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Disclosures of Self-Injurious Thoughts and Behaviors to Parents in the Context of Adolescent Therapy: A Qualitative Investigation

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Abstract

Self-injurious thoughts and behaviors (SITBs), including suicidal thoughts, suicide attempts, and nonsuicidal self-injury, are highly prevalent among adolescents. Identifying adolescents at risk for SITBs relies on their disclosure, and these disclosures commonly occur in therapy context. Moreover, therapists often breach confidentiality to inform adolescents' parent or guardian when they disclose SITBs. Research has explored rates of and barriers to disclosure among adolescents, yet no studies have examined adolescents' experiences of disclosure in the therapy context. Further, no studies have examined adolescents' experiences when their parents are then informed. In this study, we examined qualitative responses from 1,495 adolescents who had experienced a SITB disclosure in the therapy context. Qualitative questions included asking adolescents to describe how the SITB disclosure occurred, how their parents were informed, and their parents' reactions. Using open and axial coding, several themes emerged. Adolescents described therapist breaches of confidentiality as collaborative, noncollaborative, or unclear. Adolescents described their parents' affective responses, communication about SITBs, validating and invalidating responses, treatment-oriented responses, and ways that parents restricted their access to people, places, and activities. Findings have implications for the development of clinical guidelines when adolescents disclose SITBs in therapy and highlight areas for future research in adolescent SITB disclosure.

Keywords

Suicide; self-injury; adolescent; psychotherapy; parent-child communication

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Introduction

In the United States, suicide is the second leading cause of death for adolescents and young adults ages 10-24 (Heron, 2018). National data suggests that approximately 22% of high school aged youth have experienced suicidal ideation (SI) in the prior 12 months, with 10% reporting a suicide attempt (SA) (Youth Risk Behavior Survey Data, 2022). Adolescence also marks a period of elevated risk for non-suicidal self-injury (NSSI), the act of intentional self-harm without associated suicidal intent, and approximately 17% report NSSI at some point in their lives (Swannell et al., 2014). Self-injurious thoughts and behaviors (SITBs), inclusive of NSSI, SI, and SA, are related to long-term adverse mental health outcomes and functional impairment in adolescence and into adulthood, e.g., greater stress, psychological symptoms and disorders, and substance misuse (Daukantaitė et al., 2021; Wilkinson et al., 2018). Further, many adolescents at risk for SITBs do not access mental health services, highlighting the need for improved screening and identification (Husky et al., 2012). To enhance risk identification and connection to appropriate treatment, disclosure of SITBs is essential. Yet, little is known about SITB disclosure experiences in adolescents. The current study aims to examine adolescent experiences disclosing SITBs to their parents/caregivers (via themselves or their therapist) in the context of therapy, a setting in which these disclosures are more likely to occur.

Disclosures of Self-Injurious Thoughts and Behaviors

An essential component of SITB risk identification and treatment in adolescents is their honest disclosure of these thoughts and behaviors. Research on SITB disclosures in adults finds that SITB disclosures in adults are more common with friends and other informal support persons compared to more formal mental health supports such as therapists or psychiatrists (e.g., (Calear & Batterham, 2019; Encrenaz et al., 2012; Hom et al., 2017; Mérelle et al., 2018). Limited research in adolescents finds a similar pattern, such that while adolescent SITB disclosure to anyone at any point in their lives may be high, adolescents are more likely to disclose SITBs to friends compared to mental health providers and parents (Fox et al., 2022). This is consistent with the adolescent developmental period, during which adolescents seek more autonomy and agency and relatedly, demonstrate a growing reliance on peers (Hill & Holmbeck, 1986; Zimmer-Gembeck & Collins, 2003). Despite this, adolescents' experiences disclosing SITBs to their parents/guardians (hereafter referred to as parents) remain important, as parents are often the gatekeepers to adolescent mental health treatment. Indeed, parent involvement is considered essential to most evidence-based interventions for adolescent mental health, including well-established interventions for SITBs (Glenn et al., 2019).

To date, few studies have explored adolescent SITB disclosure experiences to parents; however, findings from one study suggest rates of disclosure to parents are relatively low (Eskin, 2003), and adolescents may be less likely to disclose SI to mental health providers if they think providers might disclose to their parents (Lothen-Kline et al., 2003). Further, when both parents and adolescents are asked about adolescent SITBs, one study found that informant agreement was low to moderate, due in some cases to a lack of awareness from parents and in other cases to adolescent denial of SITBs that their parent identified

(Jones et al., 2019). Using a validated SITB interview, another study found that parent-child agreement was low to poor across most outcomes, following a similar pattern in which parents reported fewer SITBs than their children (Gratch et al., 2021). This is in line with the broader literature demonstrating consistent parent-child discrepancies in measurement (De Los Reyes et al., 2023)

In addition, fear of worrying parents or, more generally, fear of parents' reactions to SITBs, have been identified as key barriers to honest disclosure in healthcare settings (Fox et al., 2022; Lothen-Kline et al., 2003). This is especially concerning for adolescents, as parents not only facilitate treatment access but also play a central role in monitoring risk and managing adolescent safety at home. Still, we know remarkably little about the experiences of adolescents when they do disclose SITBs to trusted adults, including their parents.

Self-Injurious Thoughts and Behavior Disclosures in the Therapy Context

It is often the case that mental health providers are in the position to facilitate disclosures between adolescents and their caregivers. Mental health providers may also be required to breach confidentiality by sharing an adolescent patient's SITBs with their parent, particularly if an adolescent is deemed to be at risk for future SITBs. Experiences in which adolescents' confidentiality in therapy is breached have the potential to influence their engagement and honesty with mental health services in the future. Indeed, we previously found that when providers non-collaboratively breached confidentiality (i.e., did so without the adolescents' consent), adolescents were more likely to report dishonesty about SITBs when probed by mental health providers in the future (Fox et al., 2022). In addition, one survey study of adolescents found the most commonly reported reason for nondisclosure of suicidal ideation in therapy was the fear that it would not remain confidential (McGillivray et al., 2022).

Confidentiality breaches in therapy may also have an impact on the parent-child relationship. Preliminary findings from this sample indicate that adolescents perceive non-collaborative breaches of confidentiality in the therapy context to have a negative impact on their overall relationship with their parent(s) (Fox et al., 2022). Yet, how adolescents experience their parent's responses to their SITBs remains underexplored.

