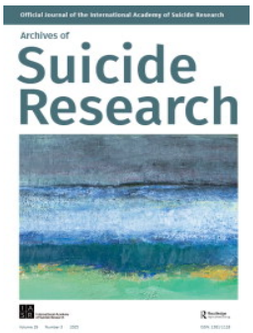

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Barriers to Youth Disclosing Self-Injurious Thoughts and Behaviors: A Focus on the Therapeutic Context

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ABSTRACT

Objective: Disclosure of self-injurious thoughts and behaviors (SITBs) can serve as a catalyst to receiving mental health and lifesaving care; yet, many young people do not disclose these experiences to their therapists. In this study we aimed to identify barriers to adolescents disclosing their SITBs to their therapists and to compare these barriers across non-disclosure of suicidal ideation, suicidal behavior, and non-suicidal self-injury.

Method: Participants ($n = 292$) all had lived experience of at least one SITB and were an average age of 15.55 years, with the majority identifying as cisgender girls (68.15%). Using inductive content analysis of open-ended responses, six main categories of disclosure barriers were identified.

Results: These overarching barriers were: Agency Theft, Irrelevance, Therapeutic (Mis)Alliance, Internalized Stigma, Anticipated Stigma, and Lacking Disclosure Self-Efficacy. The majority (85.29%) of subordinate barriers were common across the three SITBs.

Conclusions: Adolescents may hesitate to disclose their SITBs to their therapists for many reasons; prioritizing the therapeutic relationship and working collaboratively with adolescents could be instrumental in not only fostering disclosure but also an overall more positive therapeutic experience.

KEYWORDS
Disclosure; disclosure barriers; self-injury; SITB; suicidal

Self-injurious thoughts and behaviors (SITBs) include times when someone thinks about, has urges to, and/or intentionally hurts themselves regardless of intent to die (Society of Clinical Child and Adolescent Psychology, 2021). Both suicidal and non-suicidal SITBs are relatively prevalent amongst adolescent populations with 17.2% of adolescents reporting a lifetime history of non-suicidal self-injury (NSSI), coinciding with the peak onset of the behavior between the ages of 12 and 16 (Plener et al., 2015; Swannell et al., 2014). In the most recent Youth Risk Behavior Survey from the United States of America (Centers for Disease Control and Prevention, 2023), 22% of high school students had "seriously considered attempting suicide" within the past 12 months, with 18% having made a plan to do so, and 10% having attempted suicide at least once in this time. Amongst adolescents, both non-suicidal and suicidal self-injury are associated with negative academic outcomes (e.g., poorer school performance) and difficulties with mental health and interpersonal relationships, such as experiencing mood disorders and family conflict (Baetens et al., 2021; Brown & Plener, 2017; Castellví et al., 2017; Van Meter et al., 2019). Previous SITBs are associated with a

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

higher likelihood of future suicidal behaviors among adolescents (Castellví et al., 2017). Unfortunately, many young people do not disclose their SITBs, presenting a barrier to help-seeking and gaining support (McGillivray et al, 2022; Simone & Hamza, 2020).

When adolescents do disclose their SITBs, this tends to be in informal contexts, such as to friends, whilst such disclosures may sometimes catalyze future disclosures to a professional, this is not always the case (Lucena et al., 2022; McGillivray et al, 2022; Simone & Hamza, 2020). Disclosure of SITBs to therapists can cultivate a context for supports to be explored, hence the growing body of work investigating barriers to SITB disclosure more generally (e.g., Simone & Hamza, 2020; Mirichlis et al., 2023). For example, Simone and Hamza (2020) highlighted shame, anticipation of emotional and/or stigmatizing responses, concern for their confidante, and protection of the individual's own autonomy as potential barriers to disclosing NSSI among adults. Furthermore, McGillivray et al. (2022) identified barriers largely related to concerns of confidentiality breaches, suicide ideation not being perceived as serious, and anticipated negative or stigmatizing reactions from the clinician when exploring nondisclosure of suicidal ideation. Similarly, in another study examining barriers to adolescent SITB disclosure with therapists, adolescents with a SITB history reported concerns of parents being informed, fear of hospitalization, wanting to avoid burdening parents, shame, and anticipating that the therapist would assume current suicidality (Fox et al., 2022). Similar barriers were reported amongst individuals who, after not reporting ideation in a healthcare setting, engaged in suicidal behavior (Richards et al., 2019). Whilst Burke et al. (2021) and Fox et al. (2022) have provided key insights into adolescents' experiences of disclosing SITBs from the same broader dataset, little is known about how these barriers to disclosure compare across subtypes of SITBs, particularly concerning adolescents with a history of SITB who deny disclosure to therapists. As such, in this study we aimed to identify barriers to youth disclosing specific SITBs to their therapists.

