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VRIJE UNIVERSITEIT BRUSSEL

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Summary Master thesis

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Title: Differential interpretations of confidentiality when working with minors.

Promotor: Prof. Peter Theuns

Summary:

Non-suicidal self-harm (NSSI) is a sensitive issue that is mostly prevalent amongst adolescents, with life-time prevalence rates up to 20% in adolescence that scale down towards approximately 5% at later stages in life. But even though the prevalence rates are substantially high, help-seeking behaviour is remarkably low, with generally less than half of those engaging in NSSI searching for help. One of the main obstacles that has been identified are concerns regarding confidentiality and secrecy. An obvious solution would be to promise to never disclose any of the information said in therapy. Unfortunately, when working with NSSI absolute confidentiality cannot be promised, because of its harmful nature and association with suicidal behaviours. Nevertheless, this does not imply that healthcare professionals would easily reveal any information that was confided to them in confidence. We predicted that the general public may overestimate how quickly healthcare professionals would release confidential information and tested this by conducting an online survey about several situations concerning self-harming adolescents. Participants were asked to indicate how strongly they would be inclined to breach confidentiality. We found that people generally tended to guard confidentiality more strongly when the adolescent was younger, as well as when the therapist relied on only a strong suspicion. Next, scores between the general public and healthcare officials were compared, with no obvious differences being found. Furthermore, we observed scores ranging from low to high, showing the absence of an unanimous approach. Even though each case and each therapist will differ, finding more of a consensus and offering assurances of confidentiality to a certain degree may help lighten concerns and bring more people engaging in NSSI into care. This study should however mainly be seen as explorative. Nonetheless, its results may show the need for further research on the subject.

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Table of contents

Introduction

Recent research has shown that approximately 1 in 6 adolescents engages in self-harming behaviours during the span of their life (Baetens, Muehlenkamp, Grietens, & Onghena, 2011; Berk, Avina and Clarke, 2020), and that this percentage may only be on the rise (Muehlenkamp & Gutierrez, 2004, 2007; Wester, Trepal and King, 2018). Yet, despite these high prevalence rates, only about half of those engaging in self-harm search for help (Favazza and Conterio, 1989; Rowe et al., 2014; Whitlock et al., 2006). Since secrecy and stigmatization are amongst the main concerns adolescents express when searching for help (Fortune and Hawton, 2008a; Klineberg, Kelly, Stansfeld and Bhui, 2013), the promise of absolute confidentiality would seem to be the perfect solution. This can however not be done, given the risks associated with self-harm. But the fact that absolute safeguarding of professional confidentiality cannot be promised should not mean that healthcare professionals would therefore disclose information quickly or easily. However, so far there has been little research into at what point confidentiality is expected to be breached.

Professional Confidentiality

Medical and mental healthcare services often require sensitive information which patients may be hesitant to provide. Therefore, to encourage patients to comfortably enclose any important information and to establish the foundation of trust between caregiver and patient, privacy and personal data have been legally protected within modern society (Herlihy & Corey, 1996). This legal and societal protection can be found in the constitution[1], the law of 1992[2] and more recently in the European regulation of 2018[3]. This necessity however is not merely a modern demand. Moral objections towards disclosing secrets can already be found in the bible (De Spiegeleire, 2010) and an early implicit reference to secrecy in professional healthcare can be found in the Hippocratic Oath:

> *"… And whatsoever I shall see or hear in the course of my profession, as well as outside my*

[1] Art. 22 van de Belgische Grondwet

[2] *Wet van 8 december 1992 voor de bescherming van de persoonlijke levenssfeer ten opzichte van de verwerking van persoonsgegevens*.

[3] *General Data Protection Regulation (GDPR.)*

profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets (Hippocrates, 5th century B.C.).”

Presently, professional confidentiality is enforced and protected by the criminal code originating from 1867. As stated in the criminal code, confidentiality applies to ‘*all individuals that hold knowledge of secrets that were entrusted to them on account of their status or profession*’[4], also including interns, volunteers or individuals occupying religious functions (Desmet, 2014). This relates to all information that can be classified as being ‘confidential’ and covers all information either belonging to private settings or information that was implicitly or explicitly described as ‘confidential’ by the client (Berghmans, 2014). It may be important to note here that anonymous information does not fall under professional secrecy (Versweyvelt, Put, & Opgenhaffen, 2018). Anonymity means that the person in question cannot be recognized, because important personal information has been changed or removed from the story.

Exceptions to Professional Confidentiality

Even the law itself, and more specifically article 458bis and 458ter of the criminal code, already states that professional confidentiality cannot be regarded as absolute. There exist certain situations in which someone is legally allowed to breach confidentiality.

Criminal Offence

A first example would be when a crime has been committed. In this case healthcare professionals have the right, but not the obligation, to provide information. This however only includes information relevant to the particular legal dispute (Wouters, Herbots, & Put, 2009). Examples of these situations would be a client admitting to breaking the law or to being the victim of a crime; or healthcare professionals having to defend themselves and/or having to testify in court.

[4] Art. 458 SW.

Permission From the Client

It is common practice for healthcare professionals to discuss the idea of breaching confidentiality with the client before sharing information with other parties. In some cases a client might explicitly ask the healthcare professional to share information with certain people, for example other caregivers or representatives of legal institutions. This once again does not mean that healthcare professionals are obligated to share this information. Sometimes clients might ask certain information to be disclosed because they believe it will benefit them, for instance in legal disputes. If the client decides to allow a breach in confidentiality or if healthcare professionals decide to grant the request of their client for information to be shared, the client has to be informed about exactly which information would be disclosed (Berghmans, 2014).

State of Emergency

Another important situation is the state of emergency, which applies when the situation meets certain requirements. Firstly, there needs to be imminent and actual danger. This entails that the state of emergency does not apply to events in the past or distant future. Secondly, it is important that the values protected by the breaching of professional secrecy are of equal or higher significance than confidentiality itself, such as protecting someone's physical and/or sexual integrity for example. Finally, there must be no other way to successfully prevent the threat than to disclose confidential information to other parties (Desmet, 2014).

Guilty Neglect

Any member of society has the legal and moral obligation to help another person in grave danger. Whenever someone fails or refuses to do so, they could be considered guilty of neglect, provided that it would not have put them at risk themselves. Guilty neglect is considered punishable by the criminal code[5] and carries in itself an obligation to breach confidentiality, given that there is no other way to protect the client (Wouters et al., 2009).

It is important to stress however that these situations do not at all render professional confidentiality obsolete. It only ensures that breaching confidentiality is no longer legally

[5] Art 422bis SW

punishable. Health care professionals in these cases are allowed to report a crime or release entrusted information, but are not obligated to do so. They can always choose to undertake a different action, as long as they do not guilty themselves of neglect. It is also important to emphasize that only information relevant to the specific situation can be shared. Disclosing any other kind of confidential information would still be legally punishable.

However, these situations are often very open to interpretation and based on a personal assessment by the healthcare professionals. They must decide whether a situation requires confidentiality to be breached, but could be found guilty of neglect afterwards if someone was harmed because they wrongly decided not to share important information.

Confidentiality When Working With Minors

Working with underage clients is another area in which the approach of confidentiality can vary depending on the situation. In 2006 the 'Decree Legal Status of the Minor in the Integral Youth Care'[6] took effect. This decree aimed at clarifying and solidifying the rights of underage clients, seeing as their legal position within professional healthcare had been strongly fragmented. The motion lawfully captured the rights of underage clients regarding decision-making and the participation in their care. The key element that decides their degree of independence and autonomy consists of the competence of the minor. This concept is mainly based on answering the question: 'to what extent is an underage client capable of exercising their own rights and independently making decisions regarding their treatment within professional youth care?'

Above-mentioned decree attempts to answer this question by applying both an objective criterion, more specifically a minimal age of 12 years old, and a subjective measure, being the estimated maturity of the underage client[6]. The legal motion therefore considers minors who meet these criteria as being capable of making complex judgements about their own rights, interests and caregiving. Explicitly this means that professional secrecy regarding minors who fulfil the previously mentioned criteria works in the same way as confidentiality regarding adult clients.

To summarize, minors aged 12 years or older that are judged as capable of making responsible decisions in favour of their own wellbeing will have the same above-mentioned rights of confidentiality. The patients' rights of minors younger than 12 years old or minors that meet the

[6] Decreet van 7 mei 2004 over de rechtspositie minderjarige in de integrale jeugdhulp.

objective criterion, but not the subjective, will be exercised by the parents or legal guardians[7]. With regards to confidentiality, this means that an informed consent is needed before starting treatment and that the parents or legal guardians also gain the right to information about this treatment. Concretely, this concerns information about the current state of health of the minor and its expected evolution[8].

Above-described approach to confidentiality might seem like an all-or-nothing perspective, but it is not and should not be implemented as such, because the participation of the minor changes according to the evaluation of competence. For example, a minor who is ultimately judged as incapable of making completely independent decisions about their own care, can still be seen as competent to a certain extent and will be included in the decision-making process. Of course, they will only be included to the extent of their capabilities (D'haese & Put, 2015). Therefore, the cases in which a minor is completely left out and has no say whatsoever should be very rare. This way, it is even possible for minors under 12 years old to be included or even make their own decisions if judged as competent enough, although this is rather exceptional.

Definition of Self-Harm

The act of harming one's own body is a complex behaviour that has been given several names: self-injury, self-harm, self-mutilation, self-inflicted violence and self-cutting, among others (Sutton, 2007). The International Society for the Study of Self-Injury (ISSS) describes non-suicidal self-injury (NSSI) as:

'*the deliberate, self-inflicted damage of body tissue without suicidal intent and for purposes not socially or culturally sanctioned*' (International Society for the Study of Self-injury, 2018, Fast Facts section).

There are several important factors to be highlighted in the above-mentioned definition. Firstly, note that harm is conceptualized in the definition as physical harm. Secondly, the definition characterizes the harm as being deliberate. Thus, reckless or dangerous behaviour resulting in injury generally does not fall under self-harm. Other behaviours that might seriously hurt the body

[7] Art. 12 WPR
[8] Art. 7 WPR

but lack the direct intention for doing so, such as for example extreme diets, are normally excluded as well. A third important element of the definition is that the damage to the body cannot be culturally or socially accepted, as would be the case for tattoos or piercings, amongst others.

Furthermore, the American Psychiatric Association's (2013) Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5) includes the Non-Suicidal Self-Injury Disorder (NSSI-D). Because the NSSI-D also mentions most of the above-mentioned information, we shall not fully repeat it here. However, its definition and criteria can be found in the appendices. Important additions made by the DSM-5 definition are the frequency of the behaviour, which has been decided on at least 5 days during the last year, and its motivation, such as resolving interpersonal difficulties or negative emotions for example. The definition also mentions a certain mental preoccupation and urge associated with the self-harming behaviour. It is important to note that the disorder still requires more research and that the current criteria are still being evaluated (Luyckx et al., 2020). Zetterqvist, Lundh, Dahlström and Svedin (2013) for example suggested the frequency in criterion A to be too low and propose to raise it to a minimum of 10 times during the last year. Of course, this would also impact the prevalence of NSSI-D within the general population. The reasoning behind this proposition is that the frequency in clinical settings is usually far higher. Seeing as close to every person engaging in NSSI meets at least one subdivision of the criteria, regardless of whether they can be diagnosed with the disorder or not (Brausch, Muehlenkamp, & Washburn, 2016), the clinical relevance of criteria B and C has been called into question as well (Luyckx et al., 2020). Lastly, the required impairment of daily life or significant suffering needed in criterion E has been found difficult to assess (Wilkinson and Goodyer, 2011; Zetterqvist, 2015). People engaging in NSSI often experience the act as a form of relief and tend to see it as a way to resolve distress, rather than an impairment. Wilkinson and Goodyer (2011) proposed rewording the criterion and suggested that NSSI should not be seen as the cause of significant distress in daily life, but rather as a related factor to it. Given these remarks it would seem fair to say that the current conceptualization of the non-suicidal self-injury disorder still requires more evaluation and fine-tuning.

Characteristics of Self-Harm

Prevalence

Self-harm or NSSI is a universal phenomenon: people of all ages and genders across all ethnicities, social classes and cultures show self-harming behaviours (International Society for the Study of Self-injury, 2018). Several studies have found that an important at-risk population amongst those engaging in NSSI are adolescents. It is during this phase of life that self-harming behaviours usually start, given that the age of onset of NSSI most commonly lies between 12 to 16 years of age (Claes, 2012; Ghandi et al., 2018; International Society for the Study of Self-injury, 2018). Furthermore, studies agree that the prevalence of NSSI is highest in adolescence and young adulthood: Claes (2007) stated that 90 percent of all events of self-harm occur during puberty and Nock (2010) equally supported the claim that NSSI is significantly more prevalent during adolescence. A study regarding Flemish adolescents estimated their lifetime prevalence rates of NSSI to lie somewhere between 13 to 23.2 percent (Baetens et al., 2011), whilst a meta-analysis by Fliege, Lee, Grimm and Klapp (2009) even goes as far as to indicate these numbers to range from 13 to 35 percent amongst school and college students. A more recent meta-analysis conducted by Berk et al. (2020) has found lifetime prevalence rates in non-clinical populations of 17.2 percent for adolescents, 13.4 percent for young adults and 5.5 percent for adults.

And rates of NSSI may only be increasing. Several studies have reported a potential increase in NSSI behaviours, but it should be noted that these growing numbers are difficult to evaluate, due to studies often using various populations and different methods of self-harm assessment (Jacobson and Gould, 2007). Muehlenkamp and Gutierrez conducted two separate studies (2004, 2007) utilizing the same method within the same high school. They found that the life time prevalence of NSSI behaviour reported by the students had increased from 15.9 percent to 23.2 percent within this 3 year period. Similarly, Wester et al. (2018) found the number of college freshman currently engaging in NSSI to have risen from 2.6 percent in 2008 up to 19.4 percent in 2015.

Although there may be slight differences amongst studies, which might have been caused by methodological variations, it seems safe to say that currently approximately 1 in 6 adolescents engages or will have engaged in self-harming behaviour and that this proportion is increasing (Wachter Morris & Wester, 2020).