In particular, we know very little about the specific reactions or behaviors from therapy providers and parents that facilitate positive or negative experiences when an adolescent discloses SITBs in this context. Given that it can be clinically important for parents to know about adolescent SITBs, even for those in mental health treatment, understanding adolescents' experiences in this realm is critical to informing clinical guidelines and best practices. Notably, a limited body of research exploring therapists' decision-making regarding confidentiality for adolescent patients suggests therapists vary widely in their threshold for breaching confidentiality for safety, further emphasizing the importance of understanding adolescents' experiences to inform standards of practice (Rae et al., 2002).

In the current study, we aim to characterize adolescent experiences of SITB disclosures to their parents, specifically in the therapy context. First, we describe the frequency of SITB disclosures to parents. Among adolescents whose parents did not know about their SITB

history prior to a therapy mediated disclosure, we assess the degree to which adolescents believe disclosing SITBs to parents in the context of therapy was the right decision. Second, we characterize adolescents' experiences disclosing SITBs in the therapy context and how they describe their parents' reactions to these disclosures.

Method

Participants.

Participants were adolescents ages 13-17 (M = 15.71; SD = 1.11), recruited through online Instagram advertisements. Adolescents were eligible if they were within the study age range (13-17), English-speaking, US residents, reported a lifetime history of SITBs, and reported a lifetime history of mental health treatment of any kind. To determine eligibility, adolescents completed a brief screening survey via Qualtrics. Eligible adolescents completed an online assent form, followed by the full study survey. Details regarding steps to ensure responses were not fraudulent are outlined in Fox et al., 2022.

A total of 2,100 adolescents completed the screening survey, and 1,800 were eligible for the study and assented to participate. Of these, 1,706 adolescents began the survey, and 962 completed the full survey. To maximize statistical power, all adolescents who responded to questions about SITB disclosures to a parent/guardian were included in the current study, even if they did not answer all survey questions. The final analytic sample ranged from a maximum of 1,148 to a minimum of 234 adolescents. The sample was predominantly white (n = 591; 64%), with remaining participants identifying as Asian (n = 47; 5.1%), Black/African American (n = 27; 2.9%), Multiracial (n = 79; 8.6%), and Other (n = 19; 2.1%). Regarding ethnicity, 161 participants (17.5%) identified as Hispanic/Latin American. Fewer than half of participants identified as heterosexual (n = 169; 18%) and just over half (65%) of the sample identified as cisgender, with 45% identifying as transgender or gender diverse (i.e., transgender, gender queer/expansive, nonbinary, questioning, or other gender not described in our survey). Full details on sample demographics can be found in Fox et al. (2022).

Measures.

Screening.—Eligibility was assessed using items from the Self-Injurious Thoughts and Behavior Interview-Revised (SITBI-R; Fox et al., 2020), including items assessing lifetime history of NSSI, SI, and SA. Single items were used to assess mental health treatment history and age.

Demographics.—Youth self-reported age, race, ethnicity, gender, and sexual orientation.

SITB disclosure history to caregivers.—If participants endorsed SI, SA, or NSSI histories on the SITBI-R, they were then asked about their history of disclosure of these thoughts and behaviors. Specifically, 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]?*" Response options were yes or no. Next, participants were asked to indicate the degree to which they had disclosed the given behavior to a

range of people (i.e., their caregiver (parent/guardian), therapist, psychiatrist, or pediatrician (the doctor you see for check-ups and physicals), another adult that they trust, sibling, friend, acquaintance, someone they met online, and other). This question was answered using a Likert type scale; for this study, we focused only on responses about disclosures to parents. We dichotomized adolescent's responses about their disclosure to their parents, with responses of '0' (never) categorized as no history of disclosure to parents and responses of '1' to '4' (rarely to often)

SITB disclosure experiences.—For both the best and worst experiences that adolescents had when their therapist disclosed their SITBs to their parent(s), adolescents were asked to indicate whether their parent(s) knew about their SITBs prior to their therapy disclosure ("*did your parents already know you had these thoughts/behaviors before you told your therapist?*"; response options yes or no). For those who reported that their parent(s) did not know prior to their therapy disclosure, they were then asked if they thought disclosing was the right decision both at the time of the disclosure ("*Did you agree at the time that this [telling your parent/guardian] was the right decision?"*) and presently (*"Do you agree now that this [telling your parent/guardian] was the right decision?").* Response options ranged from 0-4 and included "not at all", "a little bit", "somewhat", "very much", and "extremely". In all cases, participants who indicated "not at all" were coded as not at all believing it was the right decision to share with parents.

Participants were also asked to describe their experiences when their therapist breached confidentiality and told their caregivers about the adolescents' SITBs, and to describe how their parents reacted, using a series of open-ended questions. The first set of open-ended questions focused on the *best* experiences adolescents had when this occurred. First, participants were asked, "*Thinking of your best experience sharing these thoughts and/or behaviors…How did they [therapist] tell your parent/guardian*?" Next, they were asked, "*Thinking of your best experience sharing these thoughts and/or behaviors…How did your parent/guardian respond/react?*"

The second set of open-ended questions focused on adolescents' *worst* experiences when this occurred. Following the same structure, participants were asked, "*Thinking of your worst experience sharing these thoughts and/or behaviors…How did they [therapist] tell your parent/guardian?*" Next, adolescents were asked, "*Thinking of your worst experience sharing these thoughts and/or behaviors…How did your parent/guardian respond/react?*"

Given no existing, validated measures of SITB disclosure experiences in adolescents were available at the time of this study, we developed questions related to SITB disclosures based on prior studies in adults that assessed these types of disclosures (Calear & Batterham, 2019; Eskin et al., 2015; Hom et al., 2017).

Ethical considerations

The Institutional Review Board at the University of Denver approved this study. Participant assent was obtained online; a waiver of parental consent was approved for this study. A waiver of consent is appropriate when there are minimal risks posed by the study, the waiver does not impact the rights or welfare of participants, the study could not occur

without the waiver, and participants are given all relevant information after participation. Each of these criteria were met here: the study was of minimal risk, we provided clear and age-appropriate consenting and debriefing, because we recruited online, it would be difficult if not impossible to ensure parent/guardian consent, and doing so would limit willingness to participate (e.g., adolescents who had not disclosed prior SITBs to their parent/guardian may not have been willing or able to participate if parental consent was required). Following best practices in online SITB research (Smith et al., 2021), we provided all participants who completed the screener and the full study with electronic mental health resources and a link to a self-guided safety plan.