MATERIALS AND METHODS

Procedures

The data used in this study were collected as part of a larger, existing study which received ethical approval from the Institutional Review Board at the University [Harvard University and University of Denver] and had a waiver of parental consent (see Fox et al., 2022 for full study methods details). Participants were recruited using Instagram advertisements targeting adolescents which linked participants to a brief Qualtrics screening survey. Adolescents who reported that they were between 13 and 17 years old, fluent in English, living in the US, had a lifetime history of any SITB engagement and mental health treatment were deemed eligible to participate. These individuals provided informed assent, completed a brief consent-related comprehension assessment, and continued on to the full survey. Participants were provided with mental health resources and helplines once they completed the survey, and they were entered into a lottery for gift cards valued at $25USD. Of the broader sample, the present study included only those who had *not* disclosed at least one SITB to their therapist and who had described why they had not disclosed in an open-ended question.

Participants

The sample consisted of 292 participants, aged 13 to 17 years (*M*age= 15.55 years, *SD* = 1.20) with a lifetime history of at least one SITB. Most participants were cisgender girls ($n = 199$), though 27.1% of the sample identified as transgender or gender diverse. Most participants identified as White (71.9%), a further 17.1% identified as Hispanic/Latinx, 9.2% identified as Asian, 7.2% identified as Black/African American, 4.5% identified as Native American, and 1% identified as Native Hawaiin and/or Pacific Islander. The average subjective rating of social status was 5.79 out of a possible 10 being the highest relative to other people in the USA ($SD = 1.62$). All participants were required to report at least one SITB: NSSI ($n = 262$), suicidal ideation ($n = 282$), or suicide attempt ($n = 108$), though many had experienced two (50.0%) or all three (37.7%) of these. Previous engagement with a mental health therapist of some kind was also necessary for inclusion in this study.

Measures

Demographics

Participants answered several demographic questions about age, gender, race, socioeconomic status, and history of mental healthcare. Participants were asked to select all racial identities that applied to them from a list of Native American, Asian, Black/African American, Native Hawaiin/Pacific Islander, White/Caucasian, and other. Participants could also indicate whether they identified as Hispanic/Latinx. Socioeconomic status was measured using the MacArthur Scale of Subjective Social Status (Adler et al., 2000), wherein participants are presented with a 10-rung ladder and asked to indicate on which rung they would place themselves with the highest rung being indicative of the most well-off people in their community (e.g., in the United States of America). In this study, the descriptor of "therapist" referred to: "the primary people you worked with in those treatment settings [mental health treatment], including other mental health providers (e.g., psychiatrists, nurses, counselors)."

SITB Experiences

A revised version of the Self-Injurious Thoughts and Behavior Interview (SITBI-R; self-report version) was used to identify whether participants had a lifetime history of NSSI, suicidal ideation, or suicide attempt (Fox et al., 2020). The SITBI-R has demonstrated strong reliability and validity in assessing these experiences in person via interview and online via self-report (Fox et al., 2020).

Disclosure History

For each endorsed SITB, participants were asked, "Have you ever told anyone about times where you … purposely hurt yourself without wanting to die/had thoughts of killing yourself/tried to kill yourself?" Participants indicated how often they had disclosed to therapists on a scale from 0 (never disclosed) to 4 (disclosed everytime they experienced that SITB).

Barriers to Disclosure

Participants who had not disclosed a particular SITB to their therapist were asked to: "Please describe WHY you did not share that information with your therapist" in an open-ended format.