Method

There exist various methods by which those engaging in NSSI tend to harm themselves. Most literature agrees that the most common method of self-harm is cutting or carving the skin (Halperin, 2016; Klonsky & Muehlenkamp, 2007; Nock, 2010; Victor et al., 2018) and that this method is predominantly practiced by women (Bresin & Schoenleber, 2015; Halperin, 2016). Other fairly common methods are scratching, hitting and burning one's own body (Klonsky & Muehlenkamp, 2007; Whitlock, Eckenrode, & Silverman, 2006). Additionally, it may be important to note that research has shown that most individuals use several methods of self-harm instead of just one (Gratz, 2001; Whitlock et al., 2006). The most frequent places on the body for the harm to occur are the arms, followed by the legs and stomach (Victor et al., 2018).

Gender

Early research suggested that self-harming behaviours are more strongly prevalent amongst women than men (Graff & Mallin, 1967; Rosenthal, Rinzler, Walsh, & Klausner, 1972). Although these early studies described NSSI as a typically female problem, Swannell, Martin, Page, Hasking and St. John (2014) raised some valid points of critique by noting that most of these early studies almost exclusively focused on cutting as a method of self-harm, which is predominantly more common amongst women, as has been mentioned above. They also brought attention to the fact that these studies focused on clinical populations, in which gender differences are more noticeable and may have been distorted by comorbid disorders that are more frequently diagnosed in female populations, such as borderline personality disorder. Both these factors may have resulted in a misrepresentation of the NSSI population and these early studies quite possibly overlooked a significant proportion of male NSSI.

The above-mentioned study from Swannell et al. (2014) supported earlier studies that similarly stated that there were no significant gender differences to be found (Baetens et al., 2011; Kirchner, Ferrer, Forns, & Zanini, 2011; Muehlenkamp & Gutierrez, 2004). On the other hand, Laye-Ghindu and Schonert-Reich (2005) noticed the prevalence of women engaging in NSSI to be double that of men, although they do remark certain methodological factors that could have influenced the results. The same gender ratio was discovered by Madge et al. (2008) and findings from Portzky, De Wilde and Van Heeringen (2008) equally support this gender difference.

A more recent meta-analysis by Bresin & Schoenleber (2015) compared findings from 122 studies and found that women are significantly more likely to engage in NSSI than men. They also reported these differences to be bigger in clinical samples. According to the results, women are 1.5 times more likely to self-harm than men and this scales up towards 2.25 times in clinical samples, although the authors did state these effect sizes to be rather small for epidemiological studies.

As for now there still remains a lack of consensus in the scientific field to make explicit statements regarding gender differences in prevalence rates of NSSI. It may also be important to note that more and more studies have begun to examine gender differences in NSSI not in terms of prevalence rates, but concerning other characteristics of self-harm, such as coping, frequency and method, amongst others (Andover, Primack, & Gibb, 2010; Victor et al., 2018).

Therapeutic Challenges

Part of the difficulties surrounding the treatment of NSSI is the societal view and the attitude that accompanies it. Research has shown that stigma exists towards mental illness in society (Corrigan, 2000; Monteith & Pettit, 2011; Seeman, Tang, Brown, & Ing, 2016), meaning that the public often has a negative view on mental disorders. People tend to associate several negative attributes with mental illness, such as for example poor physical hygiene (Corrigan, 2000) and violence or danger (Seeman et al., 2016). These explicit or implicit societal beliefs can have detrimental consequences, as studies have shown that it can lead to social isolation, fewer professional opportunities, negative self-beliefs and avoidance of help-seeking, ultimately resulting in poorer well-being and healthcare (Barney, Griffiths, Christensen, & Jorm, 2009; Linz & Sturm, 2013; Rüsch et al., 2014; Stänicke, Haavind, & Gullestad, 2018).

Self-harm or NSSI is not excluded from these stigmatized issues (Burke, Piccirillo, Moore-Berg, Alloy, & Heimberg, 2019). Earlier research has already pointed out that individuals engaging in NSSI often experience negative emotions such as shame and guilt about their self-harm. They also often try to hide the behaviour or avoid searching for help (Whitlock et al., 2006). Furthermore, studies have also found that NSSI is often associated with comorbid mental disorders or emotional difficulties. Researchers suggested that comorbid depressive symptoms and anxiety more commonly present amongst those engaging in NSSI than in normal populations (Muehlenkamp, 2005; Ross & Heath, 2002). In addition, Gollust, Eisenberg & Golberstein (2008) found significantly higher estimated rates of psychopathology in self-harming individuals than compared to those that do not harm themselves. Selby, Bender, Gordon, Nock and Joiner (2012)

provided similar findings and also found higher prevalence of mood swings, conflicts with others, aggression and abuse. Some studies even claim that only 15 to 20 percent of self-harming individuals do not show any comorbid mental disorders (Kiekens et al., 2018; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006).

Lastly, scientific evidence has mentioned that self-harm often carries short-term benefits that negatively reinforce the behaviour (Nock & Prinstein, 2004), but is equally accompanied by long-term effects that are often very detrimental. One advantage of self-harm that is most frequently reported is a regulatory function of emotion (Franklin et al., 2010; Weinberg & Klonsky, 2012). Individuals engaging in NSSI describe an immediate alleviation of negative affect or arousal and a calming effect following the behaviour. Several other potentially helpful functions have been identified as well, such as the regulation of cognitive processing, an anti-dissociative and an anti-suicide function, amongst others (Franklin et al., 2010; Klonsky, 2007; Weinberg & Klonsky, 2012). However, research shows that in the long term NSSI can entail several of the issues mentioned above, such as interpersonal difficulties, social isolation and permanent physical scarring. These scars often negatively influence the self-image of the individual and are experienced as shameful or expected to be stigmatized by others (Lewis, 2016).

Self-Harm and Suicide

Another negative feature of NSSI that we have not yet discussed is its association with suicidal behaviour. Yet, as is already captured in the name, NSSI is not considered as a form a suicidal behaviour. Kahan and Pattison (1984) already early on proposed a clear distinction between deliberate self-harm and suicidal acts. In support of their argument they offered a clinical comparison between both behaviours, stating differences in lethality, frequency, methodology and related thoughts or feelings. Several other authors have explored these factors and have equally reported dissimilarities between both populations (Brausch & Gutierrez, 2010; Lee, 1987; Muehlenkamp, 2005; Sonneborn & Vanstraelen, 1992). For instance, suicidal acts usually show high lethality and low frequency, whereas deliberate self-harm commonly presents more chronically and repetitively, but with low lethality.

Differences in attitudes towards life or death and feelings associated with both behaviours have similarly been discovered. Suicidal acts are obviously strongly focused on ending one's own life. In contrast, deliberate self-harm is rarely accompanied by the intention to die or by suicidal

thoughts (Kahan & Pattison, 1984; Patton et al., 1997; Ribeiro et al., 2016; Simeon & Favazza, 2001), but rather by an expected and desired sense of relief (Muehlenkamp, 2005). In their study, Patton et al. (1997) even found that 94% of participants engaging in NSSI did not report serious intentions to die nor did they consider death a likely outcome of their actions. Furthermore, in the case where self-harming individuals do turn towards suicidal acts, some findings suggest they choose different methods for each of the behaviours (Stanley, Gameroff, Michalsen, & Mann, 2001). In fact, self-harm might even have an anti-suicidal function, as we briefly touched upon earlier. For example, Ross and Mckay (1979) labelled it "counter-intentional to suicide" (p. 15) and Simpson (1980) argued that the behaviour can make a person feel alive and remediate against suicidal thoughts and feelings.

Table 1

Differentiation between Suicidal Acts and NSSI.

Features	**Suicidal acts**	**NSSI**
Intention	To end one's own life	To relieve tension or negative feelings
Chronicity	Low chronicity	Repetitive and chronic
Lethality	High lethality	Low to intermediate lethality
Methods	Usually one method only	Usually multiple methods
Cognitions	Suicidal ideation and thoughts	Very rarely suicidal ideation or thoughts

Note. Adapted from "Self-injurious behavior as a separate clinical syndrome", by Muehlenkamp, J., 2005, *American Journal of Orthopsychiatry*, *75*(2), p. 328.

However, research consistently finds a clear association between suicidal ideation and behaviour on the one hand, and NSSI on the other. For example, Favazza, as well as Kahan and Pattison (as cited in Muehlenkamp & Gutierrez, 2004), discovered that 28 to 41 percent of self-harming individuals eventually report suicidal ideation. Moreover, Muehlenkamp and Gutierrez

(2004) and Whitlock et al. (2006) describe elevated rates of suicidal thoughts or acts amongst NSSI groups compared to non-NSSI populations, whilst other studies identified past self-harm as a risk factor for current suicidal ideation (Brausch & Muehlenkamp, 2007). Hamza, Stewart and Willoughby (2012) reviewed over 30 studies and persistently found results identifying NSSI as a strong predictor of suicidal ideation or acts, as well as a significantly higher chance of suicidal thoughts or attempts amongst individuals engaging in NSSI. They also noted that NSSI predicted suicidal behaviour more strongly than depression, borderline personality disorder, family functioning, hopelessness, post-traumatic stress or child abuse. Furthermore, this higher risk for suicidal behaviour correlates to the severity of the NSSI. One study for example discovered that participants showing moderate NSSI appeared to have twice the risk of suicide attempts, whereas the risk amongst those who harmed themselves severely increased tenfold (Tang et al., 2011).

In conclusion, even though NSSI does not carry any suicidal intent or ideation at the time of the self-harm, research does show individuals engaging in NSSI to be at a significantly higher risk for suicidal thoughts and behaviours. This might seem quite contradictory, especially given the short-term benefits and possibly anti-suicidal function of self-harm, but throughout the last decades several theories have been proposed to explain how both concepts might relate to each other.

Gateway Theory

One possible explanation is that both self-harm and suicide are part of the same behavioural continuum and that suicidal acts are a form of escalation or aggravation. There is ample theoretical support to be found for this idea (Brausch & Gutierrez, 2010; Linehan, 1986; Walsh, 2006), seeing as how NSSI is such a strong risk factor for suicidal acts and findings show that this risk increases with the severity of the self-harming behaviour (Tang et al., 2011; Whitlock, Muehlenkamp, & Eckenrode, 2008). Moreover, it has been discovered that self-harming individuals tend to underestimate the lethality of their actions compared to those engaging in suicidal behaviour, but not in NSSI. They also have higher expectations of being saved if the consequences of their actions would become life-threatening (Stanley et al., 2001).

Theory of Acquired Capability

Another explanation was offered by Joiner (2005). This idea integrates several concepts from habitual learning and conditioning theory. Joiner states that two conditions need to be fulfilled in order for someone to be able to undertake a serious attempt at their own life. Firstly, the individual needs to either experience what Joiner calls 'perceived burdensomeness' (i.e., the feeling of being the cause of hardship to others) or 'thwarted belongingness' (i.e., the feeling that one does not fit into this world). Secondly, they would need to acquire the capability to actually end their own life, since a suicidal act goes against our own deeply rooted instincts of self-preservation. Joiner (2005) suggests that through repeated actions that go against these primal instincts, although in softer forms than suicide, individuals learn to dull and eventually bypass these instincts. Pain, fear or tension surrounding self-injury will diminish as a result of habituation and eventually a person will become capable of severe suicidal behaviour. Joiner's theory strongly overlaps with the above-mentioned Gateway theory, but also integrates other behaviours besides NSSI, such as substance abuse, eating disorders and violent or traumatic experiences. In addition, it also mentions the necessity for feelings of either perceived burdensomeness or thwarted belongingness to be present, which the Gateway theory does not.

Indeed, evidence does exist indicating that NSSI populations feel more competent and courageous about attempting suicide, if they wished to do so (Stanley et al., 2001). Furthermore, studies have shown results suggesting that individuals engaging in NSSI experience significantly less to even close to no pain at all (Nock & Prinstein, 2005; Weinberg & Klonsky, 2012) and Nock et al. (2006) discovered that those who reported experiencing less pain during NSSI also reported more suicide attempts.

Third Variable Theory

It could be possible that the connection between NSSI and suicidal behaviour does not lie in the behaviours themselves, but is explained by a third variable influencing both behaviours. One example is the high prevalence of comorbid psychopathology that can be found with both suicidal behaviour (Cavanagh, Carson, Sharpe, & Lawrie, 2003) and NSSI (Gollust et al., 2008). The third variable theory would argue that the mental disorder incites the NSSI and ultimately the suicide attempts, instead of the NSSI leading to the suicidal behaviour. But this is but one example of many suggested potential third variables. Studies also highlight emotion regulation difficulties in

both self-harming (Gratz & Roemer, 2008) and suicidal (Pisani et al., 2013; Rajappa, Gallagher, & Miranda, 2012) behaviour, as well as higher levels of emotional distress and depressive symptomatology (Henriksson, 1993; O'Connor, Rasmussen, Miles, & Hawton, 2009; Stanley et al., 2001), amongst many other factors.

Integrated theory

Seeing as how these theories share various mutual views and ideas, researchers have since proposed integrated theories combining several concepts from these theories (Hamza et al., 2012). However, a broad unified theory explaining the precise relationship between both NSSI and suicidal behaviour is yet to be constructed. Most likely, given the theoretical support that can be found for each theory, they all hold some part of the truth, but fail to completely capture the complexity of the particular interaction between NSSI and suicidal behaviour. As for now, there is a need for more longitudinal research, which by nature requires time.

Working With NSSI in Under-Aged Clients

In 2012 the World Health Organization (WHO) ranked suicide as the third leading cause of death amongst adolescents. Earlier on we described some of the most important characteristics of NSSI, including the particularly high life time prevalence rates in adolescent populations. In addition, we mentioned that NSSI is a significant risk factor for subsequent suicidal behaviour. Although the precise connection between NSSI and suicide is not yet clear, the fact remains that combatting NSSI could not only help alleviate the associated psychological distress, but could also indirectly reduce suicidal behaviour.

Despite the significant impact of NSSI, research consistently finds low rates of help-seeking behaviour amongst NSSI populations. Favazza and Conterio (1989) reported that close to 40 percent of participants had never searched for help. Whitlock et al. (2006) similarly discovered low rates of help-seeking, even in cases of severe NSSI. Furthermore, in their meta-analysis Rowe et al. (2014) concluded that across 20 studies only one third to half of the participants attempted to seek help.

