The Problem of Self-Disclosure of Self-Harming Behaviour in Adolescence

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Abstract: Self-disclosure is the key prerequisite for the provision of help and professional intervention in the case of mental difficulties. Self-harming behaviour is a problem in this area that has been a remarkably strong taboo, and as such, this form of behaviour is often hidden. The most at risk category in this context are adolescents who demonstrably receive the least psychological intervention and for whom self-harm is a high-risk behaviour (considering its prevalence, health risks, lethality and consequences for their future mental health). This study observes the prevalence of self-harming behaviour (45.3%) in a sample of 2,210 adolescents aged from 11 to 19, and subsequently observes the willingness of the subjects to self-disclose self-harming behaviour in a sample subset of 1,002 self-harming adolescents (mean age = 15.37; 68.6% female). 55.2% of self-harmers were willing to provide data on this topic; and only 51.5% of them stated that they had disclosed their self-harming behaviour to someone else, most frequently to their peer(s) (80.0%). Female subjects disclosed this information significantly more often than men ($p = 0.000$) and were significantly more willing ($p = 0.025$) to provide data about their behaviour in this area. There were no age specificities observed in the self-disclosure by self-harming adolescents. The analysis of the results suggests a need to provide the target group of adolescents with information regarding the help available to self-harming individuals as well as a need of further scientific observation of possible barriers, facilitators or interventional (e.g. personality-related) variables.

Keywords: *self-harm, adolescence, self-disclosure, peers, age, gender;*

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1. Introduction

Adolescence is a complex transitory developmental period between childhood and adulthood. The achievement of important developmental stages - e.g. biological and sexual maturation; the development of a personal identity; the development of intimate sexual relationships with an appropriate peer; the establishment of independence and autonomy in the context of the sociocultural environment (Christie & Viner, 2005) - in our postmodern society is even more difficult. Adolescents are forced to search for their own identity, to find their place in the world, to adopt positions and find their values in an era that Zygmunt Bauman called “liquid modernity” (Bauman, 2000). A reality in which the transitory is considered to be more valuable in life than the permanent, the immediate more valuable than the long term; and considers utility to take primacy over any other value (Palese, 2013), only provides adolescents with a few cues and pillars with which they are able to build their presence and future. Young people lack certainty and clear-cut positions which could define them, so they have to pilot their way through this critical period in life alone and, given the plurality of opinions and ambiguity of attitudes, in a considerably more difficult way.

Another pitfall of present-day society is the absence of a stable family environment, which has been the primary source for socialisation and certainty, especially during childhood and adolescence (Craigie et al., 2012; Goldberg & Carlson, 2014). On average across the OECD (Organisation for Economic Co-operation and Development) countries, 41% of births occur outside of marriage (OECD Family Database, 2000). Moreover, statistics show that the mean divorce rate in EU countries (data from 2016) is as high as 44% (PORDATA, 2020). This means that the majority of adolescents do not grow up in families with both of their biological parents – they are either brought up in single-parent families or with a step-parent or step-siblings and quite often in families that are not fully functional. Studies have shown that family instability is a consistent predictor of higher levels of behavioural problems in children or that multi-partner fertility is robustly related to delinquency and problems at school (Fomby & Osborne, 2017; Mickova, 2019). Even when a new family unit is official established through marriage, the presence of a non-biological parent causes adaptation and developmental difficulties (Hubinska & Doktorova, 2019).

Finally, it is necessary to emphasise the increasing degree of online activity in the lives of adolescents. On one hand, it is a natural development that results from our co-existence with modern technologies; but on the

other, virtual reality has its limits and restrictions, and it is not able to replace certain aspects that come from the physical presence of another person. Thus, adolescents lose the opportunity to form close relationships with others, to foster bonds and relationships based on shared experiences, to feel the physical presence of another person. All these aspects exacerbate feelings of loneliness, deprive adolescents of the personal contact that may provide social support when dealing with life's problems, it may also complicate the process of the formation of mature relationships in young adulthood. Research has also shown that online social networking is closely associated with mental distress, self-harming behaviour and suicidal tendencies (Abi-Jaoude et al., 2020) in addition to several other psychiatric disorders, including depressive symptoms, anxiety, and low self-esteem among young people (Pantic, 2014). High level of smartphone use and media multitasking results in chronic sleep deprivation and may have negative effects on cognitive control, academic performance, socio-emotional performance (Abi-Jaoude et al., 2020) and relates alcohol use and smoking (Rojkova & Mydlova, 2019). Another non-trivial problem is that children are becoming addicted to modern, immaterial (or "technological") things – to the Internet, social media, smartphones, computer games and many others (Carbonell et al., 2018).

