Because it is not expected for someone of my race and someone like me to be someone that is self-harming in that way. (30-year-old, Black lesbian non-binary person)

> [B]eing bisexual in a Persian family doesn't—I can't be too honest about it [bisexuality] at all. I guess having to keep those problems [mental breakdowns] to myself can be really frustrating a lot. I guess it [hiding bisexuality] could definitely add to the load of emotions. (15-year-old, Persian bisexual female)

> I felt like I couldn't talk about things. That was my way of coping… [couldn't talk about] Anything negative that I was feeling or the different, yeah, things [related to being a gay Latina female] that were happening in my head or in my life. (25-year-old, Latina gay female)

Types of disclosure

Participants described a variety of different ways in which disclosure occurred. A few described a disclosure occurring by accident or through involuntary discovery. For example, one participant described her involuntary discovery experience when makeup covering her wounds wore off in front of friends:

> I was hanging out with a group of friends . . . and I think the makeup I had on my arm wore off. We were in this store, and one of my friends grabbed my arm and said, "What is this?" My knee-jerk reaction was like, "Oh. I have a cat." Obviously, they knew I didn't have a cat, because I had just spent the past hour talking about how I wanted a cat. (23-year-old, Latina bisexual female)

Another participant described others seeing scars on her legs when her shorts rode up:

> Well, I usually hide them, so it'll be people I'm dating, or on the off chance that I go to the beach or something, or I'm wearing shorts and they ride up a little bit, and people might catch a glimpse. (22-year-old, White lesbian female)

[1] Demographic descriptions of participants were based on self-identification from each participant.

Some participants intentionally disclosed their NSSI to others directly via verbal communication. These verbal disclosures were most often made to friends (e.g., "I told a few friends, but not any of my family." [22-year-old, South Asian queer woman]). However, most participants disclosed by making their wounds or scars visible to others. As a 25-year-old, Filipino lesbian non-binary participant explained: "Most people don't see it [NSSI methods/wounds], but sometimes my partner will see." A 22-year-old, Chicano lesbian non-binary participant also shared how they showed the result of their NSSI to a close friend, "I hadn't let this person in on my harm until they had seen it for themselves when I was brandishing it…."

Still, in many instances, participants' intentions remained unclear. Some participants described not wanting others to see their wounds or scars, yet they found themselves in situations where others might see them, contributing to discovery. For example, a participant described concern about wearing clothing that might allow others to see her scars:

> Except for maybe when I have scars, though they're not super obvious, but if I'm walking around down the street and I'm nervous to wear a t-shirt, like in the beginning, or if I'm going to a new place, be like, oh, yeah, I'm nervous to wear a t-shirt. (15-year-old, White lesbian female)

Recipients of a disclosure

Only three participants mentioned disclosing NSSI to a mental health professional (one noted above). Although some participants, disclosed their self-injury to a parent (e.g., "Well, I showed my mom." [22-year-old, Black lesbian woman]), most disclosed to friends or partners. Participants shared the trust they felt in their friends' responses to NSSI that facilitated their disclosure to these important people in their lives. For example, a 25-year-old, Black Hispanic sapphic female explained the comfort she felt knowing her friends would understand the functions of/reasons for her self-injury and would not overreact or judge her:

> My friends had seen it, and I guess I felt a little more comfortable with them knowing what was going on, because they wouldn't judge me, and they would know okay, she's going through it. It's not because she wants to kill herself. It's just more because she's hurting.

In contrast, this same participant discussed concerns about disclosing NSSI to her parents, which were concerns other participants shared. Specifically, participants' reluctance to disclose their NSSI to their parents derived from anticipated negative emotional reactions from parents learning about their self-injury:

> I guess older people, like my parents' age and other generations, did think it was a suicide attempt. They were like oh, my god, you're trying to kill yourself, or you're in this super mentally unstable place, and we need to figure out why and what's going on, and we need to do an immediate intervention. (25-year-old, Black Hispanic sapphic female)

> Um, well, I try my best not to let others see it, but my-my mom accidentally saw it and then she got upset and just mad. (19-year-old White queer female)

In summary, participants who discussed reasons for NSSI disclosure shared desires to communicate their distress and obtain support from others. Those who talked about not disclosing their NSSI explained concerns related to cultural stigmas in their families regarding mental health issues and/or sexual minority identities. Most often, participants disclosed their NSSI by allowing others to see their wounds or scars. However, some participants verbally disclosed their self-injury or experienced an accidental or involuntary disclosure. Participants disclosed their NSSI to friends, partners, mental health providers, and parents, though most often disclosed to friends and partners. Some explained the trust they felt in anticipation of their friends' responses to disclosure, compared to their parents' anticipated responses. Results below regarding helpful and unhelpful responses to NSSI disclosure suggest participants might have good reason to anticipate more positive responses from friends and negative responses from parents.

