



## Young adults who self-harm: Barriers to and facilitators of seeking help

Vanessa Florindo Salvador<sup>a,\*</sup>, Maria Gouveia-Pereira<sup>a</sup>, Beatriz Simões<sup>b</sup>, Eva Duarte<sup>a</sup>

<sup>a</sup> Applied Psychology Research Center Capabilities and Inclusion (APPsyCI), ISPA, Instituto Universitário, Lisbon, Portugal

<sup>b</sup> ISPA, Instituto Universitário, Lisbon, Portugal

### ARTICLE INFO

#### Keywords:

Deliberate self-harm  
Suicidal ideation  
Social support  
Healthcare workers

### ABSTRACT

In Portugal, the lifetime prevalence of DSH in adolescents is situated between 16% and 35% (Duarte et al., 2020a; Gouveia-Pereira et al., 2016). Help-seeking is an important facilitator to stop these behaviors, although it is known that most individuals who engage in self-harm do not ask for help (Rowe et al., 2014). Study one ( $n = 222$ ) examines the differences between two groups of young adults with a history of deliberate self-harm (participants who asked for help and participants who did not ask for help) regarding these behaviors' severity and diversity, suicidal ideation, and family conflicts. Participants completed a self-report questionnaire which included an open-ended question focused on the reasons that may or may not contribute for seeking help. Significant differences between the two groups were found for all variables and are further discussed, followed by a qualitative analysis concerning the help-seeking motives. Study two ( $n = 110$ ) used a self-report questionnaire to analyze the expectations of young adults with a history of deliberate self-harm concerning their social support network and the role of healthcare workers when they asked or thought about asking for help. These expectations included contents related with problem-solving, confidentiality, understanding and trust, support, and unburdening.

Identifying facilitators and barriers to help-seeking can be a relevant step in planning and managing interventions within deliberate self-harm. Future directions and limitations are discussed.

### 1. Introduction

Suicidal behavior is a public health concern in several countries (Arbuthnott and Lewis, 2015; Duarte et al., 2019; Guerreiro et al., 2017). In 2014, the World Health Organization (WHO) classified suicidal behavior as a public health problem and stated that suicide was the second leading cause of death amongst young people aged between 15 and 29 years old, worldwide.

For the present study, we used the definition proposed by Madge et al. (2008), which describes DSH as comprising several self-harm behaviors, motivated by an overly self-aggressive purpose, with or without suicidal intention. Even though prevalence, frequency, lethality of methods and attitudes concerning death and life may differ, the fact remains that many individuals engage in both behaviors (Hamza et al., 2012; Nock, 2010).

DSH is associated with deep states of psychological suffering (Cipriano et al., 2017; Duarte et al., 2020b; Nock, 2010), difficulties in emotional regulation (Duarte et al., 2018; Hasking et al., 2015; Klonsky, 2007) and interpersonal factors, such as family support and

relationships (Mummé et al., 2017). Typically, DSH begins during puberty and persists throughout adolescence (Barrocas et al., 2015; Duarte et al., 2020b; Guerreiro et al., 2017; Klonsky et al., 2012; Whitlock et al., 2013). DSH is one of the most significant and predictive risk factors for suicide attempts (SA; Barrocas et al., 2015; Duarte et al., 2020b) and research has established an unambiguous association between DSH and suicide. These behaviors may be understood as a gateway to suicide (Barrocas et al., 2015; Castellví et al., 2017; Duarte et al., 2019; Klonsky et al., 2012; Parra et al., 2015; Whitlock et al., 2013) since engaging in DSH might increase tolerance for physical pain and contribute to the capacity to kill oneself (Duarte et al., 2020b; Gouveia-Pereira et al., 2022; Hamza et al., 2012; Klonsky et al., 2014; Pompili et al., 2015).

Studies have shown that nine out of ten adolescents who attempted suicide have a previous history of DSH behavior (Duarte et al., 2020a) and that young people with DSH have a threefold suicide risk, regardless of the presence of other risk factors, such as depression (Barrocas et al., 2015; Duarte et al., 2019; Klonsky et al., 2014). It is also known that engaging in more severe (e.g., cutting versus biting) DSH methods, and engaging in more different methods (i.e., DSH diversity) contribute to a

\* Corresponding author.

E-mail address: [vsalvador@ispa.pt](mailto:vsalvador@ispa.pt) (V. Florindo Salvador).

<https://doi.org/10.1016/j.psychres.2023.115390>

Received 17 December 2022; Received in revised form 27 July 2023; Accepted 29 July 2023

Available online 30 July 2023

0165-1781/© 2023 The Authors. Published by Elsevier B.V. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

significantly higher risk of suicide (Duarte et al., 2020a, 2020b; Gouveia-Pereira et al., 2022; Pompili et al., 2015). In Portugal, the lifetime prevalence of DSH in adolescents is situated between 16 and 35% (Duarte et al., 2020a; Gouveia-Pereira et al., 2016; Guerreiro et al., 2017).