The above-mentioned lead to an increase in the problems experienced by the present-day adolescent population, most critically mental health issues. It is not merely an acute problem, which might disappear after reaching adulthood and after the end of the complex developmental processes of adolescence – many mental health problems that emerge in late childhood and early adolescence and contribute to the burden of disorders and also later in life (Das et al., 2016). Statistics claim that as many as three-quarters of psychiatric disorders found in adults emerge before the age of 25 (Mitchell et al., 2017).

2. Literature Review

In the context of the specific changes in modern society, which results in the existence of a more complicated set of circumstances for the healthy mental development of youths, it is obvious that taking care of the mental health of adolescents is crucial. A timely and appropriate intervention may not only significantly improve the quality of life of adolescents, but also contribute to good mental health in adulthood. A review of literature related to mental health interventions in the adolescent population clearly shows that these interventions are mostly carried out within schools (31.5%),

individual-/family-based (31.5%), followed by digital platforms (21%), and community-based (15%) (Wasserman et al., 2005). Yet, at the same time, young people are the least likely to receive care for mental health problems (Alonso et al., 2004). The question is why mental care is so rare when the importance of treatment is so high. There are several reasons - for a review, see e.g. Bruwer et al. (2011), Wakida et al. (2018) -; however, the key and primary reason is the individual's willingness to disclose the problem to others.

One of the mental health problems found in adolescents today is self-harming behaviour. Although it is not an entirely new type of high-risk behaviour, its prevalence in the population has risen alarmingly (studies report up to 25.6% – Plener et al. (2009); 45% – Démuthová and Démuth (2020); 47% – Dyl (2008); 69% – Hallab and Covic (2010)). It is reported that this behaviour is a reaction to demands from others and of modern society, the consequence of the low self-esteem of adolescents or of deficits in their socio-emotional abilities (Forrester et al., 2017; Wolff et al., 2013; Zolkowitz et al., 2017). It functions as a maladaptive strategy to cope with stress (Andover, 2012), especially in those individuals who have not developed efficient adaptive strategies. Self-harming behaviour is reinforced on a rich network of virtual platforms which promote and glorify self-harm (Lewis et al., 2011). Research analyses have shown that higher amounts of time spent on social networking websites leads to higher levels of psychological distress, poor mental health, and an increased level of suicidal ideation. It also promotes self-harming behaviour and suicidal thoughts in vulnerable adolescents (Memon et al., 2018). Once this behaviour becomes a habit as a consequence of extremely strong reinforcement (intense relief from distress after self-harm), self-harm exhibits the strong characteristics of an addiction (Blasco-Fontecilla et al., 2016).

Psychology is still putting a very high level of work into the definition of this high-risk behaviour; however, no agreement has yet been reached. For example, the fifth revision of the Diagnostic and Statistical Manual of Mental Disorders defines “Nonsuicidal Self-Injury (NSSI)” as “in the last year, the individual has, on five or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent)” (DSM-5, 2013, p. 803). The International Statistical Classification of Diseases and Related Health Problems (ICD-10), the classification system published by the World Health Organization, defines “intentional self-harm” as dozens of

forms of behaviour (see parts X60 – X84) including suicide and attempted suicide (ICD-10, 2019). However, the common features lie in the intent of the behaviour, the primary purpose of which is to induce pain (physical, mental, emotional etc.), as a reaction to a poorly handled mental burden.