Responses to a disclosure and associated feelings

Although some participants discussed why, how, and to whom they disclosed their NSSI (as detailed in the above), even more described how others responded to this disclosure based on our interview questions focused on others' responses. Participants shared varied, mixed, and often negative, responses from others and explained what they found helpful in response to disclosure. Findings regarding responses to and feelings after NSSI disclosure revealed two themes: i) *unhelpful or stigmatizing responses,* and ii) *helpful or destigmatizing responses*. Below we describe the various negative and positive responses participants experienced to disclosure.

Unhelpful or stigmatizing responses

Participants' descriptions of negative responses to NSSI disclosure suggested others most often felt three emotions when learning about participants' self-injury: i) fear, ii) anger, and/or iii) apathy. As these responses were typically rooted in NSSI stigma, participants perceived responses to NSSI disclosure based on these negative emotions as unhelpful and unsupportive, and they often led to negative feelings among our participants.

Fear

Some participants described others' responses to a disclosure of their NSSI as based on fear. Fearful responses to participants' injuring themselves felt like stigmatizing overreactions and caused participants to feel worse rather than better. For example, one participant described scaring her parents, which made her feel worse about herself, and explained that a more helpful response would come from a place of calmness and desire for understanding:

> I think it scared a lot of people, especially my parents. Um, so I think they wanted to help, and they wanted to make me feel better . . . I know it's supposed to be helpful, but then it just makes you feel, like, more bad about yourself because you're, like, oh my gosh, I'm scaring people. And then it happens more because now you're having these negative thoughts about who you are as a person. . . . The people that respond to it calmly and the people that don't make a huge deal out of it, I think are much better at helping me. (15-year-old, White bisexual non-binary person)

Fear-based responses sometimes led to controlling behavior, such as removing methods of self-injury, which participants often internalized into negative self-perceptions such as feelings of untrustworthiness. Further, such responses often perpetuated participants' engagement in self-injury.

> Generally, it's kind of like a, "You shouldn't do that." It's from a place of concern, but it's way more of they take away sharp objects. They [roommates/partners] almost have a controlling response…. I feel like I have the urge more, and I feel like I can't be trusted and that they don't trust me. (24-year-old, White bisexual woman)

> Then my dad, he could barely look at me 'cause he was so sad. It really, really scared my parents. They really care…they blamed my best friend for some reason even though my best friend had—didn't even know…. Then they took away my phone, so I was upset. I could tell they cared, and I just didn't like the way they handled it. (15-year-old Persian bisexual female)

However, some participants faced controlling behaviors without a fearful response from those to whom they disclosed. For example, one participant explained how a worried response did not feel pathologizing and, instead, motivated the participant to seek other coping mechanisms:

> It doesn't make me feel good…. 'Cause sometimes I've done it in front of my girlfriend, and I regret it. 'Cause I'm like, "Oh, I didn't want her to see me like that." It also worries her . . . . That's been a reason I've been really trying to prevent it from happening and take—do all the things that I need to calm myself down to prevent myself from doing that.... It's made her really sad and feel bad for me. She tries to get me to stop when I do it, physically pull my arms and hands and stuff, so I stop. (24-year-old, Black lesbian non-binary person)

Similarly, another participant described how, as an adolescent, they initially felt upset with their mother for her controlling response to their NSSI. However, upon reflection, the participant understood their mother's response:

> I was kind of annoyed at [mom] for taking [tools for NSSI] away, but, I mean, I think ultimately that was good for me. (18-year-old, White pansexual genderfluid person)

Other times, responses based on fear led to expressions of sympathy that felt pathologizing to participants. One participant explained how these expressions made her feel awkward around others, negatively impacting her relationships:

> [T]he only other people that have noticed it have been partners that I've been with. It's something where some people understand and then some people get so scared and they feel—I can feel their perception of me change and they suddenly feel sorry for me and feel scared and worried…. It feels like they're walking on eggshells around me. (21-year-old, White lesbian femme)

These fear-based responses also sometimes contributed to participants' concealment of their NSSI and associated distress:

> I think people are generally really worried about me when they find out. They're unsure what to do and they don't really get it, obviously. They also are thinking, just wanting me to stop and being like, do you think you're gonna do this forever, whatever…. I think my parents also do get really worried. (15-year-old, White lesbian female)

Anger

Several participants described others feeling angry in response to NSSI disclosure. Responses based on anger most often came from parents. Though stigmatizing responses of anger may originate from a place of fear, participants appeared to perceive these two responses differently. Still, participants' feelings associated with expressions of anger largely mirrored their negative feelings associated with responses of fear, particularly feeling uncomfortable and unsupported:

> My cousin, when she first found out, she had a really, really negative interaction. Was really mad at me for it. I think she just didn't know how to respond. (15-year-old, White lesbian female)