Analysis

Initial Coding

Open-ended responses from the survey were collated and coded, with 255 participants reporting barriers to disclosing NSSI, 284 reporting barriers to disclosing suicidal ideation, and 108 reporting barriers to disclosing suicide attempt. We conducted inductive content analysis (Elo & Kyngäs, 2008; Erlingsson & Brysiewicz, 2017; Hsieh & Shannon 2005) to identify barriers to SITB disclosure. This involved generation of a codebook to facilitate the preparation and coding of open-ended responses whereby phrases formed the units of analysis. Participant responses were actively read multiple times for familiarization. Once the codebook was finalized, the primary coder completed three rounds of open-coding (i.e., one for each SITB) and frequencies were tallied for each code.

Secondary Coding

Data were split into three subsets (i.e., disclosure barriers for suicidal ideation, suicide attempts, NSSI). The coding of the suicidal ideation responses was first cross-checked by a secondary coder to determine the reliability of the first author's method of coding. The secondary coder was trained to check the first author's coding for the entire suicidal ideation subset, to ensure consistency. Discrepancies in coding between the first and secondary coder were discussed. Once this precedent had been established, O'Connor and Joffe's (2020) guidelines were followed such that, 10% of the suicide attempt and 10% of the NSSI responses were selected at random to be cross-coded (a total of 35 cases). Using the *irrCAC package* for R (Gwet, 2019), Gwet's first-order agreement coefficient (AC_1) was calculated as an indicator of intercoder reliability (Gwet, 2008). Very good intercoder reliability, as indicated by the AC_1 $(.92 - 1)$ was achieved (Gwet, 2014).

Organization

Throughout the coding process, similar codes were noted with further collating occurring once the initial codes were agreed upon in the inter-coder process. Diagraming facilitated this organization of codes into categories and sub-categories until a Categorical Map was finalized (see Figure 1).

RESULTS

Identify Barriers to Youth Disclosing SITBs to Their Therapists

Barriers did not appear to be unique to specific SITB types; instead, 85.29% of codes were reported as a disclosure barrier across all three SITBs. The frequency of each disclosure barrier per experience is presented in Table 1. Five overarching barriers to youth

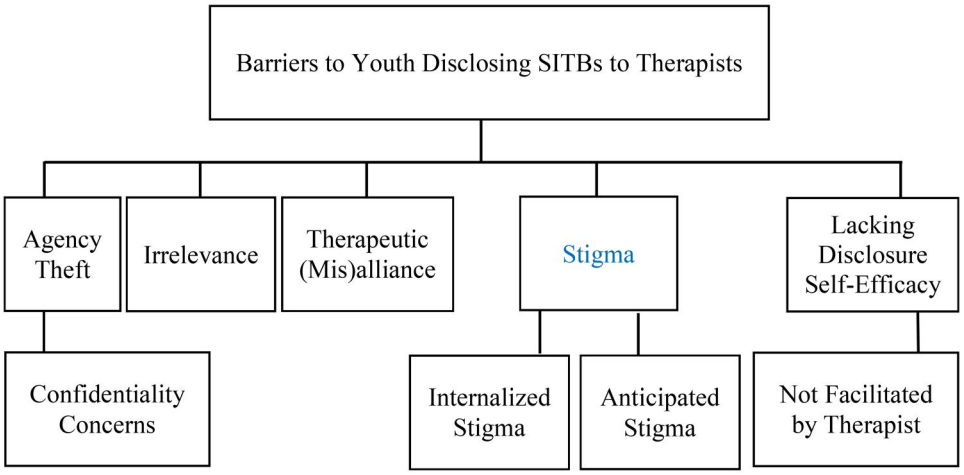

FIGURE 1. Barriers to youth disclosing SITBs to mental health providers.
Note. The above figure shows the five categories derived from the content analysis, the middle row of boxes reflects the overarching barriers to disclosure, with the bottom boxes reflecting sub-categories.

disclosing SITBs to their therapists were identified (see Figure 1 and Table 1). The most reported category of disclosure barriers was "Agency Theft," reflecting participants' concerns for their agency and autonomy potentially being compromised, particularly regarding unsolicited interventions and breaches to their confidentiality. The next category was that of "Irrelevance" with participants indicating that disclosing their SITBs would not be relevant to their therapeutic experience and/or expecting that there would be more helpful alternatives than disclosing to a therapist. Stigma was highlighted as another key barrier to disclosure, captured in the sub-categories of "Internalised Stigma" and "Anticipated Stigma." Participants also shared aspects of their relationship with their therapist which deterred them from disclosing their SITBs to them, as captured in the "Therapeutic (Mis)alliance" category. Finally, the barriers captured in the category "Lacking Disclosure Self-Efficacy" ranged from individuals not knowing how to go about disclosing their SITBs to the prospect of disclosure being too overwhelming, particularly when not facilitated by the therapist. More detail about each identified barrier is provided below.