The level of risk of self-harming behaviour is high in adolescents. Adolescents often perform serious self-injury, expose themselves to significant health risks and tend to repeat this behaviour. It then becomes addictive. In addition, self-harm is often associated with high occurrence levels of other mental disorders - e.g. depression (Knorr et al., 2016; Zubrick et al., 2017) - or a high-risk attempted suicide (Mitchell & Dennis, 2006; Peterson et al., 2008). Self-harming behaviour is frequently described as a “gateway” to suicide (Whitlock et al., 2013). Suicide itself accounts for 9.1% of deaths in the 15- to 19-year age group and is ranked as the third major cause of mortality in this age group (Wasserman et al., 2005). Another non-negligible problem is that self-harming is a maladaptive strategy for coping with a burden, and as such, this behaviour does not resolve the problems that triggered it, quite the opposite, it contributes to those problems. It is clear that timely help and professional intervention is pivotal to cope with self-harming behaviour in such cases.

However, professionals report that many self-harming adolescents keep their self-harming behaviour secret and are very unlikely to self-disclose, which substantially complicates the possibility to provide help. This phenomenon is known as help negation (Thomas et al., 2013) and represents the behavioural refusal or avoidance of obtaining and engaging with the available help (Wilson & Deane, 2001). An individual’s tendency and desire to conceal personal information predicts one’s help-seeking intent (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995). Self-disclosure is a process whereby a person verbally reveals private feelings, thoughts, beliefs, or attitudes to another person (Derlega et al., 1993; Leaper et al., 1995). It is, therefore, a first step towards help, which is often abandoned within the group of self-harming adolescents. Another important factor is the person to which adolescents self-disclose – research shows that disclosure of NSSI to parents may facilitate an informal attempt to seek help, which improves the extent to which they cope and reduces suicidal tendencies, but that disclosure to peers might reduce the perceived level of social support and encourage NSSI in others (Hasking et al., 2015). However, even disclosure to peers may bring positive results, as they may receive advice from others (parents, siblings or professionals who they tell further on) and pass this back to their self-harming friends.

3. Methodology

3.1 Objectives

Self-disclosure is a key step towards seeking help with self-harming behaviour. The objective of the study is to reveal:

- the amount of self-disclosure in self-harming adolescents;
- the gender and age differences in the willingness to self-disclose;
- the categories of the people to who self-harming adolescents disclose their self-harming behaviour;
- the possible differences in the extent of self-harming behaviour in terms of the likelihood of self-disclosure.

3.2 Data collection

The data was collected during 2018 and 2019 using a questionnaire that contained three major areas:

- basic demographic and personal data (age, sex);
- a modified Self-Harm Inventory (SHI) (Sansone & Sansone, 2010) that assessed a relatively wide range of forms (20) of self-harming behaviour and provided the extent of the self-harming behaviour. Previous studies (Démuthová & Doktorová, 2018) have confirmed the relatively high internal consistency of this modified questionnaire (Cronbach's $\alpha=0.809$). SHI was also used in order to classify a subject as a member or non-member of the group of self-harming individuals. To be classified as a self-harmer, it was necessary to admit to one form of self-harming behaviour with a frequency of 2 or 3 (sometimes or often), or to admit to several forms of self-harming behaviour with a frequency of 1 (rarely) or above;
- data regarding the self-disclosure of self-harming behaviour.

The data analysis was conducted using the IBM SPSS 22 statistical software. The statistical significance threshold (α) in each data analysis was set to 0.05.

3.3. Sample

The data collection was conducted during school hours at primary and secondary schools, with the consent of the subjects or their guardians. 2,210 adolescents participated in the study, with 1,002 (45.3%) of them being placed in the group self-harming adolescents based on the criteria set out above. The analysis was only carried out on the latter group which

comprised 687 (68.6%) female and 315 (31.4%) male subjects with a mean age of 15.37 years (SD = 1.56).

4. Results

Of the total number of 1,002 self-harming adolescents, only 55.2% (N=553) were willing to say whether they had disclosed their self-harming behaviour to anyone. An analysis of the responses is presented in Figure 1.