Obstacles to Help-Seeking

So what exactly keeps these adolescents from reaching out and asking for help? Fortune and Hawton (2008a) identified stigmatization and confidentiality as obstacles to the treatment of self-harm in adolescents. Similarly, a study by Klineberg et al. (2013) reported participants describing NSSI as a private and sensitive matter and admitting to being reluctant to talk about the behaviour. Negative experiences following previous disclosure and fear of labelling or the spreading of rumours were the primary reasons as to why they hesitated, with respect and secrecy being the two aspects they valued and wished for most, if they were to reach out for help. In addition, the previously mentioned scientific review by Rowe et al. (2014) also pointed out several potential barriers that may prevent self-harming adolescents from seeking help. A few of these include the belief that they can or should cope with their issues by themselves, not knowing where to look for support, not perceiving the self-harm as serious enough of a problem, communicational difficulties and fears surrounding the prevention of future self-harming behaviours, stigmatization and confidentiality. Whilst taking a slightly different approach, Jones et al. (2011) researched self-harming individuals that use internet fora to talk about their issues and found results indicating that they preferred it to offline settings. The reasons being that they felt less judged and more reassured about their anonymity, which also lead to them being more open about their self-harm.

It seems fair to say that stigmatization and secrecy play an important role in NSSI and that they may even prevent individuals from receiving the help they need. Simply promising absolute secrecy when treating NSSI seems like it would be the perfect solution to bring more self-harming individuals into treatment and supportive networks.

Limitations of Professional Confidentiality

Unfortunately, absolute secrecy can never be promised, and this is particularly the case when working with minors engaging in NSSI. In an online article directed at caregivers for self-harming adolescents, De Vos (2009) clearly mentioned that there should be no guarantee for secrecy when offering help. Claes (2012) equally stated that assuring complete confidentiality within this specific therapeutic context would most likely be a promise that could never be kept.

There are several reasons as to why this is the case. First of all, because of the associated risk for suicidal ideation and behaviour, it must always remain possible to contact the appropriate healthcare institutions or other necessary third parties in case of escalation. Secondly, even

without any aggravation of the NSSI, studies consistently show that individuals engaging in NSSI underestimate the lethality of their self-harm (Fortune & Hawton, 2008b; Harris & Myers, 1997; Stanley et al., 2001). So it is still quite possible for life-threatening injuries to occur, even in the absence of escalation towards actual suicidal intent. Therefore, anyone offering to help an individual engaging in NSSI can never promise absolute secrecy.

Of course, this does not mean that healthcare professionals would completely disregard their professional confidentiality. As we mentioned before, confidentiality may only be breached in case of an emergency and with no other available options. It may be interesting to explore whether there are differences in expectations between the general public and healthcare professionals, seeing as how studies have shown that participants were unsure about how others could help (Berger, Hasking, & Martin, 2013), nor did they know where to turn for support or what to expect (Fortune et al., 2008b; Klineberg et al., 2013). It may be preferable to first explore informal sources of support, such as friends or family, since they are more commonly approached by self-harming adolescents than professional ones (Rowe et al., 2014).

Hypotheses

Since there is little prior research to be found, this study wishes to explore whether decisions and expectations surrounding breaches of confidentiality differ between healthcare professionals and the general public. We hope that a better understanding of the expectations and decisions of those involved, i.e. both formal and informal sources of help and ultimately the self-harming adolescents themselves, could lead to higher rates of help-seeking.

Because several studies have found adolescents proclaiming concerns surrounding secrecy, we expect the general public to underestimate how strongly healthcare professionals would guard confidentiality. On the other hand, we anticipate healthcare professionals to strongly preserve confidentiality, taking into account the deontological code and their professional training. Thus, we predict healthcare professionals to be significantly less inclined to inform the parents than other participants. Furthermore, since confidentiality regarding minors has an objective age criterion, we also expect that the older the minor in question is, the more strongly confidentiality will be guarded. Finally, given the lack of conclusive consensus within the scientific community, we cannot formulate any theoretical predictions with regards to the influence of the gender of the underage client or the method of discovery.

Method

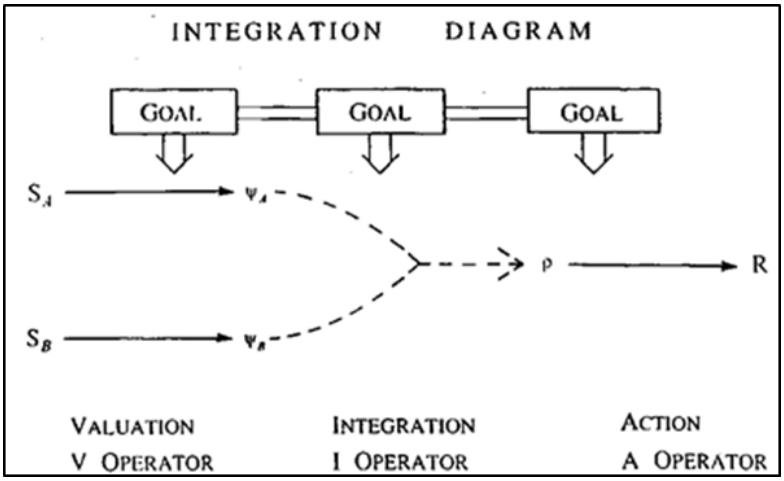
Functional Measurement

This study adopts the Functional Measurement approach, which is part of the Information Integration Theory (IIT) designed by Anderson (1971). The purpose of IIT is to find universal laws explaining how people integrate several factors into one single decision, whilst still paying attention to interpersonal differences (Anderson, 2013). It is not surprising that this method is very applicable to research involving participant's judgements, given that its intention is to explore the integration of information in decision-making processes.

The core elements of the Information Integration Theory consist of (1) the Functional Perspective (2) Cognitive Algebra and (3) Functional Measurement theory (Noble & Shanteau, 1999).

Figure 1

Information Integration Diagram



Note. The external stimuli (S_A and S_B) are transformed in the valuation-process (V) into psychological goal-oriented values Ψ_A and Ψ_B. These internal values are then integrated into a covert response (ρ). This internal response is then externalized into an observable overt response (R). Reprinted from *Information Integration Theory: Unified Psychology based on three mathematical laws* by N. H. Anderson, 2016, *Universitas Psychologica, 15*(3), p. 126. Copyright 2013 by the American Psychology Association.

Figure 1 shows the theoretical view suggested by IIT: the first core element of IIT, namely the Functional Perspective, states that our actions and thoughts are directed towards certain goals. When we produce these thoughts or take action we are all influenced by various stimuli. This is what is called multiple determination. These stimuli receive a value depending on our goals. Thus, a sip of coffee (S_A) may be given a certain value (Ψ_A) through the valuation-process by its taste. Other associated factors, such as the temperature of the drink (S_B) will similarly be given a certain value (Ψ_B). These values are not found in the stimulus itself, but are external and depend on the situation. For example, the taste of coffee with sugar may be valuated more strongly when someone craves a sweet taste. Likewise, the value of hot coffee may be many times greater when it is snowing and the person in question feels very cold.

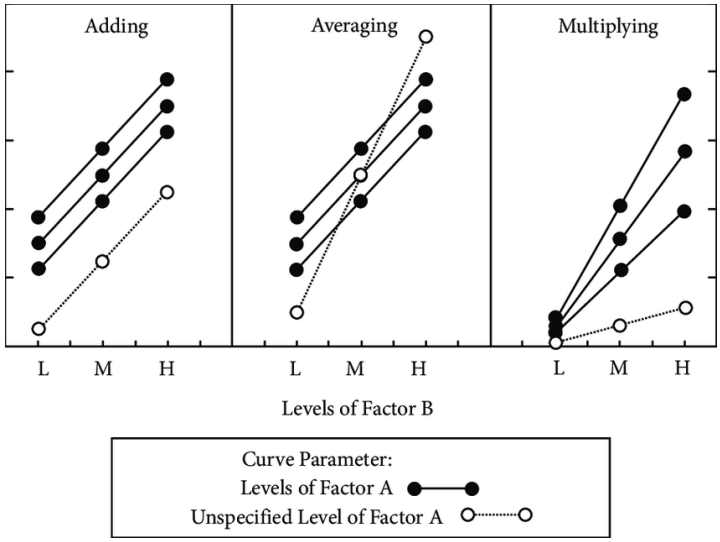
Afterwards, all values are taken together in the integration-process, producing a unified implicit response (ρ). This would be the complete sensory experience of drinking that sip of coffee, for example. This response will then be externalized in the action-process to become an observable reaction (R), such as a smile expressing enjoyment. Figure 1 shows the integration of two stimuli according to IIT, but the same process applies to multiple stimuli.

How these variables are integrated is what Anderson (1996) calls Cognitive Algebra, the second fundamental component of IIT. He suggests that the integration of information mostly follows one of three mathematical laws: addition, multiplication or averaging. Very attentive readers might at this point raise questions as to how we can discover which law is used in a certain situation, given that only the external stimuli (S) and explicit behavioural response (R) are directly observable. After all, both the attribution of values (Ψ) to the stimuli and the integration-process into an implicit reaction (ρ) happen internally and cannot be observed. Therefore it can also not be measured empirically. This measurement problem was challenging enough to be labelled 'the problem of the three unobservables' by Anderson (1996).

The third key feature of IIT, Functional Measurement, offers a quite graceful solution to this problem of the three unobservables. Whilst trying to render the unobservables observable would most likely be either futile or inconclusive, Functional Measurement simply resolves this issue by investigating the observable outcome (R). Since both the external response (R) and the starting stimuli (S) are empirically measurable we can then, through inductive reasoning, strongly predict which mathematical law would have been used in the integration-process.

Figure 2

Plots produced by Adding, Averaging or Multiplying rules.



Note. Reprinted from 'Information integration as a basic cognitive process' by R. Singh, 2011, *Handbook of psychology in India*, p.77, Oxford University Press.

We shall use the example of the mathematical law of addition to explain this more concretely. A first important concept is the idea of meaning invariance. Let's take the example of forming an impression of a dog based on three adjectives. Imagine one of those three adjectives is 'energetic'. In a first case, the dog is described as wild, aggressive and energetic, whilst in a second case as playful, friendly and energetic. Does the meaning of 'energetic' change based on the other factors it is paired with?

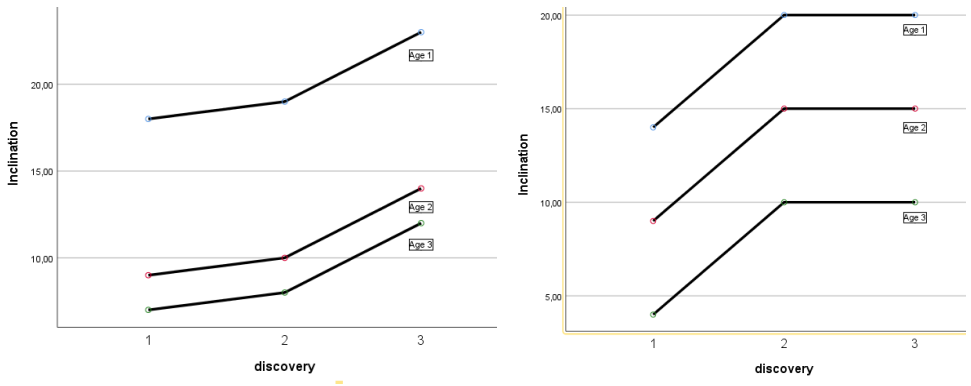
Imagine that 'energetic' is the adjective with the strongest positive influence on the impression and that its meaning does not change. If combining these adjectives would be done by adding them together and we would plot all possible combinations into a factorial design, then the 'energetic' condition would lie at a constant distance above the other curves. This is because 'energetic' adds the greatest level of 'positive impression' and since the meaning or value of 'energetic' remains constant, this addition of 'positive impression' will be constant as well. Therefore, observed parallelism implies that the integration of the variables was done by addition. Another benefit of parallelism is that observing parallel curves strongly implies that the external response (R) is a valid measurement of the unobservable ρ. This assumption is based on the fact that parallelism can hardly ever be found by accident (Anderson, 1996). Similar explanations have

been given for the two other laws of cognitive algebra and observing their corresponding factorial plots implies the same benefits as for the rule of addition. It may be important to note that this inductive reasoning offers very strong evidence that a specific mathematical law has been used, but that this evidence is not absolute.

Lastly, meaning invariance does not mean that everyone attributes the same meaning to a variable. The valuation-process can change depending on the person or the goal. To continue with the same example, an 'energetic' dog may be seen as more desirable by someone who is a very active person. For this individual, the curve associated with the factor 'energetic' will most likely be positioned higher within the factorial plot, seeing as it will be given a greater value. Meaning invariance solely implies that this meaning of 'energetic' does not change depending on which other factors it is paired with. Similarly, the adjectives can receive different values depending on whether the person in question wants the dog for protection or for affection. Thus, this invariance of meaning applies to the integration process and does not exclude interpersonal or situational differences in the valuation-process. Figure 3 illustrates this by showing two factorial plots that both provide evidence for an addition rule, yet are clearly very different from each other.

Figure 3

Example of interpersonal differences in parallelism



Note. Adapted from '*A functional theory of cognition'* by Anderson, N., 1996, p. 43. Copyright 1996 by Lawrence Erlbaum Associates, Inc.

This is only a very brief summary of the main principles of IIT. Unfortunately, it would go beyond the scope of this dissertation to fully explain IIT. For a more detailed description, such as

the exact distinction between the adding and averaging rule, which both rely on observed parallelism, readers are referred to *A Functional Theory of Cognition* (Anderson, 1996).

Participants

Given the lack of previous research we chose a broad perspective and focused on the general public, although certain subpopulations could admittedly prove incredibly interesting to explore. It is important to note that studies on ethics and correct approaches to confidentiality have already been previously conducted. The small amount of existing literature mentioned here refers specifically to the question whether people expect breaches of confidentiality to easily occur in cases of non-suicidal self-harm.

To assess this particular question as broadly as possible, people from any gender, ethnicity, nationality or culture were welcome to participate in this study. Because of current societal and practical limitations and to ensure a sufficient amount of participants, we opted for online recruitment through an anonymous link, although this made it hard to control who could participate in this study. Considering that the nature of the content might possibly be sensitive for very young individuals, the sole restriction applied to this study was the inclusion of an obligatory question where, by answering, participants stated that they were of legal age. In addition, the study was reviewed and approved by an ethical committee (ref. 2020/160).

This study aimed to include 50 to 70 participants to be able to find statistically significant results. After recruitment precisely 68 individuals took part in this study. Their respective subdivisions with regards to the demographic variables are described in the tables below:

Table 2

Participants' distribution with regards to age

Age category	Frequency	Percentage
20-29	47	69.1
30-39	4	5.9
40-49	3	4.4
50-59	10	14.7
60-69	4	5.9

Note. Available options with no participants were not included.