Agency Theft

Many participants expressed concerns that disclosure of their SITBs could create opportunities for their own agency to become compromised. Whilst for some this reflected exercising their agency in not wanting to disclose their SITB to their therapist, more often this reflected predictions that if they were to disclose their SITBs, it would lead to further actions irrespective of their wishes. Participants highlighted the possibility of being pressured or forced into hospitalization, being medicated, and/or being removed from their household, for example by government services. Some participants directly stated that such interventions were something that they "didn't want," whilst others shared negative perceptions or past experiences which they wanted to avoid, with one

TABLE 1. Barriers to disclosing SITBs.

		Count for SITB *n*(% for code)			
Categories *n*(%)	Codes	SI	SA	NSSI	Examples
Agency Theft 472 (40.41)	Fear of Hospitalization/ Further Referral	63(51.64)	30(24.59)	29(23.77)	"scared they were going to put me in a mental hospital, and from how my peers described it, it is a hellhole" "i [sic] didn't want to be forced to … go to more therapy"
	Not wanting to disclose	9(37.50)	8(33.33)	7(29.17)	"I had no intent on sharing that information with them."
	Fear of being medicated	12(63.16)	2(10.53)	5(26.32)	"I was scared of being put on meds after hearing about the symptoms that may occur"
	Expected to stop SITB	4(25.00)	2(12.5)	10(62.50)	"I didn't want her to try and stop me. I liked that I could control the pain. I didn't want her to take that from me."
	Not wanting to be forcibly removed	4(80.00)	1(20.00)	0 (0.00)	"fear of cps [Child Protective Services] taking me away."
Sub-Category: Confidentiality Concerns	Expecting breach of confidentiality/Not wanting parent/ guardian to know	151(54.71)	44(15.94)	81(29.35)	"she told me at the beginning of our sessions that she would have to notify my parents if I was suicidal. I don't want my parents to find out, so I haven't told her." "My mother was in the room and I don't trust her with anything because she … would tell everyone and it's not their business."
	Previous confidentiality breach by a therapist	6(85.71)	0(0.00)	1(14.29)	"had a bad experience with a therapist in the past where she recorded our discussion without my knowledge and played it for my parents."
	Information was too personal	0(0.00)	1(33.3)	2(66.67)	"It was something very personal. That only I should know."
Irrelevance 227(19.43)	SITB was not relevant to therapy goals	44(45.36)	14(14.43)	39(40.21)	"I wasn't in therapy when I was self-harming. It feels irrelevant to bring it up years after the fact." "I was doing good at the time, didnt seem relevant to talk about something I wasn't struggling with" "that wasn't what I was in therapy for"
	Perceived lack of seriousness	31(43.66)	8(11.27)	32(45.07)	"I didn't think my thoughts were serious enough to share because I thought- Everyone wants to die sometimes I don't need to tell her." "It wasn't a major problem so I didn't see the point [in disclosing]."

(*continued*)

TABLE 1. Continued.