Data analytic plan

SITB disclosure history and disclosure experiences: Quantitative analysis.

We examined the frequency that participants endorsed questions about whether they had disclosed SITBs to their parent, whether their parent knew about their SITB history prior to their therapy disclosure, and the degree they felt it was the right decision for their SITB history to be disclosed to their parents in the therapy context at the time and in the present.

SITB disclosure experiences: Qualitative coding.

Using content analysis methods (Neuendorf, 2002, 2018), we first read through the responses to familiarize ourselves with the data. Participant responses from the two open-ended questions about adolescents' best and worst experiences were compiled and organized into *thematic units*, which refers to a portion of text that captures a unique idea and can be assigned a specific code. For example, the response stating, "My therapist helped me tell my parent and I was nervous about telling them" includes two thematic units: 1) "My therapist helped me tell my parent" and 2) "and I was nervous about telling them". Subsequently, participants' responses are often divided into several thematic units.

Authors AB and TB then developed the codebook for the best and worst experiences descriptions, which consists of thematic categories, taking an inductive approach. During the open coding stage, we first independently generated thematic categories using batches of 50-100 units and then met for consensus and discussion. We applied the codebook to an additional 50-100 units and generated additional thematic categories. We continued this iterative process until no more thematic categories were identified and the codebook sufficiently captured the ideas expressed in the qualitative responses.

During this process, we identified ten broad thematic categories, with 18 thematic subcategories for responses to the question, "*Thinking of your best experience sharing these thoughts and/or behaviors…How did they [therapist] tell your parent/guardian*?" and 36 thematic subcategories for the question, *Thinking of your worst experience sharing these thoughts and/or behaviors……How did your parent/guardian respond/react?"*. See Appendix I for full codebook with broad thematic categories and subcategories.

During the axial coding stage, coders CA, JP, and DM were first trained to reliability. First, coders separately coded a subset of thematic units. Concordance at 80% was operationalized as reaching reliability; during training, coders continued coding sets of thematic units until

they reached 80% concordance. Once trained to reliability, all coding was completed by two coders independently, who then met to resolve discrepancies and reach consensus. Participants' demographic information were masked to coders.

Results

Results indicated that 40.3%, 35.4%, and 42.8% of adolescents had *never* disclosed their NSSI, SI, and SA, respectively, to their parent(s) in their lifetimes (Table 1).

Parent Knowledge of SITB Prior to Disclosure

When asked about their *best* experience during a therapists' breach of confidentiality, participants reported equal rates of their parents knowing vs. not knowing about their SITBs prior to their disclosure in therapy (n = 297 indicated their parent(s) knew; n = 297 reported their parent(s) did not know). For those who reported that their parent did *not* know prior to their therapy disclosure, most participants reported that at the time of the disclosure, they did *not* believe it was the right decision (n =144; 45.3%). At the time of completing the survey, most youth (n = 112; 35.1%) still felt that telling their parent after disclosing to their therapist was still not the right decision (Table 1).

When describing their *worst* experiences disclosing SITBs in the therapy context, most (62.2%; n = 279) participants reported that their parents did *not* know about their SITBs prior to their disclosure in the therapy context. Further, of those youth who indicated their parent(s) did *not* know prior to their therapy disclosure, a majority (72.7%; n = 165) indicated they did not think disclosing SITBs to their parent(s) was the right decision at the time of the disclosure. Similarly, when reflecting on this experience, a majority of youth (49.8%; n = 114) indicated they did not believe this was the right decision right now/at the time of completing the survey.

Qualitative Data

Below, we describe the thematic categories that emerged from coding the open-ended responses. The same themes emerged across the best and worst experiences responses, and therefore, we present the qualitative data from these responses together. The frequency each thematic subcategory appeared in the best and worst experiences data, and examples of responses for each category, are summarized in Table 2.

Therapists' approaches to telling parents about adolescent SITBs—

Adolescents' descriptions about whether and how their therapist approached telling their parents about their SITBs fell into four broad categories: collaborative breaches of confidentiality (i.e., there is some indication that the therapist and adolescent discussed how or when to tell parents), non-collaborative breaches of confidentiality (i.e., therapist discloses to parents without adolescent's knowledge/involvement or against adolescent's wishes), cases where collaboration was unclear, or cases where the therapist did not disclose SITBs to their parents at all. Some adolescents also described experiences related to non-disclosure or partial disclosure. Further, some adolescents reflected on experiences of disclosing SITBs without including the full details (e.g., "I didn't share in complete detail

but I've been getting slightly more honest with what I felt before and what events caused me to feel it to that extent."). Other adolescents reported that they either did not or would not disclose SITBs to their parent in the future based on their prior experiences (e.g., "I didn't tell my mom, she would have sent me to live with someone where I'm unsafe for being trans").

Collaborative breaches were generally described positively, and in most cases, adolescents described that both the therapist and the adolescent were involved in telling the parent when it was collaborative. For example, one adolescent wrote, "My therapist helped me tell them during a family session she was present in." When breaches were done collaboratively, most often, both the therapist and adolescent were involved in telling the parent. When breaches were made non-collaboratively, the therapist most commonly disclosed to the parent(s). In these instances, adolescents often described feeling like they did not know the therapist was going to tell their parent(s) or that they were forced to do so; for example, "The therapist told my mother without my permission and gave me no heads up as to what she would say." Another adolescent described, "My therapist asked if she could tell my mom, and did so anyways after I said no. She forced me into telling my step dad and sister, telling them everything (non life threatening things included) I had trusted her with." Adolescents consistently experienced these noncollaborative breaches as forced, intrusive, and at times, unexpected. In some of these examples, adolescents also described ways in which the therapist invalidated them or was ineffective in how they handled the disclosure. For example, one adolescent said, "It felt like they [parents] didn't understand me at all and my therapist did nothing to help them understand."