Table 3

Participants' distribution with regards to religion

Religion	Frequency	Percentage
Atheism	41	60.3
Catholicism	10	14.7
Islam	2	2.9
Other	7	10.3
No Answer	8	11.8

Note. Available options with no participants were not included.

Table 4

Participants' distribution with regards to parenthood

Parenthood	Frequency	Percentage
Yes	15	22.1
No	53	77.9

Table 5

Participants' distribution with regards to professional occupation

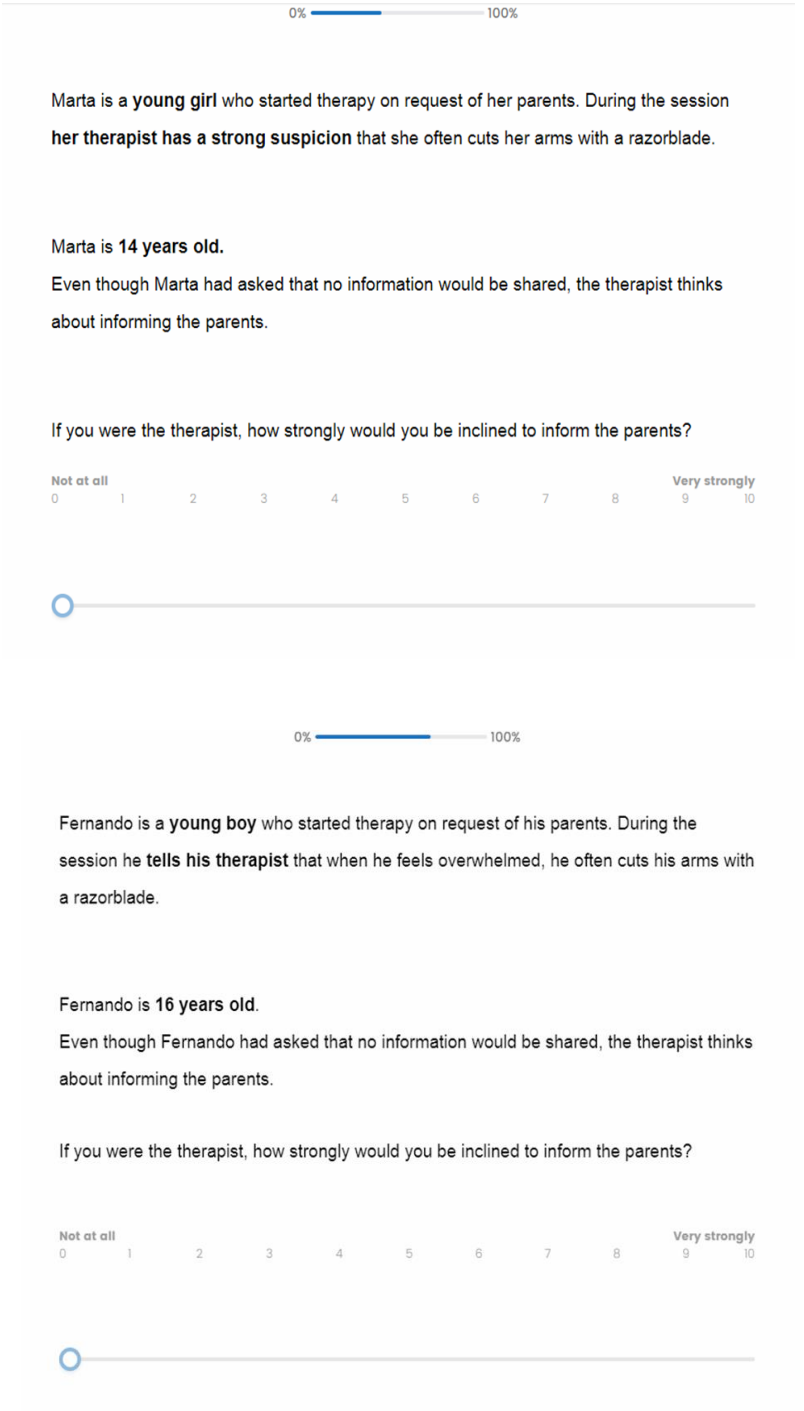
Occupation	Frequency	Percentage
Healthcare professional	14	20.6
Healthcare professional in training	11	16.2
Other	43	63.2

Material

The experiment consisted of 24 ethical dilemmas presented in an online-survey, 18 of which included all the variables (combined condition) and 6 of which did not include variable A (uncombined condition). A few are shown below as an example.

Figure 4

Example of survey scenarios



The dilemmas were made following a 4x3x2 factorial design with the variables being the following:

(A) Age of the underage client: 12, 14 or 16 years old (or not mentioned).

(B) Method by which the self-harm was discovered: client tells the therapist about the self-harm, the therapist notices recent scars or the therapist has a strong suspicion.

(C) Gender of the underage client: male or female.

To minimalize confounding variables we chose to keep the method, frequency and location of the self-injury constant. We defined these respectively as 'cutting with a razorblade'; 'often' and 'on the arms', seeing as these are the most common method and location. In each dilemma the underage client was given a fictive name as to achieve more realism. Furthermore, to differentiate between male and female, the fictional clients were either referred to as being a 'young boy' or a 'young girl'. Each story mentioned that the minor did not wish the parents to be informed and each participant is then asked to imagine how strongly they would be inclined to inform the parents.

The survey also included four demographic questions, namely the participants' age category, their religious or spiritual beliefs, whether they have children and whether they are healthcare professionals (in training). In correspondence with ethical considerations, the question regarding the religious or spiritual beliefs of the participant is provided with an option to abstain from answering.

Since English was chosen as the preferred language for this dissertation, the questions and dilemmas were similarly presented in English. This decision was made as to reach as many participants as possible, as well as to avoid possible bias created by translation. Lastly, Qualtrics was used to make and distribute the online questionnaire.

Procedure

Firstly, an anonymous link providing access to the online questionnaire was distributed on social media, namely Facebook. Potential participants first received introductory information on the study and their informed consent, after which they were asked to indicate whether they were of legal age. Participants stating that they were younger than 18 years old were directed towards the survey end without viewing or answering any questions. Thus, only participants that had confirmed that they were of legal age were included in this survey. Next, the dilemmas were presented to

each participant in random order. After making a decision for each dilemma the participants were asked to answer the demographic questions. This was followed by the survey end, where participants were thanked for their time and effort.

Since this was a one-shot study, no follow-up appointments were necessary. Also, because entry to the study occurred through an anonymous link and because there was no need to collect any names, nor any geographical information, participants' identities remained protected. Participation to this study took around 10 to 15 minutes and participants that only partially completed the survey were not included in the statistical analysis nor in the results of this study.

The entire survey can be found as an appendix attached to this study. Therefore, any readers that wish to see more detailed information, for example the specific information given to participants, are referred to the appendices.

Statistical Analysis

After the first steps in our statistical analysis we will simply observe the factorial plot and infer which algebraic rule was used to integrate our variables: adding, averaging or multiplying? However, since any data set will carry a certain amount of error-data or 'noise', it may well be impossible for us to observe a factorial plot that is completely parallel or that perfectly follows the linear fan design (Anderson, 1996). So how can we make a distinction between normally occurring deviations due to error-data and real deviations that disprove the theoretical model?

Analysis of variance (ANOVA) tests can make this distinction and will be used to verify the model (Mairesse, 2007). Table 6 shows an overview of the possible outcomes and their interpretations.

Table 6

Possible Outcomes of Analysis of Variance (ANOVA) Tests.

	Main effect	**Interaction effect**
Addition rule	Yes	No
Averaging rule	Yes	Yes
Multiplication rule	No	Yes
Other outcomes	No	No

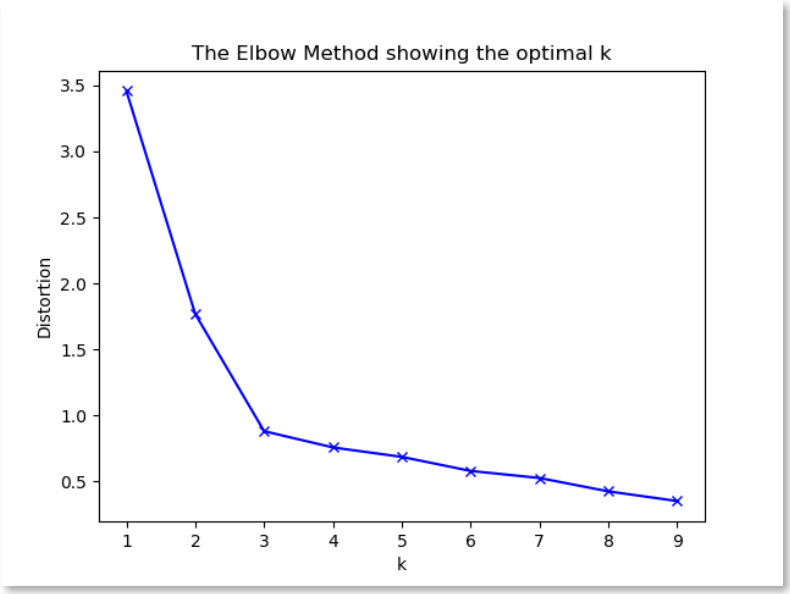
Note. Other outcomes, i.e. outcomes that cannot be explained by either the addition, averaging or the multiplication rule, could be the result of non-linear scaling or differential weighting (Anderson, 1996).

Furthermore, we would like to explore whether our entire data set can be divided into subgroups based on interpersonal differences or the integration strategies that were used. It is quite common for studies to identify different groups of participants. These groups can be found by using cluster analysis and may for example differ in which values they attribute to the variables or what algebraic rule they apply. There are however several choices to be made, such as the type of clustering or distance measure, as well as what standardization method to use. Since there is no method that is clearly superior or preferable to another, these decisions depend on the type of research that is being conducted and the data that is to be interpreted.

Hofmans and Mullet (2013) wrote an influential article in which they suggested that for Functional Measurement research a K-means clustering approach should be applied to the raw data. As for the distance measure they proposed using the Euclidian distance. One feature of K-means cluster analysis is that it requires the number of clusters (K) to be predetermined. This can be done by first performing a hierarchical clustering with increasing amounts of clusters (K=1; K=2; K=3 …) and calculating the total amount of variance for each performed cluster analysis. Next, this variance is plotted into what is called an 'elbow plot'.

Figure 5

Graphical elbow plot method to identify optimal number of clusters



Note. Reprinted from Pythonprogramminglanguage, retrieved June 6, 2020, from https://pythonprogramminglanguage.com/kmeans-elbow-method/ Copyright 2020 by https://pythonprogramminglanguage.com

The total amount of variance will decrease as the number of clusters increases as a result of the data points being closer to the centres of these clusters, simply because there are more clusters. However, increasing the number of clusters also increases the complexity of the model and may force data points that should belong to the same cluster to be split into smaller, separate clusters. In this way, responses with only very little differences could be grouped apart simply because too many clusters were demanded. On the other hand, choosing too few clusters could similarly lead to very different responses being grouped into the same cluster (Cracco & Thiery, 2003). Thus, to find the optimal value for K we need to minimize complexity whilst also trying to keep the total amount of variance as low as possible. This optimal number of clusters can be seen on the graph as the spot where the curve suddenly flattens (Steinley, 2006), because it indicates that the decrease in variance slows down, even with increasing numbers of clusters. In the example given by figure 5 the optimal number of clusters according to this method would be 3.

Commenting on this method, P. Theuns (personal communication, July 1st, 2020) addressed a few considerations in a presentation given at the 4th Conference on Information Integration Theory and Functional Measurement. A first reflection to be made is that one could choose not to include all data points in the analysis by using only the extremities, since all other data can be found in-between. This would help balance the amount of data in the combined and uncombined conditions. In addition, it would be possible for two respondents to use the same strategy, but due to interpersonal differences, one may consistently give significantly lower ratings than the other. Thus, they would not be clustered together, although they do use the same strategy. This could be resolved by applying a centering method to the data. Finally, a cluster analysis does not always give the same result. We can evaluate the stability of the clustering by repeating the analysis with different orders of respondents and comparing the results.

In our cluster analysis we chose to include all data-points. This was mostly decided because the variables ‘gender’ and ‘method of discovery’ are nominal variables, making it difficult to rank them. As to the option of data-centering, we similarly decided against that option, because even though it would reveal certain patterns of responses that would otherwise stay hidden, it would simultaneously group together both low scores and high scores that use the same answering pattern.

Results

Analysis of Variance (ANOVA)

As our first step we performed a 4×3×2 analysis of variance with repeated measures on our total dataset. This fourth condition of the first variable (age of the client) consisted of the uncombined condition in which the age of the client was not mentioned at all.