Figure 1. Data on the disclosure by adolescents of their self-harming behaviour to others

Source: Authors' own conception

Figure 1 reveals several facts: 1/ although the subjects responded to questions regarding self-harm and admitted it, 44.8% chose not to provide information regarding self-disclosure; 2/ only 51.5% of those who responded to the question on self-disclosure were willing to disclose their self-harming behaviour to someone; 3/ and even within this group, a large proportion of the subjects (28.1%) refused to specify who they had informed. It is clear that there is a substantial degree of unwillingness among self-harmers to disclose information on their self-harming behaviour. Where self-disclosure happened, in the vast majority of cases the recipients of this information were (80.0%) peer/s (friend/s or classmate/s), followed by parent/s (14.6%) and specialist/s (2.9%), who were either psychologists or doctors. The preference to disclose to peers over other groups was confirmed by the statistical significance of the distribution differences in the

prevalence of individual recipient groups (Chi-Square = 1,242.009; $p = 0.000$).

Based on the analysis of self-disclosure and sex, it is apparent (Table 1) that the female subjects more frequently disclose their self-harming behaviour to others than do males. This difference is statistically significant (Pearson Chi-Square = 13.728; $p = 0.000$). Similar tendencies are observed in their willingness to reveal who they have self-disclose to – while 74.6% of female subjects provided this information (i.e. they specified to who they disclosed self-harm), in male subjects, the prevalence was significantly lower (59.2%) (Pearson Chi-Square = 4.761; $p = 0.025$).

Table 1. Self-disclosure by gender (column %)

Self-disclosure	Gender	
	Male	Female
Hasn't told anybody	62.6	44.1
Has told somebody	37.4	55.9

Source: Authors' own conception

A comparison of the age structure of those individuals who have self-disclosed to someone (mean rank = 288.43 years) and those who have not (mean rank = 264.85 years) using the Mann-Whitney U-test (significance of the Shapiro-Wilk normality test for age = 0.000) did not reveal any significant differences ($U = 34,933.5$; $p = 0.077$). Age did not also play any role in whether adolescents disclose self-harming behaviour to anyone ($U = 7,436$; $p = 0.213$).

Table 2. Mann-Whitney U-test for the extent of self-harming behaviour between two groups regarding self-disclosure

Self-disclosure	Extent of the self-harm			
	N	Mean Rank	U	p
Hasn't told anybody	268	247.63	30.318	0.000
Has told somebody	285	304.62		

Source: Authors' own conception

The results of the Mann-Whitney U-test, observing the differences in the extent of self-harm among individuals who have disclosed their self-harm and those who have not, show (see Table 2) that those individuals who have disclosed self-harm to someone suffer from self-harm to a significantly higher extent than those who have not disclosed self-harm. However, no such difference in the extent of their self-harming behaviour is present (Mann-Whitney U-test $p = 0.911$) between those individuals who have disclosed self-harm to someone ($N = 80$; Mean Rank = 143.87) but did not state to whom they had disclosed and those who were willing to specify who they had disclosed to ($N = 285$; mean Rank = 142.66).

5. Discussion

Seeking help when experiencing mental health problems is a pivotal and inevitable prerequisite for the initiation of any intervention. It is based on the willingness of an individual to disclose information on their problems and behaviour. Self-disclosure is thus an important element in the provision of help to individuals who are suffering from mental health problems. The findings of the research make it clear that the topic of self-disclosure is highly taboo. Although a relatively high proportion of adolescents admitted to self-harm (a prevalence of 45.3%, which corresponds with the findings of e.g. Dyl (2008) with a prevalence of 47%), as many as 44.8% did not answer the question regarding whether they had disclosed their problems to anyone.

Without specific research focusing on the reasons why adolescents refused to provide an answer to this specific question, it is very difficult to interpret this finding; however, it is possible to discuss the possible causes. It may be caused by an effort to protect the friends or family to whom the adolescent has self-disclosed, considering that after disclosure, these individuals may be considered to be partially responsible for the individual's behaviour. If they would not disclose this information further to relevant individuals (who may help the adolescent), they could be considered to have indirectly contributed to his/her further self-harm. Adolescents mostly choose their peers (see results in Figure 1), and not those (e.g. parents or experts) who could disclose this information to a specialist or directly provide help. It is "entrustment" rather than a real attempt to seek help. Thus, it is possible that the unwillingness to reveal whether and to whom self-disclosure was made stems from the overall mindset of the individual, who would rather harm themselves than those around them. This mindset is considered to be a typical feature of self-harming behaviour – in its essence, it involves the reversal of aggression towards oneself, without outwardly