Sometimes adolescents described experiences where it was unclear whether the breach was collaborative or not. In these instances, the therapist most frequently told the parent. For example, one adolescent said, "My therapist talked about my self-harm thoughts with my mom and I in an open conversation while I was in partial." These descriptions often did not include a clear evaluation of whether the therapist's actions were received negatively or positively by the adolescent. Finally, in instances where there was no breach of confidentiality, therapists sometimes instead disclosed other mental health problems rather than SITBs to their parents. For example, one adolescent said, "They called them on the phone and described not specifics just said I was struggling with mental health and needed close watch."

Adolescents' Perceptions of Parent Reactions to SITB disclosures

Affective Responses.: Adolescents frequently described their parents' affective or emotional reactions to the SITB disclosure. Of these affective responses, adolescents perceived their parents to be predominantly sad/upset or anxious/worried. In addition, adolescents described their parents as sometimes angry/annoyed, surprised/shocked, and experiencing other non-specific emotions (e.g., "they reacted with very strong emotions"). Adolescents also commonly described their parents' reactions as "overreacting" or "freaking out."

Communication about SITBs.: Many adolescents described their parents' communication about their SITB disclosures. Adolescents described their parents wanting to talk about or

asking to see their SITBs. For example, some parents asked to look at self-harm on their child's body; as one adolescent wrote, "She made me show her my arms every night for a few weeks until I had 'stopped'." Other parents asked their children directly about their SITBs. For example, one adolescent wrote, "I think it [disclosing SITBs] was a good idea because she brought it up more and asked me about it." Another adolescent wrote, "Mom asked a lot of questions that I didn't want to answer." Many adolescents also provided responses suggesting their parents did not acknowledge their SITB disclosure at all. One participant noted that after the therapist disclosed to the parent, "My parent didn't even really acknowledge it…. Didn't ask anything, didn't modify the behavior that caused me to start in the first place." Further, some perceived their parents to not care about the SITB disclosure (e.g., "My dad just didn't really care. He brushed it off and said it's something we just have to deal with") or noted that their parent was quiet/said very little about their SITBs. Finally, adolescents also perceived that their parents felt uncomfortable discussing or managing their SITBs.

Treatment-related responses.: Adolescents often described myriad parent responses related to changes in adolescents' mental health treatment. Many responses described their parent engaging in instrumental support (i.e., taking concrete steps to access mental health treatment/support). Parental instrumental support often involved connecting the adolescent to another therapist or psychiatrist; for example, "but she got me a new therapist and psychiatrist as soon as she could." In some cases, adolescents described requiring emergency or intensive treatment services or the therapist recommending a higher level or change in the type of care. These higher-level services were often described negatively by the adolescent. One adolescent wrote, "they just went along with whatever the therapist said, agreeing to take me back to hospital despite the fact that I wasn't having suicidal tendencies." Another adolescent wrote, "My parents admitted me to the mental hospital since they didn't feel like dealing with me." Further, adolescents sometimes noted that their parent was either aligned or not aligned with their current therapist or treatment plan. For example, one adolescent wrote, "but they (parents) trusted my therapist to work through it with me." On the contrary, another adolescent explained, "They have done a better job trying to understand me, but not so much as to take me to actually therapy. I only attend the free confidential therapy the clinic at my school offers."

Restricting youth access.: Adolescents frequently described that their parents responded to SITB disclosures by restricting access to something or someone in their lives. Across best and worst experiences, adolescents most frequently described that their parents reduced their privacy and/or increased monitoring following their SITB disclosure (e.g., "I had constant surveillance for months"). Restricted access also involved access to technology (e.g., "she took away my phone and told me to pray"), lethal means (e.g.,"[my parents] made it harder for me to have access to self harm tools"), friends, significant others, or social outlets ("[my parents took away] being able to see my boyfriend and his family"), and restriction without specification (e.g., "[my parents] took away my things"). The restriction of access to people, places, and things was often described negatively by adolescents, suggesting that these responses felt punitive or unhelpful.

Invalidation.: Many adolescents stated that their parents responded in ways that were invalidating. Invalidating responses were frequently characterized by dismissive or rejecting responses (e.g., “my parent said that I was fine and left it at that”; “my mom makes fun of me now for it.”). Adolescents also described their parents as responding in anger or disappointment directed at the adolescent. For example, one adolescent stated, “they told me I was a terrible friend for leaning on my friends…and were overall very upset and angry at me.” Further, many adolescents described parents labeling them as manipulative or attention-seeking (e.g., “they said I was being dramatic and trying to get attention”). Finally, adolescents described guilt induction, wherein parents’ responses made adolescents feel guilty for having SITBs. For example, one adolescent explained, “[my parents said they] gave me everything, that they worked hard and that I was being stupid for wanting to die.”

Validation.: Adolescents also described parents validating their experiences with SITBs. Most frequently, adolescents described their parents as providing validation through emotional support and by expressing their understanding of what the adolescent was going through. For example, one adolescent said, “They have helped me a lot along my journey and have always been understanding.” Another described that their parents “now understand what’s going through my head (better than they did).” One adolescent also wrote that their parent “assured me she wasn’t mad.” Adolescents also described their parents as providing validation through affirmations or expressions of love, such as “Ultimately they [parents] said they still loved me.” Notably, adolescents more frequently described *invalidating* responses than validating responses in response to *both* their best and worst experiences disclosing SITBs in the context of therapy.

Adolescent affective responses.—We also identified one adolescent-focused thematic category: adolescents’ affective responses. In many cases, adolescents not only described how their parents responded affectively to their SITB disclosure, but also their own affective experiences around the disclosure. Adolescents frequently described their own experiences of anxiety and worry, sadness and distress, and anger or annoyance during this experience. Regarding anxiety, adolescents often described feeling anxious about their parents finding out about their SITBs. For example, one participant described, “I’ll be real, it was scary but I knew it had to happen.” Adolescents also described feeling sad about sharing their SITBs, with one participant stating, “this was a really painful experience…this is probably the most painful memory I have.” Adolescents frequently noted that talking about their SITBs with their parents was uncomfortable and stressful. For example, one stated, “It made it really uncomfortable and hard for me to deal with.” In addition, adolescents described feelings of shame or embarrassment (e.g., “I don’t remember most of the experience but I remember feeling ashamed.”) and anger (e.g., “I was SO pissed off”).