> When my mom found out, she was sad, but I also think she was angry, which wasn't helpful. She tried to force me to go see a therapist at the time. We went to the therapist's office. It was a man, and she goes in with me and tries to explain the situation to him. Instead of being like, "Oh. She's self-harming, and I'm concerned," She goes like, "Oh. Yes." She gestured with her hands like a slice…. I remember looking at her and then looking at the man who —I felt like he looked uncomfortable...my mom was uncomfortable…. It made me uncomfortable. (23-year-old, Latina bisexual woman)

Participants always perceived responses based on anger as unhelpful. Sometimes these responses perpetuated stigma and negative feelings between participants and the parents to whom they disclosed their NSSI. For example, a couple of participants described how their parents' expressions of anger evoked feelings of sadness, frustration, and anger within themselves:

> I think, my parents were really angry with me. They said I was being dramatic, and that it's insane that I'm doing that. That was the response I got from them, was a lot of frustration…. That definitely made me feel like first, really sad that they were not understanding me, and then also, just really angry that they would treat me like that, basically. (22-year-old, Indian lesbian woman)

> My mom would sometimes see the after effect. Um, she hated it…. She'd be really sad and angry, and I was kinda neutral to that feeling. I was happy that she finally noticed, like, how bad I'm feeling that I had to take it out on myself, but then I was unhappy by the way she reacted 'cause it was just, like—it didn't feel supportive. It just felt like, "Why would you do that?" (16-year-old, Latinx lesbian non-binary person)

Apathy

A few participants also shared experiences of receiving apathetic responses from others to the disclosure of their NSSI. Al-

though participants may have preferred such dismissive responses in contrast with overreactions based on fear and anger, these apathetic responses that minimized participants' NSSI served to reinforce the behavior as an acceptable coping strategy:

> I think she [my sister] didn't really care that much, because she thought that it wasn't that severe, I think, which is also true…. I think she thought it was funny that that's all I was doing [scratching]…. That made it feel a little bit of a lighter situation, like it's not that big a deal, 'cause I was getting concerned why I was doing this. I think that, I guess, reinforced the idea that it didn't really matter, which is also what made me feel like it's fine to keep doing this. (22-year-old, Indian lesbian woman)

> Then some of the kids my age or a little older would make, I guess, light about the situation. Not in the sense that they were making fun of me, but just oh, when my friends do that—one of my old friends said she slaps them where they cut themselves, to tell them not to do it again. (25-year-old, Black Hispanic sapphic female)

Helpful or destigmatizing responses

When others responded positively to participants' disclosure of NSSI, they most often demonstrated concern or emotional support and/or offered an alternative coping strategy. These helpful responses made participants feel seen, understood, and supported.

Concern

A few participants reported their NSSI disclosure was met with expressions of concern. These expressions of concern in response to disclosure appeared to differ from responses based on fear by originating from a conscious place of love and focus on the needs of participants. Participants perceived calm responses of genuine concern as loving and supportive, in contrast to fear-based responses that made participants feel bad, as described above. Expressions of concern also appeared to demonstrate a destigmatized understanding of participants' overwhelming negative emotions and their use of NSSI as a coping strategy. Such responses helped participants feel less isolated and more connected to caring people in their lives:

> [M]y friends who I did tell at the time, were very concerned about me. They were worried that my situation was, I guess, worse than they thought, with living there with my parents. (22-year-old, Indian lesbian female)

> If I was with people my age or at least a little bit older, a lot of the times they were super understanding about it, or they'd be like yeah, I cut myself, too; I know exactly what you're going through…. Definitely made me feel like I wasn't alone. I guess I appreciated the fact that they saw it for what it was, like more of a symbol of being hurt than wanting to end your life. (25-year-old Black Hispanic Sapphic female)

However, not all participants initially responded positively to others' expressions of concerns. For instance, one participant discussed how initially they were upset when a friend at school discovered their NSSI and pushed the participant to talk to a mental health professional:

> ...they were really worried and wanted me to actually go into the psych ward or just try to talk to someone about it and I ended up not doing that…. At the time, I was more panicked that...I would get in trouble for something like that. They wanted to talk to the guidance counselor at school and I was mad at them about it...but in hindsight, they were just really caring about me, so I feel bad about being mad about them. (24-year-old, Hispanic Black bisexual gender-nonconforming person)

Emotional support

Other participants described people responding to disclosure with emotional support. Almost all accounts of experiences of emotional support participants perceived as helpful or destigmatizing in response to NSSI disclosure described participants' friends or partners. Participants who received an emotionally supportive response to NSSI disclosure described feeling relieved and cared for following this interaction:

> When I told people who are close to me, they also were just very, I would say supportive and understanding and here for me…. It made me feel loved and supported. (22-year-old, Black lesbian female)

> The only person who has seen me do it is my partner. Um, she is very supportive and, like, is very good at not making me feel judged for it. Um, yeah, she does want me to keep working on redirecting it, um, and not, you know, not targeting myself…. (23-year-old, White gay non-binary person)