Categories *n*(%)	Codes	Count for SITB *n*(% for code) SI	SA	NSSI	Examples
	Self-Efficacy to manage SITB	18(69.23)	1(3.85)	7(26.92)	"I felt like i had it under control" "the only person who can help me is me"
	Did not realize they had engaged in SITB	5(29.41)	0(0.00)	12(70.59)	"I didn't realize that they were suicidal thoughts … I assumed that everyone wanted to fall asleep and never wake up."
	Did not expect disclosure to be helpful	8(50.00)	2(12.50)	6(37.50)	" I don't think there's anything they can really do to help"
Stigma 208(17.81)					
Sub-Category: Internalized Stigma	Not wanting to impact people in personal life	19(73.08)	3(11.54)	4(15.38)	"I didn't want to worry my parents" "I didn't want to bother anyone with my problems."
	Shame/Embarrassment/ Guilt	7(26.92)	5(19.23)	14(53.85%)	"I was ashamed of myself for it. she had offered me help and it would be selfish of me to say that after everything, I still wanted to die"
	Not wanting to appear as attention seeking/weak/ backtracking	13(52.00)	3(12.00)	9(36.00)	" I don't want her to think I'm doing it for attention" "I didn't want to be seen as weak" "wanted to seem like I was getting better and that I didn't take a step back in my progress"
	Not wanting to impact therapist	9(45.00)	1(5.00)	10(50.00)	"I felt as though it would worry them" "I don't want to be a burden. I want them to feel like they are good at their job"
	Not wanting to disappoint anyone	6(46.15)	3(23.08)	4(30.77)	"I didn't want to disappoint anyone"
Sub-Category: Anticipated Stigma	Expected judgment	16(53.33)	6(20.00)	8(26.67)	"I was also afraid that I would be judged harshly "
	Anticipated future discrimination	9(60.00)	1(6.67)	5(33.33)	"worried it would ruin a future career"
	Previous poor experiences with mental health services/disclosure	7(63.64)	1(9.09)	3(27.27)	"Mental health care was the worst for me. I sought to be comforted and helped and most of the time, I felt like I was trapped" "she told me it was selfish to do suicide so i kept it to myself"
	Anticipated an overreaction	6(60.00)	1(10.00)	3(30.00)	"I was also scared … it would become a big panicked mess." "I just didn't want them to make a big deal out of it"
	Anticipation of being treated/thought of differently	4(40.00)	3(30.00)	3(30.00)	"I didn't want my … therapists to think of me differently."
	General fear/anxiety	11(50.00)	4(18.18)	7(31.82)	"i was scared" "the thought of having to handle it was very overwhelming and anxiety-inducing."

(*continued*)

TABLE 1. Continued.

Categories *n*(%)	Codes	Count for SITB *n*(% for code) SI	SA	NSSI	Examples
Therapeutic (Mis)alliance 177(15.15)	Lacked trust	29(49.15)	13(22.03)	17(28.81)	"I didn't trust him enough"
	Did not feel comfortable with therapist	20(71.43)	3(10.71)	5(17.86)	"I wasn't comfortable with my therapist"
	Expected lack of care/ compassion	13(54.17)	4(16.67)	7(29.17)	"Because they also wouldnt care. They want a paycheck, not a problem."
	Felt awkward/ uncomfortable in the situation	10(45.45)	4(18.18)	8(36.36)	"It was mostly just uncomfortable."
	Rapport was generally poor	12(54.54)	6(27.27)	4(45.45)	"I switched so often I never built a relationship enough" "I never thought that my therapist and I connected with each other, she was too pressuring."
	Perceived inexperience/ unpreparedness of therapist	13(59.09)	6(27.27)	3(13.64)	"they wouldn't know what to do"
Lacking Disclosure Self-Efficacy 84(7.19)	Disclosure too overwhelming/generally lacking disclosure self-efficacy	15(71.43)	5(23.81)	1(4.76)	"because i didn't know how to disclose to them" "It is very hard for me to open up about things" "I've never said it aloud and it felt like way too much to admit."
Sub-Category: Disclosure Not Facilitated by Therapist	Not afforded chance to disclose	16(50.00)	4(12.50)	12(37.50)	"I didn't get a chance! It was all about god and what he could do for me, nothing about my actual mentality."
	Were not asked if they had lived experience of SITB	10(40.00)	6(24.00)	9(36.00)	"My therapist never questioned me about my self harming nor suicidal tendencies so I assumed she did not care."
	Did not want to initiate the disclosure	0(0.00)	6(100.00)	0(0.00)	"I didn't want to bring it up if she wasn't going to."

Note. Here "n" denotes the number of responses containing that code/category, hence a single response may be counted multiple times if it contains more than one code. Categories and their contents are presented in order of frequency.

participant sharing: "the mental hospitals where I live are horrible and I was not going to be hospitalized." Agency over one's own SITB engagement was also highlighted, as participants felt that their therapist may expect them to cease self-injuring or interfere with future self-injury-related plans. For example, one participant expressed, "I don't want them to make me stop." Others reflected on the function that their SITBs served for them, with one participant noting that "it helps me cope with my thoughts and I don't want to stop."