Discussion

The present study examined adolescents’ experiences with disclosing SITBs within the therapy context, with an emphasis on understanding their experiences with suicide risk-related breaches in confidentiality to guardians, and their perceptions of how their guardians subsequently responded. Overall, results point towards several important areas of future

research and have key implications for how to improve adolescent experiences when breaches of confidentiality may need to occur in the therapeutic setting.

Our findings suggest that even in a sample of adolescents with a history of mental health treatment, parents are often unaware of their children's SITB history prior to a disclosure in therapy. Indeed, only about half of participants said their parents were aware of their SITBs before disclosing them to their therapist. It is therefore relatively common for therapists to be in a position where they may breach confidentiality and inform parents that their children are experiencing SITBs.

Unexpectedly, results highlighted substantial overlaps when asking adolescents to consider their best and worst experiences with disclosures in therapy. These overlaps demonstrated that even when adolescents are considering their *best* experiences, many negative features persist. For example, most participants said they did not believe that sharing their disclosure with their parents was the right decision either at the time it happened or now. The remarkable similarities between these best and worst experiences descriptions underscore the importance of therapists undertaking breaches of confidentiality with much consideration and care. These similarities further underscore the importance of preparing parents for these disclosures and supporting parents as they navigate the aftermath of such disclosures.

When considering findings regarding collaboration, or lack thereof, in breaking confidentiality to disclose SITBs to parents, results highlight that adolescents often feel they do not have control over whether or how their SITBs are shared with their parents. Findings are particularly concerning in light of previous study findings that non-collaborative breaches are associated with a greater likelihood of adolescents saying that they hid or lied about their SITBs to a therapist after these experiences (Fox et al., 2022). These findings beg the question of how adolescents understand confidentiality in the therapy context, and how we may better inform adolescents of these guidelines before assessing risk to give them more agency during an important period in which they are developing autonomy, self-identity, and improved capacity to self-regulate (Farley & Kim-Spoon, 2014; Gullone et al., 2010; Zimmer-Gembeck & Collins, 2003). It is also critical to acknowledge the challenging ethical and legal considerations that arise when managing SITBs and confidentiality in psychotherapy; these considerations can lead to clinical decision-making that may not always align with what adolescents perceive to be most validating or helpful and often involve a lower risk threshold for adolescents compared to adults (Bond & Mitchels, 2011; Duncan et al., 2015). Indeed, pediatric mental health providers have the challenging task of both delivering supportive and high-quality therapy, while also assessing and managing SITB risk which often requires parental involvement (Boukouvalas et al., 2019; Petit et al., 2018; Cwik et al., 2020). Assessing and managing risk while preserving or building a therapeutic alliance is an incredibly difficult task for clinicians, especially considering the lack of consistent training in suicide and self-harm care provided in most graduate programs (Cramer et al., 2013). The difficulty of this task is compounded by challenges related to preparing parents to respond to suicide risk breaches (i.e., learning one's child may be at risk for suicide) in ways that are helpful and not harmful to their children. Notably, in a recent review (Bernert et al., 2014), it was noted that many formal clinical practice guidelines did not include guidelines specific to issues of confidentiality, highlighting the need for more

work in this area that engages key stakeholders (e.g., parents, adolescents, clinicians) and simultaneously addresses issues of autonomy in pediatric healthcare (Martakis et al., 2018)

When asked to reflect on their experiences of their parents' reactions to their SITB disclosure in the context of therapy, responses revealed several important themes. Adolescents frequently described their parents' emotional responses to the SITB disclosure. Together, these reports suggest that, perhaps unsurprisingly, many parents may struggle to regulate their emotions when they learn that their child engages in or is at risk for SITBs, and that adolescents are attuned to these affective responses. Supporting parents in effective emotion regulation and emotion socialization (the modeling and coaching of emotions; Morris et al., 2007) may be a critical focus of treatment to support parents in processing and modeling emotional reactions to their child's SITBs in ways that will promote communication and safety. Adolescents' reports also suggest that they interpret their parents' emotional responses in a range of ways that may reduce their likelihood of sharing with their parents in the future for fear of hurting them or punishment. Additionally, approaches such as dialectical behavior therapy for adolescents (Mehlum et al., 2014), which emphasize the importance of both adolescents and their caregivers learning skills to regulate emotions, may be well-suited to support positive SITB disclosure experiences.

Relatedly, though adolescent reports of parents' communication about SITBs were variable, adolescents frequently reported their parents did not acknowledge their SITBs at all. These descriptions indicate that parents need support in how to have open, non-judgmental communication with their children about SITBs. For youth, active avoidance of discussing a SITB disclosure may be experienced as invalidating or uncaring. It may also inadvertently send the message to adolescents that their parents are not comfortable hearing about their feelings or that their parents do not care, thus potentially reducing the likelihood of future disclosures and/or contributing to the adolescent's worsening risk for suicide.

Parents understandably may feel scared, nervous, and uncertain about how to act, given the lack of education in this space. Indeed, research suggests that parents report relatively low levels of self-confidence in their ability to identify suicide warning signs, obtain a commitment from their child to refrain from engaging in suicidal behavior, and their ability to keep their child safe if their child has suicidal thoughts (Czyz et al., 2017; Ewell Foster et al., 2021). Such doubt may breed anxiety about saying the wrong thing and may lead parents to experience strong negative emotions related to feeling helpless in the context of a feared outcome. Although normative and understandable for parents to feel ill-equipped to manage suicide risk, feeling this way may inadvertently negatively impact their child. Indeed, in a study of parents of adolescents recently discharged from the emergency department after a suicidal crisis, lower parental self-efficacy in engaging in several suicide prevention activities was associated with increased adolescent suicide-related outcomes over a four-month follow-up period (Czyz et al., 2017). Thus, equipping parents with the language and skill to facilitate open communication about SITBs may be important to promote future disclosure and support positive adolescent outcomes.