Table 7

ANOVA main and interaction effects

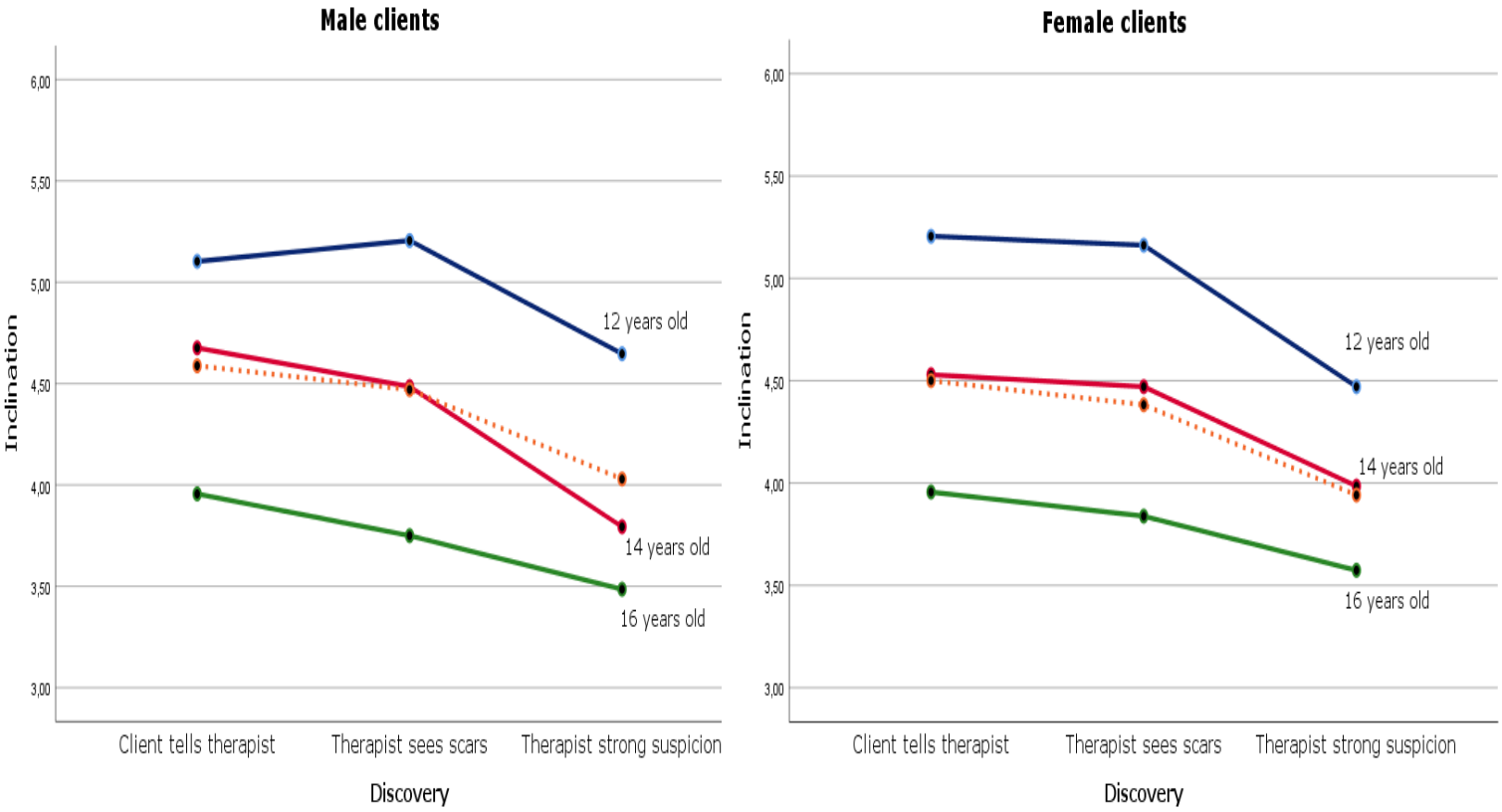
	df	***F***	**Sig.**	**Partial Eta Squared**
Age	2.25	28.62	<.001	.3
Discovery	2	8.81	<.001	.12
Gender	1	.25	.621	<.01
Age×Discovery	5.71	2.27	.039	.03
Age×Gender	3	.85	.467	.01
Discovery×Gender	2	.14	.872	<.01
Age×Discovery×Gender	5.22	1.09	.368	.02

Note. The Huynh-Feldt correction has been applied to the results where necessary.

We found most main effects to be significant, whilst most interaction effects were not. These results were also visually reflected in our factorial plot, which clearly showed indications of parallelism between the curves. One data point that deviated the strongest from parallelism and is thus worth mentioning is the scenario in which the therapist relies on a strong suspicion and the client is 14 years old and male. A sudden decrease in score could be observed here, possibly indicating this to be an exceptional scenario or perhaps the result of an accidental outcome of our sample.

Figure 6

Factorial plot from 4×3×2 ANOVA on total data



We found main effects for both the age of the client (F(2.25,150.89)= 28.62, p= <.001) and the way in which the therapist discovered the self-harming behaviour (F(2,134)= 8.81, p= <.001), with the age of the client having the strongest influence (η_p^2= .3). Thus, participants were most inclined to breach confidentiality when the clients were 12 years old (M=4.97, SD= .36) and least inclined when the clients were 16 years old (M= 3.76, SD= .34). Furthermore, respondents were generally more likely to inform the parents when the client told the therapist about the self-harm (M= 4.56, SD= .37), than when the therapist relied on a strong suspicion (M= 3.91, SD= .33). The size of our η_p^2 indicated this main effect of age to be strong, whilst the main effect of discovery was moderate. However, we should interpret these results with caution given our relatively small sample size. We did not find a significant main effect regarding the gender of the client (F(1,67)= .25, p= .621), meaning that participants did not make a significant difference between male clients (M= 4.35, SD= .34) and female clients (M= 4.33, SD= .34). The only significant interaction-effect we discovered was the one between age and discovery

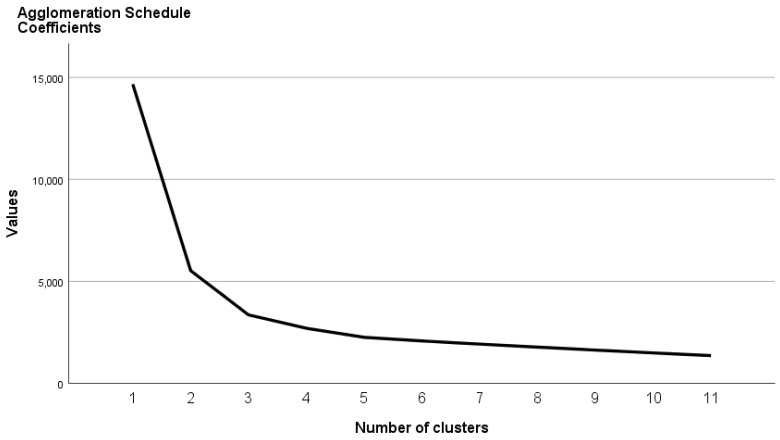
(F(5.71,382.64)= 2.27, p= .039). We could observe this interaction in the factorial plot as well: our curves decreased significantly less between the conditions in which the therapist sees the scars and the condition in which the therapist relies on a strong suspicion when the client is older. In other words, participants were significantly less inclined to breach confidentiality based on a strong suspicion when the client was younger than when the self-harm was discovered otherwise.

Cluster Analysis

We performed Ward's hierarchical clustering method first as to decide the number of clusters to be included in our K-means cluster analysis. Figure 7 shows the produced elbow graph.

Figure 7

Elbow graph produced by Ward's method hierarchical clustering



Following this graph we opted for 3 clusters to be made when performing the K-means cluster analysis.

Table 8

ANOVA main and interaction effects for cluster 1

	df	***F***	**Sig.**	**Partial Eta Squared**
Age	1.45	8.69	.002	.25
Discovery	2	3.62	.034	.12
Gender	1	3.41	.076	.12
Age×Discovery	5.33	1.41	.221	.05
Age×Gender	2.35	2.11	.121	.07
Discovery×Gender	2	.17	.844	<.01
Age×Discovery×Gender	3.21	1.12	.348	.04

Note. The Huynh-Feldt correction has been applied to the results where necessary.

Table 9

ANOVA main and interaction effects for cluster 2

	df	***F***	**Sig.**	**Partial Eta Squared**
Age	2.32	17.95	<.001	.45
Discovery	1.63	2.05	.150	.08
Gender	1	4.44	.047	.17
Age×Discovery	6	.65	.691	.03
Age×Gender	3	.72	.542	.03
Discovery×Gender	2	1.23	.301	.05
Age×Discovery×Gender	4.42	.58	.694	.03

Note. The Huynh-Feldt correction has been applied to the results where necessary.

Table 10

ANOVA main and interaction effects for cluster 3

	df	***F***	**Sig.**	**Partial Eta Squared**
Age	1.70	6.24	.008	.27
Discovery	1.61	4.43	.028	.21
Gender	1	.11	.740	.01
Age×Discovery	4.55	1.66	.161	.09
Age×Gender	3	.75	.527	.04
Discovery×Gender	2	2.33	.113	.12
Age×Discovery×Gender	4.45	.69	.619	.04

Note. The Huynh-Feldt correction has been applied to the results where necessary.

Our first observation is that we found a low-scoring cluster, i.e. cluster one; an average-scoring cluster, namely cluster two and a high-scoring cluster being cluster 3. Each cluster showed a significant main effect for the age of the client with participants being more inclined to breach confidentiality when the client in question is younger. This variable also had the strongest influence in every cluster, judging by the η_p^2. We could also notice that participants were least willing to inform the parents when the therapist relied only on a strong suspicion. In terms of differences, cluster 2 showed a significant main effect of gender ($F(1,22)= 4.44$, $p= .047$), whilst cluster 1 and 3 did not. Participants in cluster 2 were slightly more inclined to breach confidentiality with female clients ($M= 5.18$, $SD= .2$) compared to male clients ($M= 5.1$, $SD= .19$), with this being especially the case in the scar-condition. This effect was admittedly not the greatest, given that its p-value lied only just below the cut-off. Similarly, we found a significant main effect of the method of discovery in cluster 1 ($F(2,52)= 3.62$, $p= .034$) and 3 ($F(1.61,27.39)= 4.43$, $p=.028$) and not in cluster 2 ($F(1.63,35.97)= 2.05$, $p= .150$). We could see that scores did not differ very strongly for the condition in which the clients told the therapist about the self-harm and the condition in which the therapist noticed the scars, with younger minors even causing a small spike in scores in the scar-condition. This was especially the case in the high-scoring cluster. Lastly, there was a noticeable drop-off in scores in the suspicion-condition. None of the clusters showed any significant interaction effects.

Figure 8

Factorial plot from 4×3×2 ANOVA for each cluster

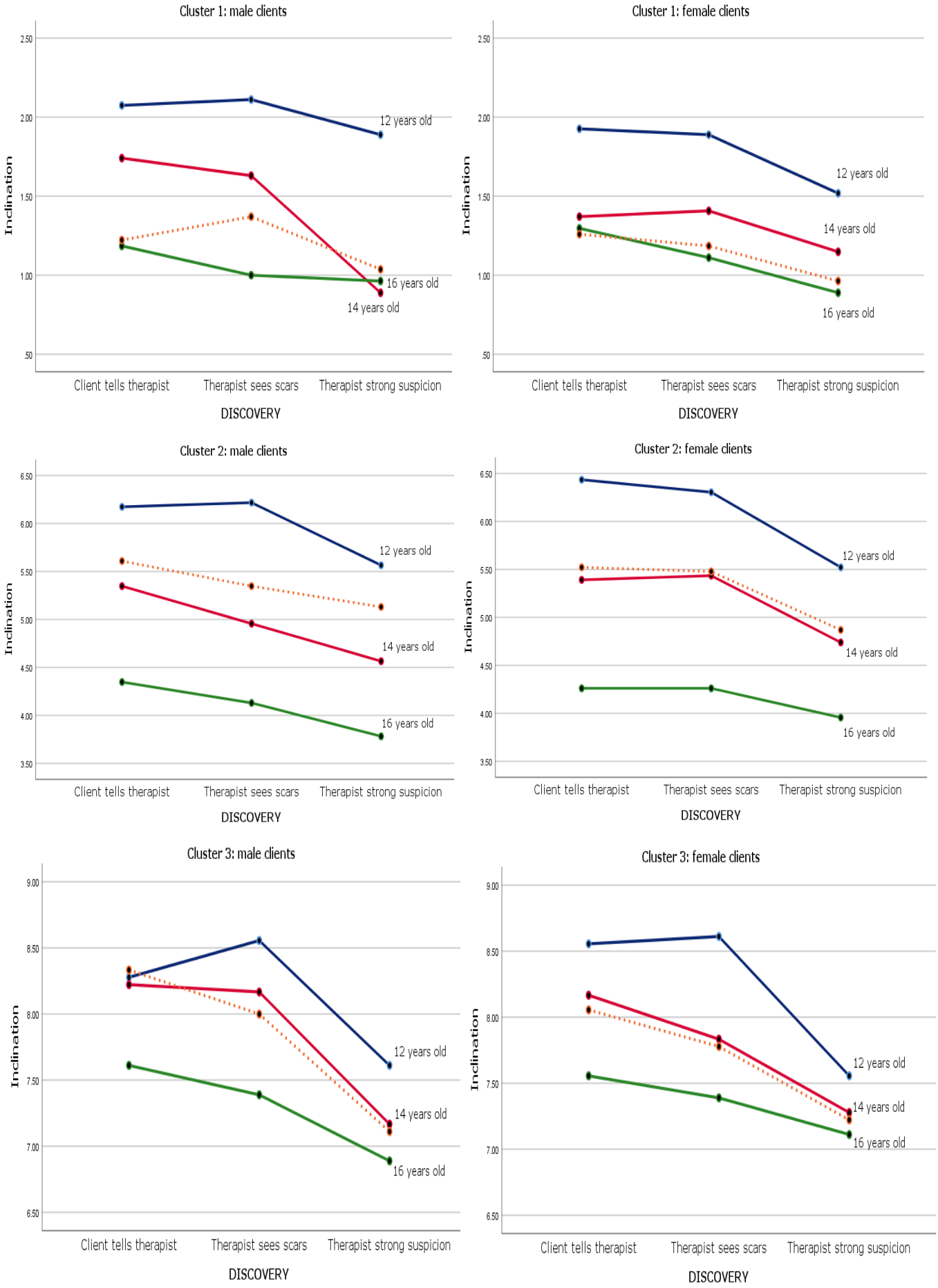


Table 11

Clusters' number of participants and healthcare professionals (in training)

Cluster 1	Number of participants	27
	% Healthcare professionals	33
Cluster 2	Number of participants	23
	% Healthcare professionals	35
Cluster 3	Number of participants	18
	% Healthcare professionals	45

Note. Other demographic variables were too unevenly distributed in our sample to assess correctly and were therefore not regarded.

Next, we investigated in what way healthcare professionals (in training) were distributed amongst our clusters. Following our hypotheses, we expected most healthcare professionals to strongly preserve confidentiality and thus give significantly lower scores than non-healthcare professionals. This was however not the case as can be seen in table 11. We could notice that healthcare professionals were more or less evenly distributed amongst all clusters, with the highest percentage in the high-scoring cluster.

Finally, to test the stability of the clustering, we manually randomized the order of our responses through excel and repeated our 3 cluster K-means clustering and repeated measures ANOVA to investigate whether the same clusters would still be found. We repeated this process 10 times and managed to observe the exact same clusters every time, thereby concluding our clustering analysis to be reasonably to robustly stable. Adding more repetitions would of course provide us with stronger evidence of this stability, but we decided to settle on 10 repetitions, since this task was performed manually.