Confidentiality Concerns. Participants reported having concerns about their confidentiality being breached. For example, many participants reported that they did not disclose their SITBs to their therapist as they expected that other people would discover this "very personal" information. These concerns stemmed from anticipation that others, particularly parents, would learn of their SITBs either via a forward disclosure from the therapist/another third party, or by overhearing if they were present in the therapeutic setting. Sometimes this expectation was informed by previous confidentiality breaches,

for example one participant shared, "I had a bad experience with a therapist in the past where she recorded our discussion without my knowledge and played it for my parents." Concerns of parents/guardians learning about their SITBs was a significant deterrent to disclosure for many participants, namely in anticipation of their parents' reactions, (e.g., "my mom would … get mad at me."), with some being "terrified" of their parents' reactions.

Irrelevance

Some participants did not perceive such disclosures to be helpful or even necessary. Often this was due to their perception of their SITBs as not being relevant to their therapeutic goals, when there were more pressing issues at hand, or if they were no longer experiencing SITBs during the therapy. For example, one participant explained, "the main reason is that it was not relevant at the time as I was no longer struggling with it." Relatedly, some participants felt the level of SITB severity did not warrant a disclosure; for example, one participant stated, "It's not a danger to me and so many people have it worse." Others noted the distinction between suicidal ideation with and without active intent; for example, "I knew I wasn't going to go threw [sic] with it … It was a couple of times of thinking but not action." Further, some participants indicated confidence or preference in managing their SITBs independently, expressing that disclosing their experiences in a therapeutic setting would be redundant and could potentially interfere with their own autonomy (as described in "Agency Theft"). Of note, not all participants considered their thoughts or behaviors to be classified as SITBs: "At the time, I didn't even realize that these behaviors were self-harm. When self-harming is discussed, it tends to be more focused on more obvious behaviors such as cutting or burning yourself, while mine have tended to be more like hitting and scratching myself."

Therapeutic (Mis)Alliance

Many participants expressed that a poor therapeutic relationship was a notable barrier to them disclosing their SITBs in therapy. This was sometimes described in broad terms reflecting poor rapport or not feeling comfortable with their therapist, though others noted more specific considerations. Barriers described in this category included: a lack of trust; feeling uncomfortable disclosing at that time in that setting; and expecting a lack of care or compassion from the therapist if they did disclose. For example, one participant stated, "I don't tell people about it because I feel like no one cares." Other participants believed that their therapist would not understand or be prepared to respond appropriately. Examples of this included statements such as, "she was … naïve," "she seemed inexperienced," "I don't trust that she'd know what to do anyway."

Stigma as a Barrier to SITB Disclosure

Whilst many of the barriers reported by participants reflect potential consequences of stigma, this category captures barriers to disclosure that specifically pertain to internalized and anticipated SITB stigma.

Internalized Stigma. Internalized stigma about one's SITBs occurs when an individual internalizes broader stereotypes about self-injury, contributing to negative self-evaluations (Corrigan & Rao, 2012). Participants identified feelings of "guilt," "shame," and "embarrassment" as barriers. Further, participants sometimes indicated feeling apprehensive to disclose their SITBs, as to not impact people in their personal life, notably parents and close friends. Adolescents described, for example, "because I don't want people to worry about me." In addition, some adolescents reported they did not want to burden their therapist with the information. Participants projected internalized beliefs about their SITBs stating that they could be: "seen as weak" and "just seeking attention." Other participants feared disappointing others through disclosure. Some participants noted wanting to seem "better," with a sense that disclosing their SITBs would interfere with them being able to leave that experience "in the past."