> [T]he last time that I self-harmed, I think my partner had seen it, the most recent time that I had self-harmed. She asked me, "What's going on? Do you wanna talk about it? Is there something I can do to support you, to help this not be the way that you cope with your emotions?" I appreciate that approach, and that level of support that I received from her. (28-year-old, Filipino-American lesbian female)

Offer of alternative coping strategies

Beyond showing emotional support, some participants described others responding to a disclosure by actively offering alternative coping strategies to engaging in NSSI when participants felt overwhelming distress. All these suggestions came from friends or partners, and most often the alternative coping strategies involved communicating with the friend or partner instead of self-injuring:

> [M]y best friend found out. She just was like asking if I was okay. She asked me to not do it anymore and just talk to her when I needed to. They just were very—they were trying to just be supportive about everything and be kind. (18-year-old White lesbian female)

> It's only a couple of my friends and they've very firmly told me to stop and have encouraged me to call them when there's a problem…. [I felt] Better and more relieved to know that I have some people who actually really care. (14-year-old White pansexual female)

Overall, participants received more unhelpful or stigmatizing responses, based on fear, anger, or apathy, to their disclosure

of NSSI than helpful or destigmatizing responses demonstrating concern, emotional support, and offers of alternative coping strategies. Most of the negative responses, especially anger, came from parents and made participants feel poorly about themselves and their relationships with the respondent. In contrast, positive responses more often came from friends and partners, and made participants feel loved and supported.

Discussion

This study adds valuable insights regarding sexual minority women's lived experiences around disclosure of NSSI and subsequent responses from others. While a majority of our participants had their self-injury accidentally discovered, many also disclosed their self-injury through actions that resulted in others seeing their wounds/scars, most often friends and partners, with hope of receiving support and validation for their distress. These findings are consistent with existing studies of NSSI disclosure within other populations (Simone & Hamza, 2020) and may suggest sexual minority women hold concerns about others taking their struggles seriously, making them similarly less willing to actively disclose. The motivation to voluntarily disclose NSSI to obtain support and understanding of one's distress, as expressed by our participants, is consistent with findings showing the primary interpersonal function of engaging in NSSI involves communicating distress to others (Muehlenkamp et al., 2013). However, the fact that many of our participants disclosed their NSSI through subtle behaviors, such as showing wounds/scars, suggests there remains strong stigma and shame surrounding NSSI that likely prevents active, verbal disclosure. Some participants also spoke about cultural stigmas toward sharing mental health struggles and their sexual minority identity as barriers to open disclosure, which may further hinder help-seeking and inadvertently increase NSSI (Crockett & Caviedes, 2022; McGraw et al., 2023; Rowe et al., 2014). These reports underscore the importance of reducing mental health, NSSI, and sexual minority related stigmas, so young sexual minority women feel comfortable disclosing their struggles and seeking help.

As anticipated, participants experienced a variety of responses from others to NSSI disclosure/discovery. These responses largely reflected a dichotomy of being either stigmatizing and hurtful or destigmatizing and helpful (with more participants experiencing hurtful responses) and further impacted the well-being of participants and their future willingness to disclose their self-injury. Themes identified in the current analysis with young sexual minority women are consistent with the limited research on lived experiences of NSSI disclosure among college students (Rosenrot & Lewis, 2020; Simone et al., 2023) and underscore the importance of others' responses to NSSI disclosure in facilitating and/or hindering further support seeking (Park et al., 2021). Of note, while our sample was uniquely comprised of young sexual minority women, participants' experiences of both stigmatizing and destigmatizing disclosure reactions align with those reported by heterosexual youth (Park et al., 2021). This continuity across sexual identity suggests experiences with NSSI disclosure may share some universal features practitioners can integrate into proactive educational awareness programming designed to support young people engaging in NSSI.

One salient finding involved the preponderance of negative and unhelpful responses to disclosure of NSSI. Negative responses characterized by anger and fear mostly came from parents, whereas negative peer/sibling responses were largely characterized as apathetic. Interestingly, participants perceived most of the unhelpful reactions as coming from a place of concern, but grounded in a profound lack of understanding or compassion, which generally resulted in a negative impact on participants. These findings are supported by prior qualitative research with parents who reported significant fears about and struggles to understand NSSI, along with uncertainty regarding how to respond to disclosure (Oldershaw et al., 2008). Reactions of anger and fear frequently resulted in our participants feeling worse due to internalizing negative self-perceptions, guilt, and undermining their resilience. Furthermore, participants experienced over-reactive, controlling responses as punitive and disempowering. Consistent with previous research on mental health effects of negative responses to NSSI disclosure (Park & Ammerman, 2020), subsequent negative feelings to these responses reinforced our participants' hesitancy to further disclose NSSI and led some to increased self-injury to cope with their exacerbated distress. Similarly, participants interpreted apathetic responses as endorsing NSSI, which, for some, reinforced continued self-injury. Together, the experiences of negative responses often increased participants' distress, strained relationships, and resulted in further concealment of NSSI, essentially undermining attempts at activating support. Although little prior research has examined the association of negative responses to NSSI disclosure on subsequent mental health, research with sexual minority youth consistently shows rejection and negative reactions by parents and others to disclosure of sexual identity is linked to long-lasting adverse health outcomes (Rosario et al., 2009; Ryan et al., 2015).