Discussion

Study Results

With NSSI being prevalent amongst adolescents (Berk, Avina, & Clarke, 2020) and being associated with suicidal behaviour (Hamza, Stewart, & Willoughby, 2012), providing help for as many self-harming adolescents as possible could be an important task. Unfortunately, help-seeking rates are remarkably low (Rowe et al., 2014) and research has found that one of the main obstacles preventing self-harming individuals from reaching out are concerns surrounding confidentiality (Hawton, 2008a). Although absolute confidentiality can never be promised, it may be possible that adolescents, and by extension the general public, overestimate how quickly confidentiality would be breached. To explore this idea, we asked both the general public and healthcare professionals to indicate how strongly they would be inclined to breach confidentiality in several scenarios concerning self-harming adolescents in treatment. We applied the Functional Measurement approach to our analysis, as to evaluate which cognitive rule participants used to combine information from the different variables.

Our results showed strong support in favour of addition and averaging rules. Looking at our repeated measures ANOVA, we found almost exclusively significant main effects and non-significant interaction effects. This could be observed to a certain extent in the factorial plots, which reveal signs of parallelism. Some factorial plots however (e.g. cluster 1 male clients) did show cross-over effects between the uncombined and combined conditions, which strongly supports an averaging rule. The notion of an averaging rule would imply that variables can compensate for one another in those scenarios, which does not happen when an addition rule is applied. There were no factorial plots that provided evidence for a multiplication rule.

We found no clear unanimous decision with regards to breaching confidentiality, seeing as the participant's scores ranged from low to average to high. In addition, there was no clear difference in the distribution of healthcare professionals amongst these ranges of scores, which disproved our first hypothesis.

Furthermore, we could notice an influence of the age of the client across our main analysis and all of our clusters: the older the minor in question, the less people were inclined to breach confidentiality. This was a confirmation of our second hypothesis and could possibly be explained

by assuming that people tend to judge older adolescents as more autonomous and more capable of making their own decisions. One could say that this is reflected within our legal system as well, more precisely by the objective criterion of confidentiality stating that the minor needs to be at least 12 years old in order to consider treating them and their confidentiality as adult. We could see this notion being reflected in our results.

We could not formulate a hypothesis based on prior research with regards to gender or the method by which the self-harm was discovered. Looking at the gender of the client, we observed a significant effect in only one cluster and this effect was in addition only just below the cut-off value. Thus, it would seem fair to say that our participants did not make different decisions based on gender. This finding is in line with current research, seeing as it is still left undecided whether there are any significant gender differences in self-harming behaviour (Bresin & Schoenleber, 2015; Swannell et al., 2014). And even if the evidence in support of gender differences would become overwhelming, momentarily it seems highly unlikely that these differences would be as strong as to demand an entirely distinct approach for each gender. Concerning the method by which the therapist discovered the self-harm, we found that participants tended to be least inclined to breach confidentiality when the therapist relied on a strong suspicion, whilst being generally most inclined when the minor told the therapist about the self-harm. People may interpret the minor introducing the topic themselves as a sign that they may be more permissive towards disclosure since the subject is now out in the open. Situations in which the therapist noticed scars resulting from the self-harming behaviour were similarly evaluated as the ones in which the client informs the therapist, with participants being mostly less inclined in the case of older clients and slightly more inclined when dealing with younger clients. This may be the result of participants associating scars with high severity or danger and may cause them to feel a need to protect the underage client, especially in the case of younger adolescents. Evidence does exist suggesting that the more scarring is present in NSSI, the higher the severity of the self-harm and subsequently the risk for suicidal behaviour (Burke, Hamilton, Cohen, Stange, & Alloy, 2016). However, it may be beneficial to tread carefully and to recognize in which way we approach these issues, seeing as these scars are often a source of stigmatization and shame (Lewis, 2016). It is important to acknowledge the possible implications that scars may have, without turning them into symbols of danger and taboo that should remain hidden.

Limitations

Although our number of responses was well within the predicted range of required participants, it was still rather difficult to distinguish true deviations from the statistical model from accidental effects resulting from an arbitrary sample. A significantly larger amount of participants would have resolved this to a certain extent, but would similarly have been difficult to pursue due to practical issues and time management. Besides sample size, the participants' distribution amongst the demographic groups was notably uneven. For instance, nearly 70% of our respondents were between 20 to 29 years old, with the remaining 30% divided amongst 4 other age divisions. A similar unequal distribution could be observed for religion or spiritual beliefs, with atheism far outnumbering the other options. In addition, there were nearly 4 times as many participants who did not have children than participants who did. Lastly, our final, and for this particular study most important subgroup, consisted of roughly 37% of respondents who were healthcare professionals (in training) compared to 63% who were not. Even though this is by far the most equally distributed subdivision in our study, it is still far from optimal and we should therefore remain dubious towards any interpretations based on these demographic variables.

Another point of potential critique is the translatability of our experiment to reality. Research always seeks a balance between practical considerations and realism. We have tried in several ways to make our design as realistic as possible, e.g. by adding an introduction and giving our imaginary clients realistic names. However, an experimental setting could never provide as much information as real cases have, simply because it would make the number of questions increase exponentially. In most realistic cases, the therapist would always discuss breaches of confidentiality with the client before taking any action, so one may argument that the scenario used in our study is quite far from reality. It is worth noting however that this study does not evaluate which plan of action to take, but rather whether there are any significant differences between healthcare professionals and the general public in their tendency or expectation of breaching confidentiality. At no point in this study was there a mention of one course of action being preferable to others. Nonetheless, there may be other scenarios that are closer to reality.

Because of practical considerations this study chose not to include self-harming minors themselves, as they would have been a considerably harder audience to reach. This is not necessarily a shortcoming in itself, since a broad examination within the general public can be a fine starting point in cases where a lot of prior research could not be found. However, by not

including this particular population, this study overlooks its primary target and should essentially be seen as explorative.

Future Directions

This study did not find a clear distinction in the tendency to breach confidentiality between healthcare professionals (in training) and the general public. Even more so, there was no unanimous response at all amongst healthcare professionals with scores ranging from high to low. Given that previous studies (Hawton, 2008a; Rowe et al., 2014) found concerns surrounding secrecy and stigmatization to be one of the main obstacles for help-seeking behaviours, it may be helpful to explore these scenarios more deeply. Although every case of self-harm is unique and will differ from other cases, creating adjustable universal guidelines may still be possible and beneficial. Creating some guaranties of discretion and making them publically known could potentially make self-harming minors feel more reassured in their privacy, even if absolute secrecy could still not be promised. Unfortunately, it may be presumptuous to make any big claims or assumptions on the basis of this study, given its limitations. The results could however be regarded as an indication that there may indeed be more to explore about professional confidentiality in the case of self-harming minors. It could for instance be beneficial to explore whether ensuring confidentiality (to a certain degree) more strongly might help bring more people engaging in NSSI into professional healthcare. Moreover, exploring the attitudes of self-harming minors themselves may be a worthwhile endeavour. This would however be something for future studies with larger and more representative samples to discover.

Furthermore, our choice of variables was both explorative and based on previous literature. More precisely, opinions surrounding gender and self-harm are still divided, whilst we did not find any research about the effect of the method in which self-harm is discovered. Therefore, other combinations of variables may find other or surprising results. For example, it would have been very interesting to add a variable describing the autonomy of the adolescent and to explore it besides the age variable. This possibility was briefly explored, but was eventually decided against because it would either have replaced other variables or it would have added too much complexity. In future research it would however be interesting to see whether the effect of age would still be observed when an evaluation of the autonomy of the minor is added besides it as a variable.

Conclusion

Opposed to what we expected to find, healthcare professionals (in training) scored very similar to the general public in that their scores were strongly scattered and ranged from low to high. Even though each case will differ in reality and each respondent is equally a unique individual with their own beliefs and personality, without any degree of professional consensus it is understandable for those contemplating to seek help to be hesitant, even more so given the stigmatization and shame that is associated with NSSI. In addition, we found that people tended to be more inclined to breach confidentiality when the adolescent was younger and when the NSSI was revealed by the adolescent or by visible scars. Although a very young age and scarring can indeed reflect a certain severity of the situation, we should still remain cautious of the strong role that stigmatization can play at this sensitive age. Alleviating concerns regarding secrecy may be one way to attempt to ease these issues and to raise help-seeking rates amongst those engaging in NSSI. And even though absolute confidentially cannot and should not ever be promised, enforcing more professional consensus and informing the public may be a beneficial middle ground. Unfortunately, the limitations of this study render these ideas mostly hypothetical. Nevertheless, this study can be regarded as explorative and point out a need for further exploration on the subject.

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Appendix A

DSM-5 definition of Non-Suicidal Self-injury Disorder (NSSI-D)

A) In the last year, the individual has, on 5 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, and excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent).

Note: The absence of suicidal intent has either been stated by the individual or can be inferred by the individual's repeated engagement in a behaviour that the individual knows, or has learned, is not likely to result in death.

B) The individual engages in the self-injurious behaviour with one or more of the following expectations:

- To obtain relief from a negative feeling or cognitive state
- To resolve an interpersonal difficulty
- To induce a positive feeling state.

Note: The desired relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behaviour suggesting a dependence on repeatedly engaging in it.

C) The intentional self-injury is associated with at least one of the following:

- Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act
- Prior to engaging in the act, a period of preoccupation with the intended behaviour that is difficult to control
- Thinking about self-injury that occurs frequently, even when it is not acted upon.

D) The behaviour is not socially sanctioned (e.g., body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to picking a scab or nail biting.

E) The behaviour or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning.

F) The behaviour does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behaviour is not part of a pattern of repetitive stereotypies. The behaviour is not better explained by another mental disorder or medical condition (e.g., psychotic disorder, autism spectrum disorder, intellectual disability, Lesch-Nyhan syndrome, stereotyped movement disorder with self-injury, trichotillomania [hair pulling disorder], and excoriation [skin picking disorder]).

Appendix B

Online survey: circumstances for breaching confidentiality when working with minors

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Please take part in this clinical study to evaluate the general public's opinion regarding breaching of confidentiality when working with minors.

Your participation in the study is voluntary and must remain free of any coercion: this means that you have the right to not take part in the study or to withdraw without giving a reason, even if you previously agreed to take part. Your decision will not affect your relationship with the investigator.

All your data are collected anonymously. The investigator of this survey is bound to uphold professional secrecy about the collected data. In reports, data will never be connected to a participant's identity. A participant's identity as such will never be revealed or reported on, including in a scientific publication. Only the investigator and his staff have access to the data and data will only be used to answer the scientific questions of the survey.

In the unlikely event that participation in this study causes any distress or harm, please contact any of the following healthcare facilities: Centrum Algemeen Welzijn (CAW), Centrum Geestelijke Gezondheidszorg (CGG), Zelfmoordlijn 1813, general practitioners or a trusted loved one.

More information on your informed consent rights

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Many minors who self-harm experience feelings of shame or guilt and try strongly to avoid discovery of their deeds, which may cause a huge challenge to caregivers in treatment of self-harm. In such situations professionals may need to choose between respecting the right of the child for confidentiality on the one hand and the parent's right for information about their child on the other.

- This study investigates people's view on breaching confidentiality when working with minors in case of self-harm.

- The views of professionals and the general public will be compared.

- This study is open to participants from all cultures and genders.

- Participating will take some 15 to 20 minutes.

- Only legal adults can participate.

- We hope to include about 50-70 participants.

- This study is conducted as part of a Master thesis.

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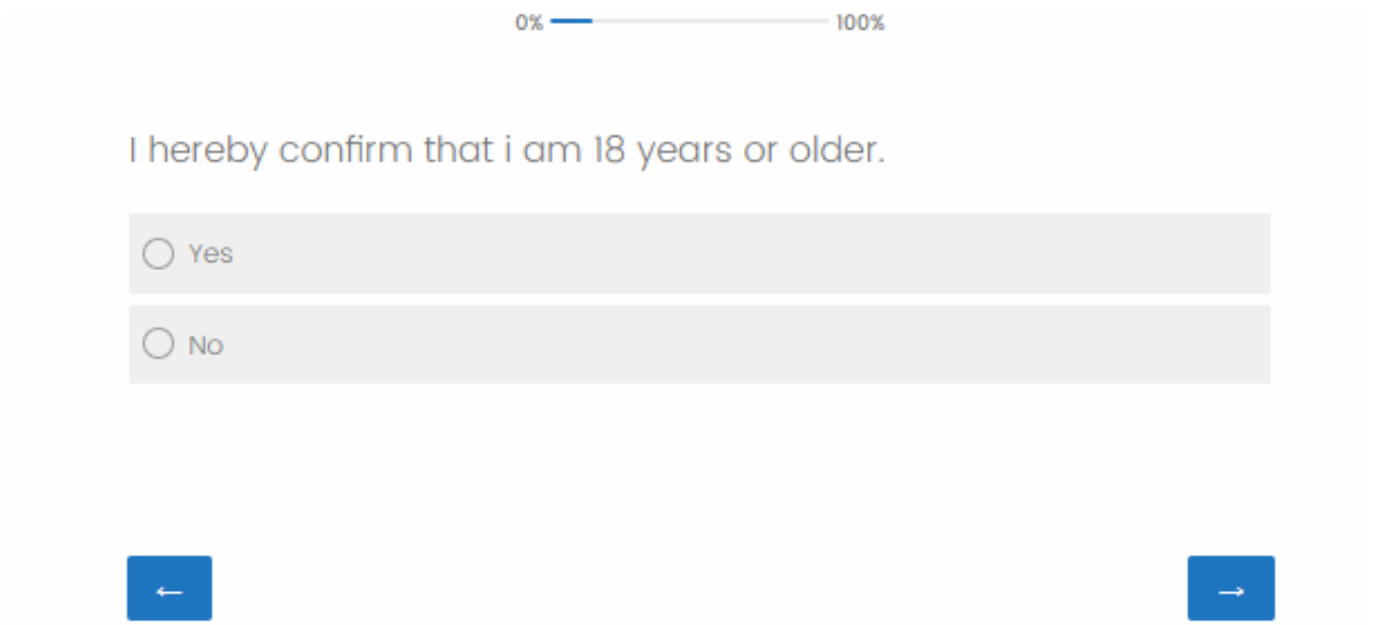
Instruction:

- This study consists of **18 scenario's regarding confidentiality that you are kindly asked to evaluate.**

- At the end you will be asked some **demographic questions**.

- Each of the following scenario's describes the case of a self-harming child who asks the therapist **not to tell their parents** about the self-harm.