Adolescents also frequently talked about the treatment recommendations that were made, the ramifications of their disclosures related to treatment, and how their parents aligned

with their treatment plan. Adolescents were more likely to report parents being aligned with their therapist or treatment in best experiences, and more likely to report parents not being aligned with their therapist or treatment in their worst experiences. These results highlight how, despite adolescence marking a period of growing independence from parents and family (Zimmer-Gembeck & Collins, 2003), parents still play a critical role as facilitators of adolescent engagement in mental health care. Indeed. greater perceived parental social support (including instrumental, informational, emotional, and appraisal support) is associated with lower odds of suicide attempt history (Miller et al., 2015). Importantly, adolescents' experiences when they were required to or recommended to go into higher levels of care (e.g., psychiatric hospitalization) were often described negatively, consistent with prior work examining barriers to SITB disclosures (Fox et al., 2022) and negative experiences in high levels of psychiatric care (Moses, 2011). Therapists may consider providing adolescents and families with a clear rationale for higher-level care when it is recommended. Further, given evidence that hospitalization for suicide risk may be iatrogenic, hospitalization should be considered only in small proportion of cases when risk cannot be managed otherwise (Ward-Ciesielski & Rizvi, 2021).

Parents often responded to SITB disclosures by restricting adolescents' access to people, places, and things. Consistent with clinical guidelines, adolescents commonly reported that their parents restricted their access to lethal means. Gold standard risk management protocols (e.g., Safety Planning; Stanley et al., 2018) include means restriction coaching, which has evidence when implemented at the population-level (Hawton et al., 2012; Mann & Michel, 2016). It is also a primary component of Safety Planning, a Joint Commission-recommended brief intervention demonstrating evidence as an effective intervention for reducing suicidal behavior (Nuij et al., 2021; Stanley et al., 2018). Furthermore, parents are often encouraged to increase monitoring of their at-risk children, to identify if/when their children's risk is becoming more acute and may require additional intervention.

While restricting access and increasing monitoring are consistent with evidence-based interventions for periods of elevated risk, adolescents in our study perceived generalized restriction of access as punishing. Feeling punished for being honest about their SITBs in the context of therapy may inadvertently reduce future openness to both therapists and parents. Thus, we suggest a balanced approach to restriction of access, with therapists and parents providing a clear rationale and timeline for such restrictions to reduce the perception of restrictions as punishment. It is also important to note that providers and parents should be particularly mindful of the possible deleterious effects of restricting adolescents' access to effective coping strategies, such as spending time with friends, engaging in hobbies, or using social media to feel socially connected or to distract from painful emotions (Wadley et al., 2020). When developing a plan to manage risk, we suggest a collaborative approach, which is supported by studies of family-based interventions for at-risk youth (e.g., Asarnow et al., 2011). A more targeted restricted access plan that considers both risks and important sources of support in the child's environment may make sense (e.g., removing sharps from the bedroom, administering medication daily). Further, setting clear boundaries and expectations around social activities may allow adolescents to access these important and beneficial supports safely.

The theme of validating and invalidating parental responses also emerged frequently in these data. Validation skills are an important target in adolescent SITB treatment, and both parent validation and invalidation have been shown to impact adolescent SITB treatment outcomes (Adrian et al., 2018, 2019). Furthermore, parental support may buffer the impact of stress on suicide risk (Kang et al., 2017). Parental validation through showing understanding may help adolescents to feel less alone or isolated, and may serve to bolster trust and communication about future SITBs. On the contrary, mounting evidence indicates that parenting styles characterized by invalidation (Adrian et al., 2018), low emotional support, rejection, or neglect are associated with increased adolescent self-harm, SI and SA (Donath et al., 2014). Therefore, when SITB disclosure itself is faced with invalidation, it is reasonable to assume SITB risk may be heightened, and that future disclosure may be unlikely, resulting in a pernicious confluence of risk.

Together, study results emphasize the potential clinical utility of teaching parents emotion regulation strategies, effective and nonjudgmental communication, and how to best validate their child's experiences. Parents may also benefit from education around steps to help their children maintain safety while maximizing their personal autonomy and access to protective coping skills, even in the context of this risk. These parenting skills are not easy skills to master, underscoring the importance of frequent parent involvement in therapy.

Results have important implications for providers and adults who interact with children across settings. Often, adults and mandatory reporters (e.g., school personnel, researchers, medical professionals, coaches) discover that a minor may be thinking about suicide and/or that they may have engaged in self-harm. These discoveries commonly result in notifying the child's parent about this potential risk. Our results highlight that most parents lack knowledge and skill in managing these difficult conversations with their children, even when these conversations are initiated in the context of their child's mental health treatment. Care should be taken to weigh the pros and cons of sharing with parents in these situations, particularly in the absence of co-occurring parent education and ongoing support in managing their child's mental health. Additionally, those who are not mental health professionals may have limited experience discussing and managing SITBs and are often not familiar with clinical best practice. Thus, adults without formal mental health training who may be in the position to report SITBs to parents may benefit from training and support specific to suicide and self-harm.

Results should be interpreted in light of important study limitations. All data are based on retrospective self-reports from adolescents who have a history of both SITBs and mental health treatment. Thus, results are limited by memory biases, and generalizability is limited by the characteristics of this specific sample. Indeed, adolescents without mental health treatment histories may have very different experiences when mandatory reporters share their SITBs with a parent, and these experiences cannot be inferred from these results. These qualitative data only captured adolescents' experiences with therapists, and not with other mental health providers, such as psychiatrists or psychiatric nurse practitioners. Adolescents' experiences disclosing SITBs in other mental health contexts may differ. In addition, while the sample was comprised of significant sexual orientation and gender identity diversity, the sample lacked in racial and ethnic diversity; additional qualitative and quantitative work is

needed to understand how experiences may differ based on identity. Additionally, results do not include corresponding reports from parents or therapists. As with all experiences and memories, perceptions may differ across people, and reports would likely vary substantially if parents and therapists were directly queried in addition to adolescents. Importantly, work to develop and validate reliable measures of disclosure experiences is needed to move the field forward in this area. Further, we do not have longitudinal data assessing how these experiences impacted adolescents' mental health or their treatment experiences over time.

These limitations point to several important future directions, including studies assessing the perceptions of parents, teenagers, and therapists (or other mandatory reporters) after SITBs are disclosed across a range of settings, as well as studies assessing risk prospectively. We recruited this sample online via social media, and adolescents who were interested in participating in this study may have pre-existing negative biases toward mental health treatment and/or SITB disclosure. However, it is important to note that we recruited adolescents with history of SITBs and mental health treatment broadly, rather than specifically seeking out adolescents with negative experiences of self-disclosure. Further, the function of adolescents' SITBs may be an important area for future research, as this may be related to how and when adolescents disclose, as well as their experiences after disclosure. In addition, it may be clinically informative to explore how adolescents' views of their disclosure experience, and whether it was the right decision to disclose, changes over time.