Although the European Union and the WHO have made suicide prevention a priority (WHO, 2014), little is known about how help-seeking decisions are made during times of personal crisis and what influences them (Owens et al., 2005) in this context. Additionally, little is known about the people to whom individuals who engage in DSH disclose their behaviors or ask for help (Fortune et al., 2008). In a case-controlled psychological autopsy study, Owens et al. (2003) discovered that three quarters of those who died by suicide were not receiving mental health care from a specialist at the time of death. In 2000, a national psychiatric morbidity survey in the United Kingdom found that less than 40% of adults with a mental health disorder sought help from a general practitioner (Singleton, 2000), similarly to other results found in several countries, such as the Netherlands (Bijl and Ravelli, 2000), Australia (Henderson et al., 2000), and Canada (Bland et al., 1997). These findings, aligned with clinical experience, underline the importance of young people asking for help from mental healthcare practitioners in a timely manner.

Help-seeking refers to any action carried out with the perceived need for personal, psychological and/or health care with the goal of finding new alternatives to cope with the challenges one is facing (Hasking et al., 2015). On the other hand, help-negation refers to help avoidance or withdrawal from certain types of help. One of the most important facilitators of help-seeking in the context of DSH is the individual's comfort with self-disclosure (Hasking et al., 2015; Gray et al., 2022) and the feeling of being understood. One of the most significant barriers is stigma and the fear of negative reactions, which encourage secrecy, increase feelings of isolation, and erode levels of perceived support (Gray et al., 2022; Hasking et al., 2015; Maple et al., 2020).

Trying to obtain feedback from young people on counselling strategies in a school prevention program, Biocalti et al. (2018) found the themes of trust and confidentiality scored the highest, indicating that for young people, confidence is important to promote help-seeking behaviors. Similarly, Fortune et al. (2008) conducted a study involving more than 6000 students from schools in England and concluded that: (a) DSH was frequently understood by young people as not serious or significant because it occurs as a result of impulsivity at a specific moment; (b) more frequently, boys said that their intention to self-harm was not serious so they did not need help; (c) the most important theme was the belief that they could stop by themselves so they did not need help from anyone; (d) several adolescents expressed their preoccupation with not being taken seriously and understood; (e) some of the adolescents said they did not want help even though they recognized they needed it; (f) girls were particularly concerned about being labeled as "attention seekers"; (g) a central concern for those who did not know any peers who self-harmed was the fear of being labeled as "crazy"; (h) some adolescents said that self-disclosure would hurt the people they loved and make things worse; (i) some participants who wanted help said they did not know where to go or who to ask; and (j) adolescents found it difficult to talk about their problems. These results are consistent with more recent research (e.g., Frey et al., 2018; Hasking et al., 2015; Klineberg et al., 2013) and systematic reviews (Michelmore and Hindley, 2012; Rowe et al., 2014).

The decision to consult an expert is a major issue regarding help-seeking on the pathway to mental (or indeed general) health care (Owens et al., 2003). Family members and social network (e.g., peers and teachers) may play an important part in determining if suicidal individuals seek help from a mental health-care practitioner (Biddle et al., 2010; Luoma et al., 2002; Owens et al., 2003), particularly when they are engaging in DSH. Stigma, stoicism, and the belief that treatment is not necessary or will be of no use are cited as the main reasons for individuals not seeking help (Biddle et al., 2010; Biocalti et al., 2018; Gray et al., 2022; Meltzer et al., 2000). Young people between the ages

of 16 and 24 are amongst those least likely to consult a practitioner when they are distressed (Biddle et al., 2010).

Formal sources of help include psychologists, clinical/health services, and youth programs, among others. While seeking assistance from peers and family (as informal sources) promotes formal help-seeking, disclosing to parents or adults provides better resources for future assistance and is recognized as an important protective factor (Hasking et al., 2015). Parents have been identified as important facilitators in the context of DSH (Arbuthnott and Lewis, 2015; Duarte et al., 2018), and an affectionate family environment that provides space to talk about these behaviors, as well as caring and emotional support, contributes to the young person's rehabilitation and recovery (Duarte et al., 2020a; Muehlenkamp et al., 2013). Family support is identified by several authors to be a predominant factor influencing DSH cessation and to lead to help-seeking behaviors, such as seeking professional help (e.g., Mummé et al., 2017). By contrast, poor family support and parent relationships (Tatnell et al., 2014) may contribute to the maintenance of DSH as young people are likely to experience a decrease in self-esteem and poor coping strategies. Healthy family relationships should reduce the urge to self-harm by decreasing self-punishment and feelings of being unworthy and unloved, and increasing perceived support, resilience, self-esteem, the ability to tolerate distress, the capacity to develop adaptive coping strategies, life satisfaction, and effective emotional regulation (e.g., Turner et al., 2022; Whitlock et al., 2013). Even though family support and communication have been identified as a main variables influencing the maintenance and cessation of DSH, family conflict has been associated with SA in adolescence and early adulthood, and is one of the main reasons for attempting suicide (e.g., Klonsky et al., 2014; O'Brien et al., 2021).