Although negative disclosure responses were more commonly described by our participants, many also reported receiving positive responses. Positive responses were characterized by experiences of validation, efforts to understand NSSI as a coping strategy, and suggestions of alternative coping strategies. Participants especially highlighted calm responses as more effective at conveying concern in a supportive fashion, compared to the punitive experiences reflected in fearful/angry responses. These findings are consistent with a recent qualitative study of NSSI recovery, where participants described calm and understanding responses by parents and professionals as most helpful in their recovery process (Kelada et al., 2018). Collectively, destigmatizing or helpful responses appeared to enhance participants' feelings of being loved and valued, essentially strengthening their sense of connection to others. Greater social connectedness is associated with decreased risk of NSSI among adolescents (Taliaferro et al., 2020), including among sexual and gender minority youth (Taliaferro et al., 2018; Taliaferro & Muehlenkamp, 2017). Further, researchers have found individuals are motivated to cease NSSI, and feel better able to do so, when they feel connected to others (Whitlock et al., 2015). Qualitative studies of self-injury recovery also highlight the importance of having supportive relationships with others that promote healthy, alternative coping strategies over NSSI (Kelada et al., 2018; Whitlock et al., 2015). Thus, experiencing a helpful or destigmatizing disclosure reaction reflecting concern and emotional support may help to promote recovery on its own, along with positively reinforcing help-seeking.

Clinical implications

The current findings underscore the importance of ensuring individuals who disclose their self-injury receive supportive and helpful responses. Educational and awareness raising interven-

tion efforts should target parents and guardians, especially, given our participants described them as most likely to respond unhelpfully to NSSI disclosure. Providing psychoeducation and resources on NSSI, including effective disclosure response tips, to parents and guardians as part of school programming or at doctor visits may help reduce the occurrence of negative responses to disclosure (Arbuthnott & Lewis, 2015; Whitlock & Lloyd-Richardson, 2019). School programs and health curricula teaching about NSSI also may benefit from emphasizing the serious nature of self-injury, alongside a need for concern and understanding to combat the apathetic responses described by our participants.

Furthermore, clinicians may also benefit from training regarding NSSI as an effort to increase their comfort and ability to respond compassionately to disclosures of self-injury (Taliaferro et al., 2013; Taliaferro et al., 2023), given many who self-injure report negative experiences with clinicians (Muehlenkamp et al., 2012), which was also reflected in a few of our participants' experiences. Studies show that individuals with NSSI who perceived their therapist as having a supportive response and focus on understanding the NSSI prior to stopping the behavior were more likely to stay in therapy and eventually stop self-injuring (Kelada et al., 2018). Conversely, those who experienced negative therapist responses, including perceived discomfort with the topic, were less likely to remain in therapy or cease NSSI (Kelada et al., 2018; Lewis et al., 2019). Unfortunately, many therapists and other healthcare professionals report feeling unprepared to treat or manage NSSI (Taliaferro et al., 2013; Taliaferro et al., 2023), which may lead to less helpful responses to a disclosure. Providing training on self-injury in graduate/medical school and through continuing education programs that emphasize managing one's own biases and reactions toward NSSI, along with knowledge about self-injury and best-practice interventions, represents one way to improve care (König et al., 2021; Taliaferro et al., 2023).

This latter issue becomes complicated by research indicating sexual and gender minority youth are less likely than their heterosexual and cisgender counterparts to disclose NSSI to therapists (Burke et al., 2021). Indeed, only three participants in our study reported disclosing to a therapist. Since we did not specifically ask participants to whom they intentionally disclosed NSSI, we could not definitively conclude that participants felt reluctant to disclose their NSSI to therapists/health professionals. However, the fact that only three participants mentioned sharing their NSSI with a therapist may reflect some hesitancy to disclose, which is consistent with prior work suggesting concerns about therapists' reactions may dampen trust (Burke et al., 2021). Fear stands out as an important barrier to disclosure, and this may be especially relevant in therapeutic situations where young people may fear therapists or other healthcare professionals will disclose private information to parents or initiate unfavorable outcomes (e.g., hospitalization; Burke et al., 2021). Alternatively, these young people may fear disclosure to a therapist/healthcare professional could result in a therapeutic rupture in one of their few "safe" spaces. Healthcare professionals are often best qualified to offer positive support and alternative coping strategies (two identified themes) that could help reduce NSSI (Smithee et al., 2019). Therefore, therapists and other healthcare professionals (e.g., primary care clinicians) should remain cognizant that NSSI is highly prevalent among sexual minority youth and disclosure is low. Thus, mental health and medical education training programs should ensure clinicians have the capacity to elicit, assess, and manage NSSI among young people (Taliaferro et al., 2023).