Prior research has examined the points at which therapists will break confidentiality (Lothen-Kline et al., 2003; Rae et al., 2002); however, research directly examining the processes that therapists follow when breaching confidentiality and/or managing suicidality that arises with adolescent clients could be informative to better understand diversity across current practices. From there, future research and training practices could explore alternative approaches to managing child suicide risk, and how to most skillfully and supportively involve parents when necessary. Randomized control trials could even be leveraged to compare different strategies on adolescent and parent outcomes across time.

Clinical practice with adolescents experiencing SITBs involves a range of difficult decisions that therapists must navigate. These decisions carry major implications for adolescents' imminent safety, relationships with parents, future therapy engagement, and even potentially their risk for future SITBs. Best practices for managing adolescent suicide risk to date have focused on risk assessment and mandatory reporting. Less work has focused on whether and how to skillfully involve parents and guardians in this conversation, nor how to best validate and support adolescents when sharing these experiences. The present study leveraged qualitative methods to better characterize adolescents' experiences with SITB disclosure in the therapy context. Results highlight numerous areas for growth, including a focus on directly involving adolescents in the decision to share with parents and guardians and equipping parents with emotion regulation and communication skills and concrete knowledge about the steps they can take to best support their child.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1.

Adolescents' frequency of and attitudes towards disclosures of SITBs to parents.

Overall	**N (%)**
SITB never disclosed to parent: NSSI	454 (40.3)
SITB never disclosed to parent: SI	412 (35.4)
SITB never disclosed to parent: SA	260 (42.8)
Best Experience with SITB disclosure in the therapy context	
Parent knew prior to SITB disclosure in the therapy context	293 (49.9)
Parent did not know about SITB prior to disclosure in the therapy context	294 (50.09)
Did not at all believe it was the right decision to tell parent *then*[a]	143 (45.4)
Did not at all believe it was the right decision to tell parent *now*[a]	112 (35.3)
Worst Experience with SITB disclosure in the therapy context	
Parent knew prior to SITB disclosure in the therapy context	146 (37.8)
Parent did not know about SITB prior to disclosure in the therapy context	240 (62.2)
Did not at all believe it was the right decision to tell parent *then*[a]	164 (72.9)
Did not at all believe it was the right decision to tell parent *now*[a]	113 (49.6)

Note: SITB = Self-injurious thoughts and behaviors; NSSI = nonsuicidal self-injury; SI = suicidal ideation; SA = suicide attempt;

[a]Including only those whose parents did not know prior to therapy disclosure. Sample size for the questions about whether they believed it was the right decision then and now are smaller than the sample size for reporting if their parent know about SITB prior to disclosure in the therapy context because those questions occurred later in the survey and some youth did not complete the full survey.

Table 2.

Percentage of responses in each broad category and for each specific code and examples from participants.

Codebook A: Therapist disclosure to parents		Combined Best and Worst Experiences	Best experiences	Worst experiences	
Broad category	**Specific code**	**N (%) of responses within broad category**	**N (%) of responses within broad category**	**N (%) of responses within broad category**	**Example responses within each category**
Therapist approaches to breaches of confidentiality (*n* = 569 responses)	Collaborative	96 (16.8%)	87 (27.7%)	9 (3.6%)	"My therapist recommended that I sit down with one parent at a time and calmly explain my feelings in a non-confrontational manner. It worked pretty well."
					"My therapist and I talked about how we should tell my dad and the 3 of us sat down and she told him and we all talked about it and we were going to do moving forward.
					"My therapist helped me tell them during a family session she was present in."
	Noncollaborative	149 (26.2%)	45 (14.3%)	104 (41.3%)	"My parents were called and we had a meeting and I was forced to show my cuts to them."
					"The therapist told my mother without my permission and gave me no heads up as to what she would say."
					"She brought my father in the room and told me I could tell Him or she was going to. Putting me on the spot."
	Collaboration unclear	197 (34.6%)	115 (36.6%)	82 (32.5%)	"She called my mom into the room and I told her why I cut myself."
					"My therapist talked about my self-harm thoughts with my mom and I in an open conversation while I was in partial."
					"we talked (parents, therapist, patient) about it all together"
	Therapist did not disclose to parent	88 (15.5%)	59 (18.8%)	26 (10.3%)	"we have not talked about it with my parents yet."
	Therapist disclosure to parent (other mental health)	14 (2.5%)	8 (2.5%)	6 (2.4%)	"while my mother never learned the extent of things, my therapist did introduce that i have problems that would need accommodation at home."
	Therapist invalidation/ ineffectiveness *	25 (4.4%)	N/A	25 (9.9%)	"they [parents] agreed with my therapist that I was just attention seeking and selfish."
Teen non-disclosure (*n* = 47 responses)	Disclosure did not include full details of SITBs	13 (27.7%)	9 (23.7%)	4 (1.5%)	"Once again, I didn't share in complete detail but I've been getting slightly more honest with what I felt before and what events caused me to feel it to that extent."