Although different studies have attempted to understand what favors and what prevents help-seeking, no study has yet tried to clarify young people's expectations regarding the person from whom they sought help, or explored possible differences between those who sought and those who did not seek help regarding SI and the severity and diversity of DSH. Additionally, no studies on help-seeking decisions in the context of DSH have been conducted in the Portugal. Hence, one of the objectives of the present study is to increase awareness of help-seeking facilitators and barriers in young Portuguese adults who present a lifetime history of DSH, as well as to provide a portal for mapping what young people expect when they seek help.

To narrow the gap in the literature, we conducted two separate studies. The first describes and differentiates young people who sought or did not seek help in terms of the diversity and severity of DSH, SI, family conflicts, desire to stop DSH, age, and gender. In addition, qualitative data concerning the barriers to and facilitators of help-seeking were collected. The second study aims to provide information about the expectations young people have about the person they asked or thought about asking for help, as well as what they expect from professional healthcare practitioners.

Study 1: Differences Between Young Adults Who Sought and Did Not Seek Help, Desire to Stop DSH, and Motives to Seek or Not to Seek Help.

## 2. Methods

### 2.1. Participants and procedure

Participants were 222 young Portuguese adults aged between 18 and 25 years with a history of DSH. Two groups were created from the sample according to their help-seeking behaviors and are further described in Table 1.

This sample is part of a larger longitudinal study about DSH, which has been approved by ISPA – University Institute of Psychologic, Social and Life Sciences Ethics Committee. Data was collected online between 2020 and 2021. The survey's link was shared in university classes. The survey began with the presentation and contextualization of the study and a guarantee of confidentiality and anonymity. All participants gave

**Table 1**  
Sample description by groups – Age, Gender, SI, Family Conflicts, and Diversity and Severity of DSH.

Variables	Sought help	Did not seek help
N (%)	83 (37.4%)	139 (62.6%)
Age (M, SD, %)	$\bar{x}$ =21.42 ( $\pm$ 2.68)	$\bar{x}$ =21.20 ( $\pm$ 2.28)
Gender (%)	Female: 59% Male: 41%	Female: 54% Male: 46%
Suicidal ideation (M, SD, %)	$\bar{x}$ =95.34 ( $\pm$ 48.13) With SI: 80.7% Without SI: 19.3%	$\bar{x}$ =80.73 ( $\pm$ 47.80) With SI: 74.1% Without SI: 25.9%
Family conflicts (M, SD)	$\bar{x}$ =18.04 ( $\pm$ 6.36)	$\bar{x}$ =17.46 ( $\pm$ 6.32)
Diversity of DSH (M, SD)	$\bar{x}$ =3.32 ( $\pm$ 2.68)	$\bar{x}$ =5.16 ( $\pm$ 3.05)
DSH Diversity (%)	1: 7.2% 2: 16.9% 3: 9.6% 4: 16.9% 5: 12% 6: 7.2% 7: 3.6% 8: 12% 9: 3.6% 10: 2.4% 11: 6% 12: 1.2% 13: 1.2%	1: 25.9% 2: 25.9% 3: 17.3% 4: 7.2% 5: 6.5% 6: 5.8% 7: 5% 8: 0.7% 10: 1.4% 11: 2.2% 12: 1.4% 14: 0.7%
DSH Severity (%)	Moderate = 6% High = 43.4% Extremely high = 50.6%	Light = 18% Moderate = 28.1% High = 37.4% Extremely high = 16.5%

their informed consent. A final section was added in both studies with information about support contacts in Portugal for DSH and suicide (i.e., their phone numbers, email addresses, and service hours).

2.2. Measures

The research team developed a sociodemographic questionnaire and used the Inventory of Deliberate Self-Harm Behaviors (Duarte et al., 2019). This instrument presents 14 self-harm methods with different degrees of severity (e.g., “I scratched myself until a wound formed” and “I stabbed myself with needles”). While there is no consensus on the categorization of these behaviors, they are usually classified into three levels of severity (light, moderate, and high) based on the degree of injury caused (Duarte et al., 2019; Whitlock et al., 2008). For this study, SA was classified as an extremely high DSH behavior. Lifetime frequency (“never”, “once,” “2 to 10 times” and “more than 10 times”) was assessed for each behavior. The participants who responded “never” for all the behaviors were not included in the present sample. Diversity was measured by counting the number DSH methods reported by each participant.