Anticipated Stigma. Whilst internalized stigma reflects the acceptance of negative stereotypes by people with lived experience, participants also explicitly referred to anticipated stigma from their therapist and others if they were to disclose their SITB in therapy. Anticipated NSSI stigma refers to expectations that an individual will receive stigmatizing response about their NSSI (Staniland et al., 2023). At times this apprehension was described in terms of generalized "worry," and being "too scared to admit it." In other cases, participants referred to more specific expectancies, much of which reflected concerns regarding their own agency. For example, some participants expressed concerns of being thought of or treated differently by their therapist (or others who may learn of their SITBs): Examples of these concerns include, "I didn't want to be seen as someone in need of aid," "I don't want her to hate me," "fear of them thinking less of me." In other instances, participants were concerned about how therapists would respond to them directly. Participants indicated they feared their therapist would respond with judgment, infantilization (e.g., "[being treated] like a child"), or by overreacting (e.g., by making "such a big deal out of it"). Some concerns raised within this category reflect implications of aforementioned barriers, perhaps indicating that some expectancies could inform others. For example, participants noted they were worried about the impacts of unsolicited interventions or breaches of confidentiality, including concerns for future discrimination beyond the bounds of the therapist room. For example: "I was nervous of how my parents and friends would react as well," "hospitals where they are abused," and "worried it would ruin a future career." Some participants referenced previous poor experiences in mental health services or in disclosure more broadly which may have informed these negative expectations.

Lacking Disclosure Self-Efficacy

Participants also reported not feeling confident about disclosing their SITBs to their therapist. This included disclosing feeling "too overwhelming," or that it was difficult to be emotionally vulnerable with their therapist in this way (e.g., "It is very hard for me to open up about things, that was partly the reason why I was there [in therapy] as well."). Others' concerns reflected the pragmatic barrier, stating that they did not know how to disclose to their therapist.

Disclosure Not Facilitated by Therapist. In contrast to concerns over agency, this subcategory captures a lack of disclosure facilitation from the therapist as a barrier to young people disclosing their SITBs. For example, some participants indicated that they had not disclosed their SITBs to their therapist because they had not been encouraged to do so. One participant described feeling discouraged to disclose: "I almost told her, but she just shut me up and continued talking about her own problems." Other participants mentioned that the opportunity to disclose their SITB to their therapist did not "come up" and/or they were never asked if they had such lived experience. These issues are of particular salience for those who mentioned that whilst they would not be completely opposed to disclosing their SITBs to their therapist, this is not something that they wanted to initiate themselves, and so opportunities may have been missed (e.g., "If I had been asked directly I might have said it but without that initial push … ").

DISCUSSION

Therapy can provide an opportunity for disclosure of SITBs and subsequent help-seeking; yet, therapists are amongst those least often confided in as compared to personal relationships (Simone & Hamza, 2020). Though there has been some quantitative investigation into barriers associated with such disclosure in therapeutic settings (e.g., Fox et al., 2022; McGillivray et al., 2022), in this study we sought to take a more inductive and lived-experience driven approach to better understand why adolescents have not disclosed specific SITBs to their therapist. Additionally, we examined whether barriers varied across specific SITBs. Results expand on prior research and highlight several potential areas to address to facilitate adolescent SITB disclosures.

Consistent with previous research (e.g., Fox et al., 2022, McGillivray et al., 2022; Simone & Hamza, 2020). participants reported the following barriers to disclosure: concerns of internalized and anticipated stigma, the potential impact of a disclosure on the recipient, breaches to the individual's autonomy including possible confidentiality infringements, and a sense that the severity of the SITB did not warrant a disclosure. Adding to prior research, several novel barriers were also reported by participants, including lacking disclosure self-efficacy and irrelevance. These support the emerging idea that disclosure is not always the desired outcome for an individual (e.g., as per person-centred approaches to NSSI, Lewis & Hasking, 2021). For example, some participants referenced factors specific to their life context, such as risks to their wellbeing, which they anticipated outweigh any potential benefit of disclosing their SITBs. Furthermore, the SITBs may not be relevant to the young person's therapeutic goals or it may be the case at times that an individual simply does not wish to disclose their SITBs to that person, at that point in time-or at all. Participants also noted the fundamental difficult logistics of disclosure. Of note is the propensity for multiple barriers to inform a single instance of nondisclosure to therapists, and the potential for some expectancies to reinforce others. For example, if a young person's confidentiality was previously breached by their therapist, as captured in "Agency Theft: Confidentiality Concerns," this may contribute to a lack of trust in their therapist (Therapeutic Misalliance), compounding apprehension toward disclosure in this context. Future research investigating the relationships between different disclosure barriers and how

they may interact could help shed light on adolescent decision-making. Awareness of potential barriers to SITB disclosure could be utilized by therapists or other persons working with young people to collaboratively navigate such practicalities.