Codebook A: Therapist disclosure to parents		Combined Best and Worst Experiences	Best experiences	Worst experiences	
Broad category	**Specific code**	**N (%) of responses within broad category**	**N (%) of responses within broad category**	**N (%) of responses within broad category**	**Example responses within each category**
	Did not or unlikely to disclose in the future	34 (72.3%)	29 (76.3%)	5 (1.9%)	"My parents cried which made me feel worse, so after that i didn't tell [my parents] if i cut. The only other time they knew was when i didn't hide the cuts well enough"
Codebook B: Parent responses to disclosure		**Combined Best and Worst Experiences**	**Best experiences**	**Worst experiences**	
Broad category	**Specific code**	**N (%) of responses within broad category**	**N (%) of responses within broad category**	**N (%) of responses within broad category**	**Example responses within each category**
Parent affective responses (n = 464 responses)	Parent affective response (unspecified)	32 (6.9%)	24 (7.1%)	8 (6.5%)	"Every time I have informed my parents of my self harm, they have reacted with very strong emotions."
	Parent affective response (anxiety/worry)	145 (31.3%)	112 (32.9%)	33 (26.6%)	"My mom was really worried"
	Parent affective response (sad/ upset/distressed)	170 (36.6%)	131 (38.5%)	39 (31.5%)	"My mother seemed upset and possibly disappointed, and distanced herself from me for the next few days."
	Parent affective response (angry/annoyed)	56 (12.1%)	33 (9.7%)	23 (18.5%)	"My mom was pissed"
	Parent affective response (surprise/shock)	28 (6.0%)	19 (5.6%)	9 (7.3%)	"They never expected the extent of things so they were shocked"
	Parent "overreacted"	33 (7.1%)	21 (6.2%)	12 (10.0%)	"she freaked out"
Restriction of access (n = 108 responses)	Restriction of access (unspecified)	5 (4.6%)	3 (4.3%)	2 (5.3%)	"and took away my things."
	Restriction of access (technology)	19 (17.6%)	13 (18.6%)	6 (15.7%)	"she took away my phone and told me to pray"
	Restriction of access (friends/ social)	14 (13.0%)	12 (17.1%)	2 (5.2%)	"[my parents took away] being able to see my boyfriend and his family"
	Restriction of access (reduced privacy/increased monitoring)	52 (48.1%)	32 (45.7%)	20 (52.6%)	"They became overbearing and hovered over me like I was glass about to shatter."
	Restriction of access (lethal means)	18 (16.7%)	10 (14.3%)	8 (21.1%)	"and made it harder for me to have access to self harm tools."
Parent invalidation (n = 338 responses)	Parent invalidation (unspecified)	121 (35.7%)	68 (35.6%)	53 (36.1%)	"They[parents] dont really understand the concept of mental health, depression, and suicidal thoughts"

Codebook A: Therapist disclosure to parents		Combined Best and Worst Experiences	Best experiences	Worst experiences	
Broad category	**Specific code**	**N (%) of responses within broad category**	**N (%) of responses within broad category**	**N (%) of responses within broad category**	**Example responses within each category**
	Parent invalidation (says teen wanted attention or was manipulative)	66 (19.5%)	32 (16.8%)	34 (23.1%)	"My mother had a tendency to try and blame it on being a teenager and wanting attention."
	Parent invalidation (guilted teen)	43 (12.7%)	28 (14.7%)	15 (10.2%)	"My mom blamed me"
	Parent invalidation (parent expresses their failure)	22 (6.5%)	13 (6.8%)	9 (6.1%)	"My mom made it about her and got upset that I never told her as well."
	Parent responded in disappointment or anger directed at teen (e.g., yells at me, mad at me)	86 (25.4%)	50 (26.2%)	36 (24.5%)	"I got yelled at and grounded. My parents were angry at me for months but they were glad they knew now"
Parent validation (*n* = 168 responses)	Parent validation (understanding)	75 (44.6%)	62 (41.3%)	13 (41.9%)	"They have helped me a lot along my journey and have always been understanding"
	Parent validation (Emotional support)	78 (46.4%)	66 (44.2%)	12 (38.7%)	"and said she wanted to help, and she sort of has."
	Parent validation (affirmations/expressions of love or care)	15 (8.9%)	10 (7.2%)	5 (16.1%)	"…and let me know that she and my dad love me very much…"
Treatment-seeking related responses (*n* = 144 responses)	Instrumental support	69 (47.9%)	61 (58.7%)	8 (20%)	"He set up more appointments and got me a second therapist."
	Parent lack of follow-through on instrumental support	6 (4.2%)	6 (5.8%)	0 (0%)	"everytime i tell her she says that she'll help me get back on my meds or check on my mental health often but no effort was made"
	Teen ED/hospitalization/ emergency clinical services	26 (18.1%)	12 (11.5%)	14 (35%)	"I was then told I was going to inpatient because of it."
	Therapist suggested medication/higher level of care	18 (12.5%)	12 (11.5%)	6 (15%)	"Later that day my therapist told her I needed to be hospitalized"
	Parent alignment with treatment	20 (13.9%)	13 (12.5%)	7 (17.5%)	"but they (parents) trusted my therapist to work through it with me."
	Parent does not align with treatment *	5 (3.4%)	N/A	5 (12.5%)	"My mom was concerned about the medication I was taking and told me to stop taking it."
Parent communication with child about SITBs (*n* = 139 responses)	No parent acknowledgment	40 (28.8%)	18 (23.7%)	22 (34.4%)	"They kind of just ignored it and figured my therapist and I would deal with it"

Codebook A: Therapist disclosure to parents		Combined Best and Worst Experiences	Best experiences	Worst experiences	
Broad category	**Specific code**	**N (%) of responses within broad category**	**N (%) of responses within broad category**	**N (%) of responses within broad category**	**Example responses within each category**
	Parent quiet/said very little	20 (14.4%)	13 (17.1%)	7 (10.9%)	"But he was quiet and didn't say much."
	Parent didn't care	19 (13.7%)	7 (9.2%)	12 (18.8%)	"My dad just didn't really care. He brushed it off and said it's something we just have to deal with (in relation to my depression, not self harm or suicidal thoughts)."
	Parent and teen talked about or asked to see SITBs/teen's experiences	44 (31.7%)	30 (39.5%)	14 (21.9%)	"I think it was a good idea because she brought it up more and asked me about it"
	Parent unsure how to/ uncomfortable discussing or managing SITBs	16 (11.5%)	8 (10.5%)	8 (12.5%)	"Both my parents were a bit uncomfortable talking to me about the subject"
Teen affective responses (n = 109 responses)	Teen affective response (unspecified)	59 (54.1%)	32 (51.6%)	27 (57.4%)	"It's still stressful to talk about it" / "It made it really uncomfortable and hard for me to deal with."
	Teen affective response (anxiety/worry)	11 (10.1%)	7 (11.3%)	4 (8.5%)	"I'll be real it was scary but I knew it had to happen."
	Teen affective response (sad/ upset/distressed)	32 (29.4%)	19 (30.6%)	13 (27.7%)	"This was a really painful experience…This is probably the most painful memory I have."
	Teen affective response (angry/annoyed)	7 (6.4%)	4 (6.5%)	3 (6.4%)	"I was so ashamed and angry about the situation."

*Note: Codes for therapist breaches of confidentiality were further subdivided by who told the parent (therapist, teen, or both/unclear) about the adolescent's self-injurious thoughts and behaviors. See Supplemental Table 1 for full codebook and definitions.