Limitations

Although our findings bring critical insights into the NSSI disclosure experiences and responses of an ethnically diverse sample of young sexual minority women, some limitations of this research exist. First, although drawn from a large national U.S. sample, the subset of women who participated in the qualitative interviews may not be representative of the entire U.S. population of young sexual minority women. Further, interview participants were not selected for their engagement in NSSI. Therefore, not all participants were able to discuss NSSI disclosure experiences. Nevertheless, 89% of participants interviewed did report engaging in NSSI. Likewise, because NSSI disclosure was not the focus of the larger study, the interviewers asked only a small number of questions about NSSI, which were not as in-depth as if NSSI represented our study focus. Thus, the data on NSSI disclosure and responses were largely based on comments shared *spontaneously* by our participants. However, data shared without in-depth questioning suggests the topic of NSSI disclosure and responses to disclosure were important to our participants and highly relevant to their lived experiences of NSSI. Although participants' descriptions of the responses they experienced in response to NSSI disclosure made clear they experience more stigmatizing than destigmatizing responses and more stigmatizing responses from parents than friends, the qualitative nature of these data do not allow us to test these differences statistically, which would be important to explore in future quantitative studies of NSSI disclosure. Finally, we did not have a sufficient sample size to perform intersectional analyses because we did not quota sample to ensure sufficient numbers of participants in different intersectional subgroups (e.g., sexual identity x race/ethnicity) for inter-category group comparisons. We also did not directly ask about intersectionality (e.g., experiences of racism and heterosexism as a Black sexual minority woman) in the context of NSSI disclosures, and these experiences were rarely shared spontaneously. Future research would benefit from greater intersectional examination, both qualitatively and quantitatively, of diverse sexual minority women's lived experiences of NSSI and reactions received in response to disclosure, as well as subsequent long-term effects of reactions related to experiences of holding different intersectional positions.

Conclusions

Sexual minority women experienced mostly stigmatizing/unhelpful, with some destigmatizing/helpful, responses to NSSI disclosure, which impacted their perceptions of themselves and their emotional state congruent to the experience (e.g., negative reactions resulted in worsened emotions and negative self-perceptions). Their disclosure experiences are consistent with reports in other populations, highlighting the need to further reduce stigma about NSSI, as well as sexual minority identities, and provide universal education that can promote helpful responses to disclosures of self-injury.

References

Alexander, N., & Clare, L. (2004). You still feel different: The experience and meaning of women's self-injury in the context of a lesbian or bisexual identity. *Journal of Community & Applied Social Psychology, 14*, 70-84.

Arbuthnott, A., & Lewis, S. (2015). Parents of youth who self-injure: A review of the literature and implications for mental health professionals. *Child and Adolescent Psychiatry and Mental Health, 9*, 35.

Batejan, K., Jarvi, S., & Swenson, L. (2015). Sexual orientation and non-suicidal self-injury: A meta-analytic review. *Archives of Suicide Research, 19*(2), 131-150.

Bouris, A., Ramos-Guilamo, V., Pickard, A., Shiu, C., Loosier, P., Dittus, P., . . . Waldmiller, J. (2010). A systematic review of parental influences on the health and well-being of lesbian, gay, and bisexual youth: Time for a new public health research and practice agenda. *Journal of Primary Prevention, 31*(5-6), 273-309.

Boyatzis, R. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Burke, T., Bettis, A., Barnicle, S., Wang, S., & Fox, K. (2021). Disclosure of self-injurious thoughts and behaviors across sexual and gender identities. *Pediatrics, 148*(4), e2021050255.

Burke, T., Piccirillo, M., Moore-Berg, S., Alloy, L., & Heimberg, R. (2019). The stigmatization of nonsuicidal self-injury. *Journal of Clincal Psychology, 75*, 481-498.

Creswell, J., & Creswell, J. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage.

Creswell, J., & Poth, C. (2024). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: Sage.

Crockett, M., Martinez, V., & Caviedes, P. (2022). Barriers and facilitators to mental health help-seeking and experiences with service use among LGBT+ university students in Chile. *International Journal of Research and Public Health, 19*(24), 16520.

Cwinn, E., Cadieux, C., & Crooks, C. (2021). Who are we missing? The impact of requiring parental or guardian consent on research with lesbian, gay, bisexual, trans, two-spirit, queer/questioning youth. *Journal of Adolescent Health, 68*(6), 1204-1206.

DiStefano, A. (2008). Suicidality and self-harm among sexual minorities in Japan. *Qualitative Health Research, 18*(10), 1429-1441.

Dunlop, B., Harltey, S., Oladokun, O., & Taylor, P. (2020). Bisexuality and non-suicidal self-injury (NSSI): A narrative synthesis of associated variables and a meta-analysis of risk. *Journal of Affective Disorders, 276*, 1159-1172.