Disclosure Barriers Across SITBs

Whilst most barriers were common across each of the assessed SITBs, there were some key patterns of difference to consider when working with young people. Barriers that were reported for nondisclosure of NSSI and suicide ideation but not attempt were not realizing that they were experiencing SITBs and previous breaches of confidentiality. The former barrier may reflect limitations of lay-person understanding of what behaviors fall under the umbrella of NSSI. Indeed, previous research suggests that greater endorsement of NSSI occurs when using checklist assessments of NSSI methods (as was the case in this study), rather than single item measures of NSSI, as less 'prototypical' means of self-injury may be captured (Robinson & Wilson, 2020). Some participants may not have thought to disclose their NSSI to their therapist if it did not fit their conceptualization of NSSI. Similarly, the clinical relevance of suicidal ideation may be overlooked by laypeople, as it does not necessitate suicidal behavior. This notion aligns with prior research indicating that individuals are more likely to seek help for suicide attempts as compared to ideation (Ammerman et al., 2022). Similarly, not wanting to be "forcibly removed" was a barrier to disclosing suicidal thoughts and behavior but not NSSI; with NSSI engagement sometimes being perceived as less dangerous and less likely to result in in-patient hospitalization, young people may hold a lesser concern for becoming involved with systems such as child protection or inpatient hospitalization (Staniland et al., 2023). Not wanting to initiate the dialogue was only a barrier to suicide attempt disclosure. This potentially highlights the need to ask an individual directly if they are considering suicide, a key tenet of leading suicide prevention courses such as Applied Suicide Intervention Skills Training (Australia) and Mental Health First Aid (US), as it is possible that these young people would be open to receiving support but are hesitant to initiate a disclosure directly (LivingWorks, 2014; National Council for Mental Wellbeing, 2023). Future research could further compare barriers of disclosure across SITBs, accounting for the relative frequency of each SITB.

Limitations

This study has some limitations that are important to consider when interpreting the findings. For example, "Therapists" in this study included any of the primary mental healthcare providers the participant had engaged with, including psychiatrists, nurses, and others which may not align with the definition of therapists in other studies. Moreover, most participants in this study reported multiple SITBs; it remains unclear whether participants with different lifetime history of specific SITBs may impact their disclosure barriers (e.g., whether nondisclosure differs for individuals who have a history of NSSI and suicidal ideation, compared to those with experience of suicidal attempt[s]).

Implications

Results highlight two key priorities for future clinical and research practice. Firstly, our findings suggest the importance of maximizing young people's agency in the event of their disclosing a SITB. Although this presents a particular challenge when working with minors, there are opportunities for collaborating with adolescents around decisions that may directly impact them (Bradford, 2018). For example, expectations such as how limits to confidentiality operate should be clarified with the young person from the outset. Furthermore, it may be helpful to both acknowledge that there may be a host of reasons why a young person could be hesitant to disclose a history of SITBs, and indicate a genuine interest to work with them to address their concerns, if they would ultimately like to make such a disclosure. Research has demonstrated that adopting such a collaborative approach can be integral to developing a strong therapeutic alliance, the second priority highlighted in the findings (Hamovitch et al., 2018). The importance of a strong relationship between therapists and their clients, including adolescent clients, to therapeutic outcomes has been reported across mental health difficulties (e.g., Fernandes, 2021). Considering participants' descriptions of poor rapport with their therapists impeding disclosure of their SITBs, these findings provide a call to action for care providers working with young people in prioritizing client comfort, with similar lessons translating to researchers. Such considerations for practice also extend to the training of mental healthcare providers, consistent with previous recommendations (e.g., Boukouvalas et al., 2020; Hasking et al., 2023).

Conclusion

This study identified numerous barriers to adolescent disclosure of SITBs to therapists. Most barriers emerged across SITB suggesting that fostering adolescents' agency in their own care and acknowledging reasons for SITB nondisclosure in therapy may help facilitate future disclosures. Our findings of certain barriers differing across nondisclosure of particular SITBs suggests that the perceived severity and visibility of SITBs matter when adolescents consider disclosure in a therapeutic setting.

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