venting it. High levels of aggression turned out to be linked to the tendency to engage in NSSI (Haavisto et al., 2005; Tang et al., 2013). This interpretation is confirmed by other data obtained from adolescents who were willing to admit to self-harming behaviour and answer the question of whether they had disclosed their self-harming behaviour to anyone, 28% of respondents refused to state who they had informed. This reveals that although a large proportion of self-harming adolescents are willing to admit to self-harm under the condition of anonymity (which is demonstrated in the relatively high prevalence indicated in the questionnaire by the subjects themselves), this topic is still strongly taboo in discussions. The adolescents themselves described their self-harming behaviour as private, inwardly focused, often with a reluctance to disclose and seek help. They are afraid of the response they might get from others and self-harm discovered by others is often viewed as a negative experience (Klineberg et al., 2013). In any case, it would be beneficial to carry out some targeted research that focuses on the reasons why adolescents are unwilling to disclose who they have told about their self-harm despite their willingness to talk about it.

Problems with communicating self-harming behaviour are also confirmed by other important research findings – as many as 48.5% of self-harming adolescents (who provided information regarding self-disclosure) have not disclosed their self-harming behaviour to anyone. Worrying about the reaction of others may be just one of the numerous reasons for keeping this high-risk behaviour secret. It is not rare for people to see counselling as a last resort, one that should be considered only after all the other options for support have been exhausted (Vogel & Wester, 2003). In this context, Gulliver et al. (2010) conducted a systematic review of the perceived barriers or facilitators for adolescents to seek help for their mental health issues. They identified thirteen barriers (e.g. stigma and embarrassment, poor mental health literacy, a preference for self-reliance) and eight facilitators (positive past experiences in seeking help, social support, encouragement from others, confidentiality and trust in the provider). The fact that there may be many barriers that prevent the search for help or facilitators that enable it should motivate further research that focuses on the analysis of what prevents self-harming adolescents from disclosing their problem or, on the other hand, what initiates self-disclosure.

An analysis of the categories of individuals to whom self-harming adolescents self-disclose shows an unambiguous preference for peers (80.0%). The dominance of friends and classmates was anticipated – during adolescence, it is peers who are an important referential social group (Weinstein et al., 2006). However, to find such a low percentage of self-

disclosure to parents and experts raises several questions. Is self-disclosure (especially if aimed at peers) truly motivated by a search for help? Young people cannot possess the skills or knowledge required to provide effective help and professional intervention to the self-harmer. It remains uncertain whether adolescents truly expect that the disclosure of their problems to others will truly bring them help or if they are motivated by something else. For example, relief from the pressure caused by the tendency to hide and conceal their behaviour, hence they choose those individuals, who are highly unlikely to further disclose this information. Another possible motive (excluding help-seeking) could be an effort to obtain respect, admiration, pity or attention. It appears that many (especially online) peer groups work as support groups, but not helping the adolescent to stop self-harming but, quite the opposite, as support for such behaviour - for the psychological mechanisms of such effects see e.g. Prinstein et al. (2010). In any case, some adolescents approach this information responsibly and further disclose – our additional analyses revealed that 45.5% adolescents who know that someone is self-harming have communicated this to a third party, 40% of the third parties being adults (as opposed to 18.5% among self-harmers). Clearly, peers can be a vital and important element in providing help to self-harmers. The attention that is paid to the possible provision of help should also be aimed at them. It would be an opportunity to address not only the self-harmers but also their peers, who may subsequently play a major role in the provision of help by adults.

Cross-gender differences in self-disclosure of self-harm may stem from the general tendency of the female gender to disclose their problems to others more willingly (Valkenburg et al., 2011). The difference is even more striking in situations where it is possible to disclose such problems to a person known to the individual (Dindia & Allen, 1992). The higher prevalence of self-disclosure in females can be also seen in the context of the data about the prevalence of self-harm in the individual sexes. Previous studies have shown (Démuthová & Démuth, 2019) that the occurrence of self-harm is statistically significantly higher in women. However, this occurrence was reported by the subjects themselves, and so it is possible that the prevalence is higher for the female gender due to a generally greater willingness to admit self-harming behaviour, which may result in a greater degree of willingness to disclose to a specific person and furthermore to state to whom they disclosed their problems in an anonymous study. It is equally possible that other variables also played an important role in our study sample. It would be beneficial to observe the personality traits of the respondents (e.g. open-mindedness and extroversion) and their effect on

willingness to self-disclose. These and other ideas may inspire further research.