Elliott, R., & Timulak, L. (2005). Descriptive and interpretive approaches to qualitative research. In J. Miles and. P. Gilbert (Eds.), *A handbook of research methods for clinical and health psychology* (pp.147-160). Oxford, UK: Oxford University Press.

Elliott, R., & Timulak, L. (2021). *Essentials of descriptive-interpretive qualitative research: A generic approach*. Washington, D.C.: American Psychological Association.

Guo, J., Ying, J., Zhou, X., Wang, C., Lin, N., & You, J. (2023). Double hurt: The impact of interpersonal-level stigma on nonsuicidal self-injury among lesbian, gay, and bisexual individuals. *Current Psychology, 42*, 21007–21020.

Hasking, P., Rees, C., Martin, G., & Quigley, J. (2015). What happens when you tell someone you self-injure? The effects of disclosing NSSI to adults and peers. *BMC Public Health, 15*, 1039.

Hom, M., Podlogar, M., Stanley, I., & Joiner, T. (2017). Ethical issues and practice challenges in suicide research: collaboration with institutional review boards. *Crisis, 38*, 107-114.

Jackman, K., Edgar, B., Ling, A., Honig, J., & Bockting, W. (2018). Experiences of transmasculine spectrum people who report nonsuicidal self-injury: A qualitative investigation. *Journal of Counseling Psychology, 65*, 586-597.

Jackman, K., Honig, J., & Bockting, W. (2016). Nonsuicidal self-injury among lesbian, gay, bisexual and transgender populations: An integrative review. *Journal of Clinical Nursing, 25*, 3438-3453.

Kelada, L., Hasking, P., Melvin, G., Whitlock, J., & Baetens, I. (2018). "I do want to stop, at least I think I do": An international comparison of recovery from nonsuicidal self-injury among young people. *Journal of Adolescent Research, 33*(4), 416-441.

König, E., Hoffmann, U., Plener, P., & Fegert, J. (2021). Innovative professional training approaches on the German national clinical guideline for NSSI in adolescents. *European Psychiatry, 64*(S1), S229-S230.

Liu, R. (2019). Temporal trends in the prevalence of nonsuicidal self-injury among sexual minority and heterosexual youth from 2005 through 2017. *JAMA Pediatrics, 173*(8), 790-791.

McGraw, J., Oakey-Frost, D., Lefevor, G., Cocherty, M., & Tucker, R. (2023). Exploring mental health and help-seeking attitudes among sexual minoritized adults in Utah. *Psychology of Sexual Orientation and Gender Diversity*. https://doi.org/10.1037/sgd0000625.

Mirichlis, S., Boyes, M., Hasking, P., & Lewis, S. (2022). What is important to the decision to disclose nonsuicidal self-injury in formal and social contexts? *Journal of Clinical Psychology, 79*, 1816-1825.

Muehlenkamp, J., Brausch, A., Quigley, K., & Whitlock, J. (2013). Interpersonal features and functions of nonsuicidal self-injury. *Suicide and Life-Threatening Behavior, 43*, 67-80.

Muehlenkamp, J., Claes, L., Havertape, L., & Plener, P. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(10), 1-9.

Mustanski, B. (2011). Ethical and regulatory issues with conducting sexuality research with LGBT adolescents: A call to action for a scientifically informed approach. *Archives of Sexual Behavior, 40*, 673-686.

Newcomb, M., Clifford, A., Greene, G., & Mustanski, B. (2016). Parent perspectives about sexual minority adolescent participation in research and requirements of parental permission. *Journal of Adolescent Health, 59*, 443-449.

Newcomb, M., LaSala, M., Bouris, A., Mustanski, B., Prado, G., Schrager, S., & Huebner, D. (2019). The influence of families on LGBTQ youth health: A call to action for innovation in research and intervention development. *LGBT Health, 6*(4), 139-145.

Nock, M., Kleiman, E., Abraham, M., Bentley, K., Brent, D., Cha, C., . . . Pearson, J. (2021). Consensus statement on ethical & safety practices for conducting digital monitoring studies with people at risk of suicidal and related behaviors. *Psychiatric Research & Clinical Practice, 3*, 57-66.

Oldershaw, A., Richards, C., Simic, M., & Schmidt, U. (2008). Parents' perspectives on adolescent self-harm: Qualitative study. *The British Journal of Psychiatry, 193*(2), 140-144.

Park, Y., & Ammerman, B. (2020). How should we respond to non-suicidal self-injury disclosures?: an examination of per-

ceived reactions to disclsoure, depression, and suicide risk. *Psychiatry Research, 293*, 113430.

Park, Y., Mahdy, J., & Ammerman, B. (2021). How others respond to non-suicidal self-injury disclosure: A systematic review. *Journal of Community & Applied Social Psychology, 31*, 107-119.