- For each scenario, please indicate on a scale ranging from 0 (not at all) to 10 (very strongly) in **how far you think the therapist should be inclined to breach confidentiality by informing the parents.**



The stories in this study all describe children or adolescents who recently got some poor results at school and became more quiet and distant towards classmates. Their friends noticed that they had become less active and that they did not seem to have fun anymore. They said that they came across as more sad or emotionally unstable, up until the point where the parents became worried and requested their child was seen by a therapist.

The following scenarios start from this point on:

0% 100%

Amanda is a **young girl** who started therapy on request of her parents. During the session **her therapist sees** recent scars on her arm.

Amanda is **12 years old.**
Even though Amanda had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Sophie is a **young girl** who started therapy on request of her parents. During the session she **tells her therapist** that when she feels overwhelmed, she often cuts her arms with a razorblade.

Sophie is **12 years old.**
Even though Sophie had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Andres is a **young boy** who started therapy on request of his parents. During the session **his therapist has a strong suspicion** that he often cuts his arms with a razorblade.

Andres is **12 years old.**
Even though Andres had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all Very strongly
0 1 2 3 4 5 6 7 8 9 10

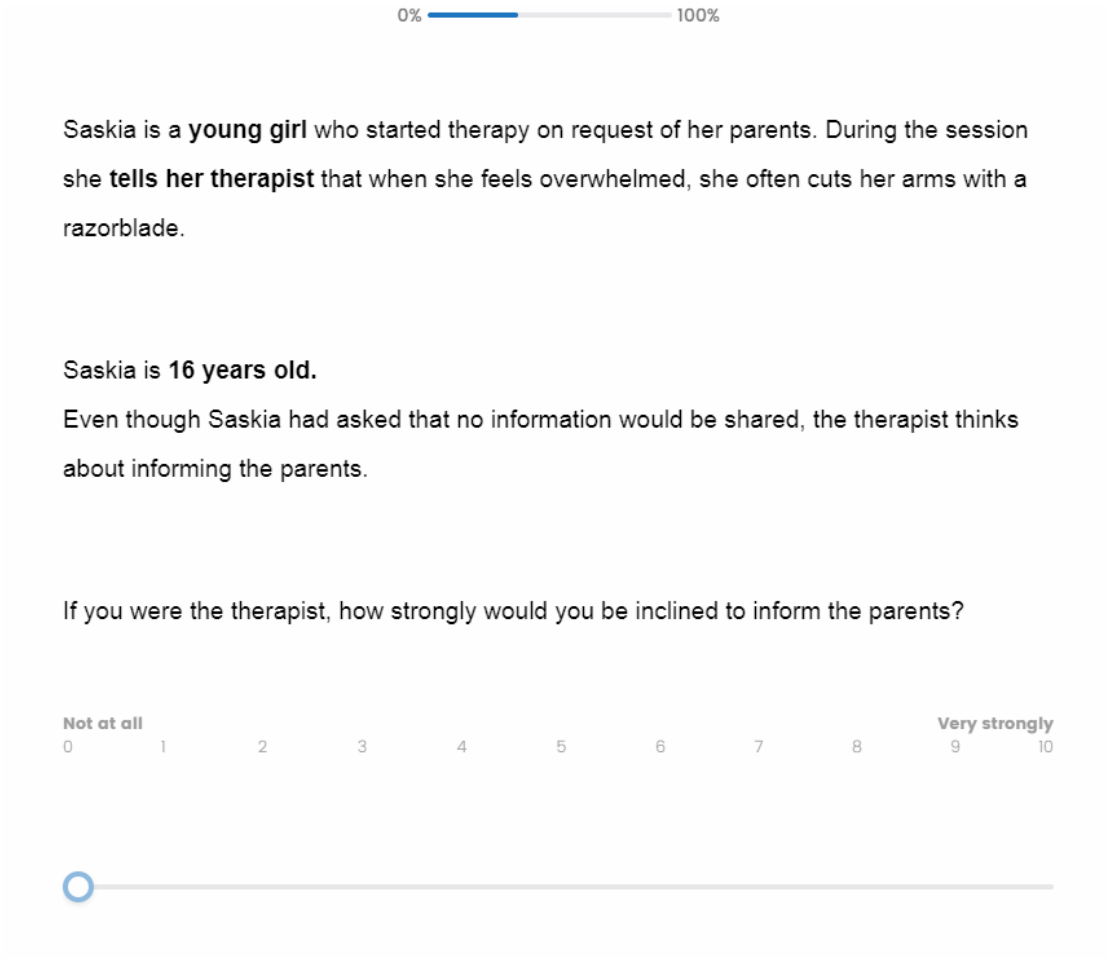
0% 100%

Lucy is a **young girl** who started therapy on request of her parents. During the session **her therapist has a strong suspicion** that she often cuts her arms with a razorblade.

Lucy is **16 years old.**
Even though Lucy had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all Very strongly
0 1 2 3 4 5 6 7 8 9 10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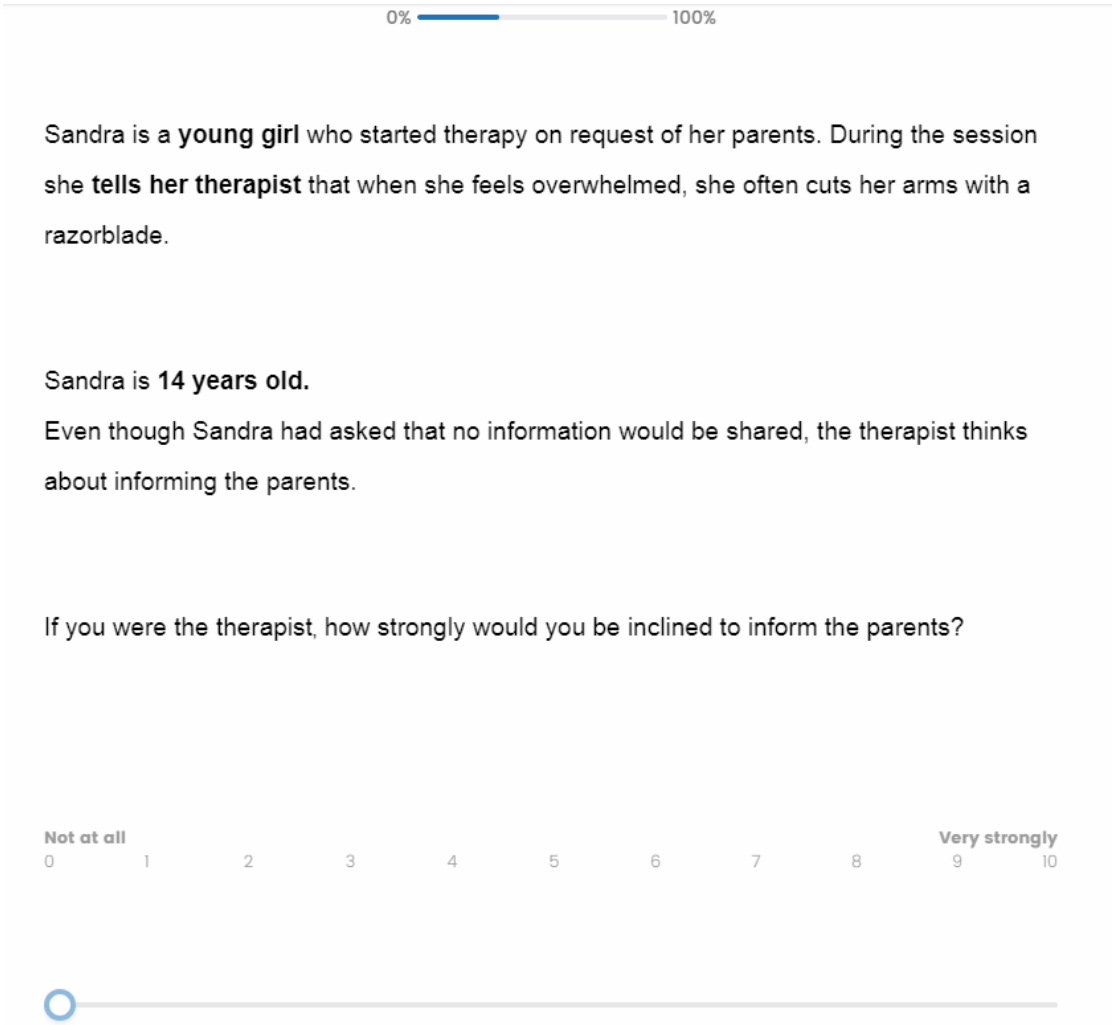
Saskia is a **young girl** who started therapy on request of her parents. During the session she **tells her therapist** that when she feels overwhelmed, she often cuts her arms with a razorblade.
Saskia is **16 years old.**
Even though Saskia had asked that no information would be shared, the therapist thinks about informing the parents.
If you were the therapist, how strongly would you be inclined to inform the parents?
Not at all
Very strongly
0 1 2 3 4 5 6 7 8 9 10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Sandra is a **young girl** who started therapy on request of her parents. During the session she **tells her therapist** that when she feels overwhelmed, she often cuts her arms with a razorblade.
Sandra is **14 years old.**
Even though Sandra had asked that no information would be shared, the therapist thinks about informing the parents.
If you were the therapist, how strongly would you be inclined to inform the parents?
Not at all
Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Marta is a **young girl** who started therapy on request of her parents. During the session **her therapist has a strong suspicion** that she often cuts her arms with a razorblade.

Marta is **14 years old.**
Even though Marta had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

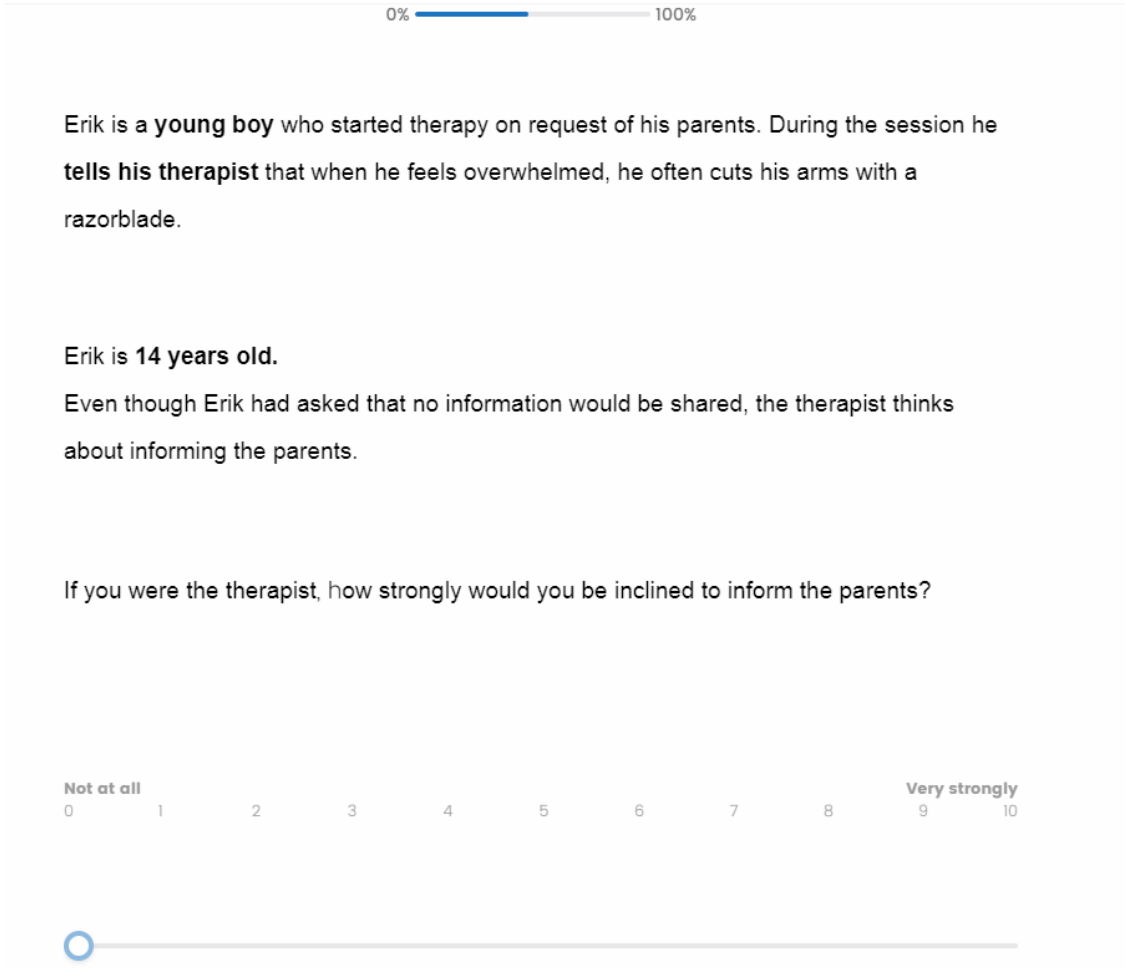
0% 100%

Ana is a **young girl** who started therapy on request of her parents. During the session **her therapist sees** recent scars on her arm.