A tendency to self-disclose may be counter-intuitive when considering age. On one hand, young children are more likely to seek social support and self-disclose, as their ability to independently solve problems, without external help, is lower than when they are older. Older adolescents are more independent and are able to mask their self-harm in a more sophisticated way. On the other hand, creating and building peer relationships and social support grows with age – older adolescents have a more reliable and wider social support network than younger individuals. Therefore, it is not surprising that the age of the self-harming adolescents did not turn out to be an unambiguous barrier in the willingness to self-disclose. Gender may also be involved in this correlation – e.g. Valkenburg et al. (2011) - stated that, for girls, self-disclosure increased sharply during pre- (10-11 years) and early adolescence (12-13 years), and then stabilized in middle and late adolescence, while for boys, the same trajectory was found although the increase in self-disclosure started 2 years later. The correlation between age and willingness to self-disclose self-harming behaviour is clearly not so simple; it is necessary to study it further and in a more complex way in combination with other relevant variables.

6. Limitations of the Study

As already mentioned above, the interpretation of the findings is limited by the absence of the reasons why adolescents are unwilling to disclose information about self-harm to others. The explanations for this phenomenon and effective intervention differ significantly: for example, an unwillingness to disclose such information may result from the self-harmer's wish to continue to self-harm and they expect others, if they knew, to intervene; however, it might also stem from a fear of being judged by others as well as the lack of someone close enough to who they could self-disclose. Thus, the results highlight that the study lacks an insight into the motivation and reasons for an unwillingness to disclose self-harm to others.

This lack of insight into the motivation even occurs in cases when the risky behaviour was disclosed. Since 80% of self-harmers disclosed their behaviour to peers, it is worth asking whether and to what extent it was actually self-disclosure (and thus a strategy for finding social support), or to what extent it was just a means to gain attention/admiration or to garner support for further self-harm. It appears that the peer environment (through social modelling/learning) may be an important variable in increasing the

risk of the initial engagement and then maintenance of self-harm in adolescents (Claes et al., 2004; Zhu et al., 2016). In this context, it may also be beneficial to observe whether self-harming individuals self-disclosed in on-line or off-line settings. It is possible that the above-mentioned circumstances are related – the motivation for self-disclosure (help vs. reinforcement of behaviour) may have an impact on the selection of the environment (off-line vs. on-line) for self-disclosure.

Another limitation in the study and at the same time a subject for further research is the analysis of the personality traits of adolescents in terms of their willingness to self-disclose. It is evident that tendencies to search for social support and the willingness to disclose sensitive information may be closely linked to characteristics such as introversion/extraversion, neuroticism or even openness. Capturing these personality characteristics may lead to a better understanding of the problem, reveal deeper correlations, and enable a higher quality of interpretation. Finally, it may be beneficial to examine the specificities of this issue in male subjects, as the representation of male subjects in the study sample was only minimal.

7. Conclusions

The willingness of self-harming adolescents to disclose this high-risk behaviour to others is very low. Yet, communicating problems is a key and unavoidable prerequisite for the initiation of help and intervention. The study showed that if adolescents disclose this behaviour to someone, it is mostly to their peers. Although their peers are usually unable to provide help, they may be an effective intermediary – almost half of them pass this information on despite its delicate nature. In the context of the findings, an application of the outputs of the research could be aimed at increasing the awareness of the potential sources of professional help among adolescents, or of the measures to take in cases of self-harming behaviour. The effect of interventions aimed at this target group would be enhanced by the fact that in addition to the peers of self-harming adolescents, it would also be directly aimed at the self-harmers. In addition, the results of this study have pointed to the need for further exploration of the perceived barriers and facilitators in seeking out help for mental health issues as well as research into other (e.g. Personality-related) characteristics that are involved in the complex decision process of whether or not to self-disclose.

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