Rogers, M., & Taliaferro, L. (2020). Self-injurious thoughts and behaviors among sexual and gender minority youth: A systematic review of recent research. *Current Sexual Health Reports, 12*, 335-350.

Rosario, M., Schrimshaw E., & Hunter, J. (2009). Disclosure of sexual orientation and subsequent substance use and abuse among lesbian, gay, and bisexual youths: Critical role of disclosure reactions. *Psychology of Addictive Behaviors, 23*, 175-184.

Rosenrot, S., & Lewis, S. (2020). Barriers and responses to the disclosure of non-suicidal self-injury: A thematic analysis. *Counselling Psychology Quarterly, 33*(2), 121-141.

Rowe, S., French, R., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adolescent self-harm: A systematic review. *Australian and New Zealand Journal of Psychiatry, 48*(12), 1083-1095.

Ryan, W., Legate, N., & Weinstein, N. (2015). Coming out as lesbian, gay, or bisexual: The lasting impact of intitial disclosure experiences. *Self and Identity, 14*, 549-569.

Schatten, H., Gaudiano, B., Primack, J., Arias, S., Armey, M., Miller, I., . . . Weinstock, L. (2020). Monitoring, assessing, and responding to suicide risk in clinical research. *Journal of Abnormal Psychology, 129*, 64-69.

Schrager, S., Steiner, R., Bouris, A., Macapagal, K., & Brown, C. (2019). Methodological considerations for advancing research on the health and wellbeing of sexual and gender minority youth. *LGBT Health, 6*(4), 156-165.

Scourfield, J., Roen, K., & McDermott, L. (2008). Lesbian, gay, bisexual and transgender young people's experiences of distress: Resilience, ambivalence and self-destructive behaviour. *Health and Social Care in the Community, 16*(3), 329-336.

Simone, A., & Hamza, C. (2020). Examining the disclosure of nonsuicidal self-injury to informal and formal sources: A review of the literature. *Clinical Psychology Review, 82*, 101907. https://doi.org/10.1016/j.cpr.2020.101907.

Simone, A., Yu, S., & Hamza, C. (2023). Understanding experiences of disclosing and receiving disclosures of nonsuicidal self-injury amongst peers in university: A qualitative investigation. *Counselling Psychology Quarterly, 36*(4), 615-637.

Smith, A., & Schwartz, S. (2019). Waivers of parental consent for sexual minority youth. *Accountability in Research: Policies and Quality Assurance, 26*(6), 379-390.

Smithee, L., Summer, B., & Bean, R. (2019). Non-suicidal self-injury among sexual minority youth: An etiological and treatment overview. *Children and Youth Services Review, 96*, 212-219.

Taliaferro, L., McMorris, B., & Eisenberg, M. (2018). Connections that moderate risk of non-suicidal self-injury among transgender and gender non-conforming youth. *Psychiatry Research, 268*, 65-67.

Taliaferro, L., & Muehlenkamp, J. (2017). Nonsuicidal self-injury and suicidality among sexual minority youth: Risk factors and protective connectedness factors. *Academic Pediatrics, 17*, 715-722.

Taliaferro, L., Muehlenkamp, J., Hetler, J., Edwall, G., Wright, C., Edwards, A., & Borowsky, I. (2013). Nonsuicidal self-injury among adolescents: A training priority for primary care providers. *Suicide and Life-Threatening Behavior, 43*(3), 250-261.

Taliaferro, L., Westers, N., Matsumiya, B., Ingraham, K., Muehlenkamp, J., & Hughes, C. (2023). Improving capacity to identify, assess, and manage adolescents engaging in nonsuicidal self-injury using patient avatars. *Medical Teacher, 45*, 1283-1289.

Taliaferro, L., Jang S. T., Westers, N., Muehlenkamp, J., Whitlock, J., & McMorris, B. (2020). Associations between connections to parents and friends and non-suicidal self-injury among adolescents: The mediating role of developmental assets. *Clinical Child Psychology and Psychiatry, 25*(2), 359-371.

Tsypes, A., Lane, R., Paul, E., & Whitlock, J. (2016). Non-suicidal self-injury and suicidal thoughts and behaviors in heterosexual and sexual minority young adults. *Comprehensive Psychiatry, 65*, 32-43.

Whitlock, J., & Lloyd-Richardson, E. (2019). *Healing Self-Injury: A Compassionate Guide for Parents and Loved Ones*. New York, NY: Oxford University Press.

Whitlock, J., Prussien, K., & Pietrusza, C. (2015). Predictors of self-injury cessation and subsequent psychological growth: Results of a probability sample survey of students in eight universities and colleges. *Child and Adolescent Psychiatry and Mental Health, 9*, 19. https://doi.org/10.1186/s13034-015-0048-5.

Zaki, L., Gross, M., & Pachankis, J. (2017). Help-seeking for nonsuicidal self-injury in sexual minority adolescent and young adult females. *Journal of Gay & Lesbian Mental Health, 21*(2), 171-187.