Ana is **14 years old.**
Even though Ana had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10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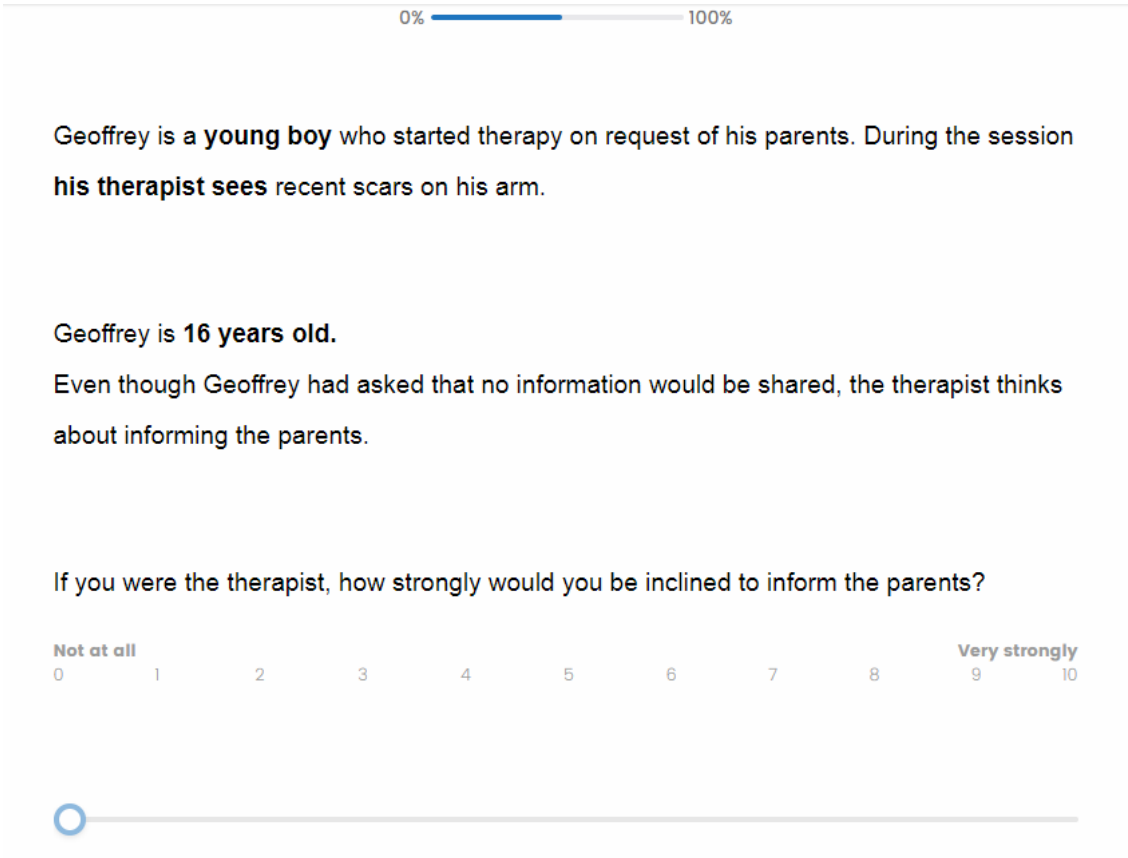
Erik is a **young boy** who started therapy on request of his parents. During the session he **tells his therapist** that when he feels overwhelmed, he often cuts his arms with a razorblade.
Erik is **14 years old.**
Even though Erik had asked that no information would be shared, the therapist thinks about informing the parents.
If you were the therapist, how strongly would you be inclined to inform the parents?
Not at all
Very strongly
0 1 2 3 4 5 6 7 8 9 10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Geoffrey is a **young boy** who started therapy on request of his parents. During the session **his therapist sees** recent scars on his arm.
Geoffrey is **16 years old.**
Even though Geoffrey had asked that no information would be shared, the therapist thinks about informing the parents.
If you were the therapist, how strongly would you be inclined to inform the parents?
Not at all
Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Andrew is a **young boy** who started therapy on request of his parents. During the session **his therapist has a strong suspicion** that he often cuts his arms with a razorblade.

Andrew is **16 years old.**
Even though Andrew had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Tom is a **young boy** who started therapy on request of his parents. During the session **his therapist has a strong suspicion** that he often cuts his arms with a razorblade.

Tom is **14 years old.**
Even though Tom had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Maria is a **young girl** who started therapy on request of her parents. During the session **her therapist sees** recent scars on her arm.

Maria is **16 years old.**
Even though Maria had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Fernando is a **young boy** who started therapy on request of his parents. During the session he **tells his therapist** that when he feels overwhelmed, he often cuts his arms with a razorblade.

Fernando is **16 years old**.
Even though Fernando had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Robert is a **young boy** who started therapy on request of his parents. During the session **his therapist sees** recent scars on his arm.

Robert is **12 years old.**
Even though Robert had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Silke is a **young girl** who started therapy on request of her parents. During the session **her therapist has a strong suspicion** that she often cuts her arms with a razorblade.

Silke is **12 years old.**
Even though Silke had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

John is a **young boy** who started therapy on request of his parents. During the session he **tells his therapist** that when he feels overwhelmed, he often cuts his arms with a razorblade.

John is **12 years old.**
Even though John had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Jasmine is a **young girl** who started therapy on request of her parents. During the session **her therapist has a strong suspicion** that she often cuts her arms with a razorblade.

Even though Jasmine had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

Mark is a **young boy** who started therapy on request of his parents. During the session **his therapist sees** recent scars on his arm.

Mark is **14 years old.**
Even though Mark had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

0% 100%

James is a **young boy** who started therapy on request of his parents. During the session **his therapist sees** recent scars on his arm.

Even though James had asked that no information would be shared, the therapist thinks about informing the parents.

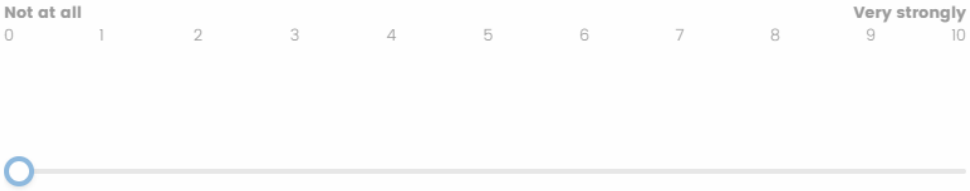
If you were the therapist, how strongly would you be inclined to inform the parents?

Not at all — Very strongly
0 1 2 3 4 5 6 7 8 9 10

Elizabeth is a **young girl** who started therapy on request of her parents. During the session she **tells her therapist** that when she feels overwhelmed, she often cuts her arms with a razorblade.

Even though Elizabeth had asked that no information would be shared, the therapist thinks about informing the parents.

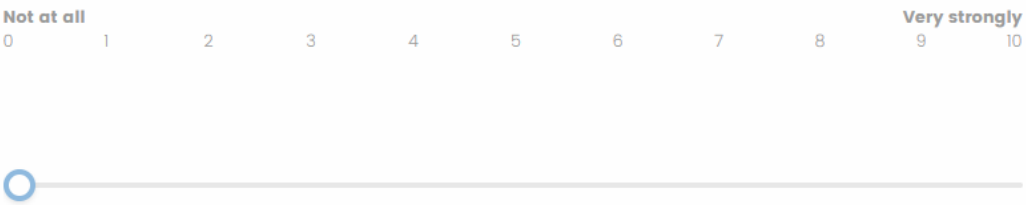
If you were the therapist, how strongly would you be inclined to inform the parents?



Jack is a **young boy** who started therapy on request of his parents. During the session he **tells his therapist** that when he feels overwhelmed, he often cuts his arms with a razorblade.

Even though Jack had asked that no information would be shared, the therapist thinks about informing the parents.

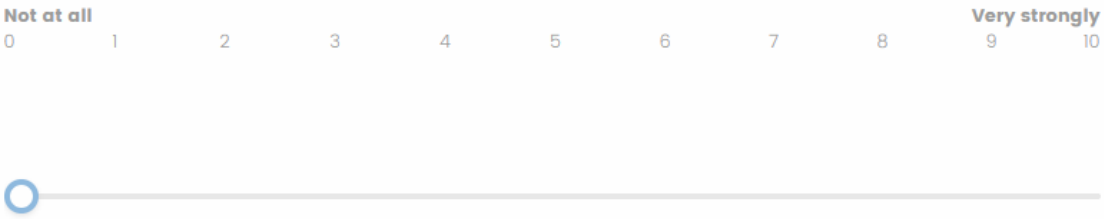
If you were the therapist, how strongly would you be inclined to inform the parents?



Oscar is a **young boy** who started therapy on request of his parents. During the session **his therapist has a strong suspicion** that he often cuts his arms with a razorblade.

Even though Oscar had asked that no information would be shared, the therapist thinks about informing the parents.

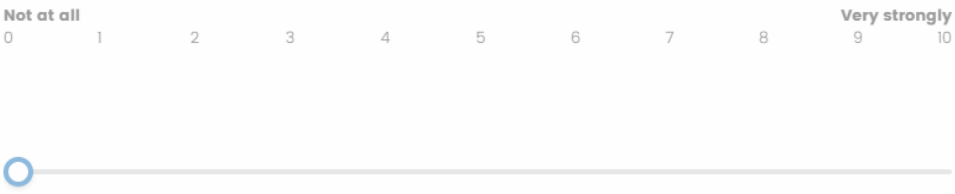
If you were the therapist, how strongly would you be inclined to inform the parents?



Paula is a **young girl** who started therapy on request of her parents. During the session **her therapist sees** recent scars on her arm.

Even though Paula had asked that no information would be shared, the therapist thinks about informing the parents.

If you were the therapist, how strongly would you be inclined to inform the parents?



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Before finishing the survey, we would like to ask you some demographic information.

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Age:

- Below 20
- 20-29
- 30-39
- 40-49
- 50-59
- 60-69
- 70-79
- 80-89

Which of the following describes your religion or philosophy best?

- Atheism
- Catholicism
- Islam
- Judaism
- Hinduism
- Buddhism
- Other
- No answer

0% 100%

Do you have any children?

- Yes
- No

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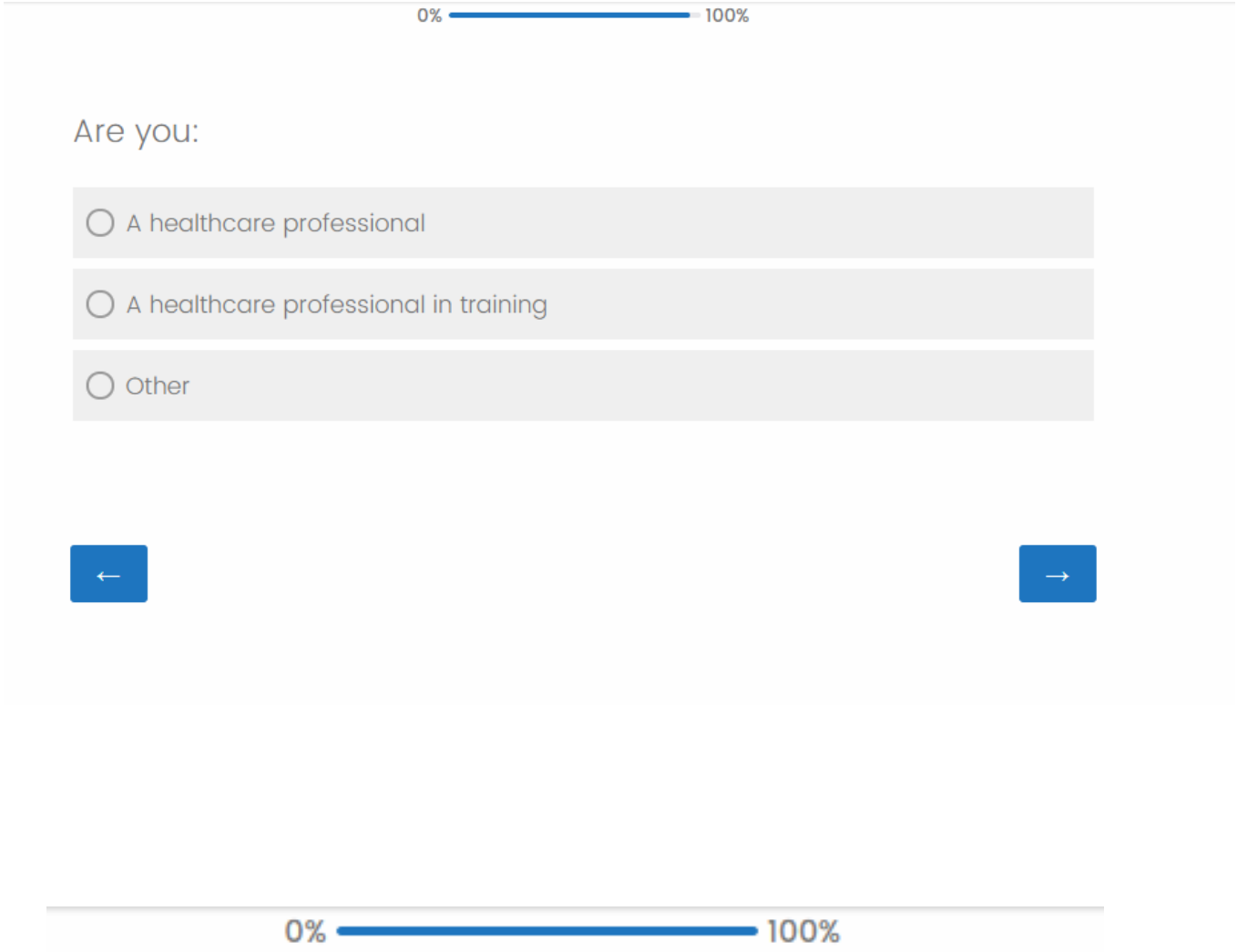
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Are you:
A healthcare professional
A healthcare professional in training
Other
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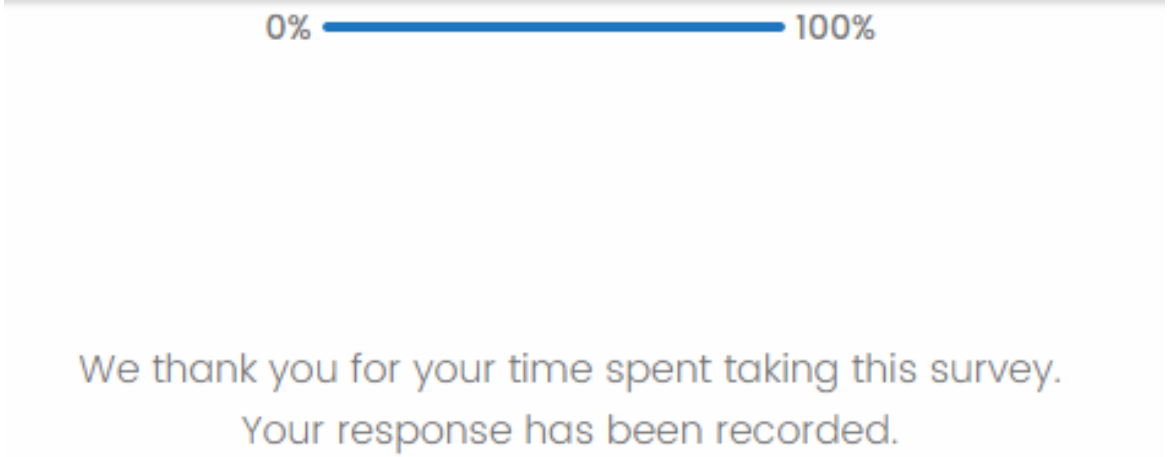
→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We thank you for your time spent taking this survey.
Your response has been recorded.