Further, the Portuguese adaptation (Ferreira and Castela, 1999) of the Suicidal Ideation Questionnaire (Reynolds, 1988), assesses the frequency and severity of suicidal thoughts. This instrument is one-dimensional and consists of 30 items. The cutoff point is 41 points; thus, scores greater than 41 indicate SI. The responses are graded using a 7-point Likert scale ranging from *never* to *always*.

We also asked the participants whether they ever wanted to stop engaging in DSH behaviors (“Did you ever want to stop these behaviors?” and “Why?”). This question allowed us to determine whether help-negation and help-seeking were influenced by the participants desire to maintain DSH. We then asked if they had sought help and why (“Did you ever ask for help to stop these behaviors?” and “Why?”). These questions were designed to gather data about the factors that facilitated or inhibited help-seeking behaviors.

Finally, we presented six items from the Portuguese version of the Family Climate Inventory (Teodoro et al., 2009). These items constitute the conflicts scale and were designed to evaluate whether the relationship between parents and their child is aggressive or conflictual (e.g.,

“We fight over anything”). This scale also uses a 5-point Likert scale ranging from “I strongly disagree” to “I strongly agree.” Higher scores mean more conflictual relations.

3. Results

3.1. Differences between young adults who sought and did not seek help

Because the assumptions (homogeneity Levene’s Test) for the use of parametric tests failed ( $p < .05$ ), we present the alternative methodology in Table 2 to explore differences between groups regarding age, gender, family conflicts, diversity and severity of DSH methods and SI.

No significant differences were found for age, gender and family conflicts between the two groups ( $p > .05$ ). However, the association between severity and family conflicts was significant ( $p < .05$ ), but only for the group who did not seek help. The Spearman association was moderate and negative between these variables ( $R_s = - 0.296$ ). We also tested differences for family conflict between the group who wanted to stop DSH behaviors ( $M = 16.33$ ;  $SD = 6.88$ ) and the group who did not ( $M = 19.55$ ;  $SD = 5.50$ ). A significant difference ( $U = 613.00$ ;  $p < .05$ ) was found only for the group who sought help. The group who did not want to seek help but asked for it had a higher mean for family conflicts.

The average for the diversity of DSH was 3.32 ( $SD = 2.68$ ) for those who sought help and 5.16 ( $SD = 3.05$ ) for those who did not, with significant differences between them ( $p < .05$ ). The group who did not seek help had a higher mean ( $M = 3.32$ ). It is important to note that 25.9% of those who did not seek help used only one method, but for the group who sought help only 7.2% of the young people reported using only one DSH method. Significant differences were found between the groups ( $p < .001$ ) concerning DSH severity. The distribution of participants per group can be seen in Table 3.

Regarding SI, the average value for this variable was 95.34 ( $SD = 48.13$ ) amongst the group who sought help and 80.73 ( $SD = 47.80$ ) amongst the group who did not seek help. The Mann–Whitney U test revealed significant differences between the two groups ( $p < .05$ ): 80.7% of young adults who sought help and 74.1% of young adults who did not seek help had SI at the time of data collection.

3.2. Desire to stop DSH

Table 4 shows the association between the desire to stop DSH behaviors and asking for help. As was noted above, 32% of the participants who wanted to stop their behaviors did not seek help, whereas some said they did not want to stop. The final questions were added to identify the reasons why the participants sought or did not seek help and to clarify these findings.

3.3. Motives to seek or not to seek help

Regarding the motives that contribute to seek or not to seek help, 170 participants answered the questions “Did you ask for help?” and “Why?” (68 for the group who sought help and 102 for the group who did not). After content analysis, 10 categories emerged (with 83 coding units) for the group who sought help and 17 categories (with 130 coding units) for

**Table 2**  
Test results for differences between the two groups (Sought Help vs. Did Not Seek Help).

Dependent variable	Test statistics	Significance
Age	$U = 5456.000$	0.495 <sup>ns</sup>
Gender	$\chi^2 = 0.544 (1)$	0.461 <sup>ns</sup>
Family conflicts	$U = 6055.50$	0.535 <sup>ns</sup>
Diversity of self-harm methods used	$U = 8058.00$	0.001
Severity of self-harm methods used	$\chi^2 = 48.709 (3)$	0.001
Suicidal ideation	$U = 6833.00$	0.021

**Table 3**

Cross-tabulation table: DSH severity amongst the two groups.

Variables		Sought help		Total
		No	Yes	
DSH Severity	Light	25	0	25
	Moderate	39	5	44
	High	52	36	88
	Extremely high	23	42	65
Total		139	83	222

**Table 4**

Cross-tabulation table: desire to stop DSH amongst the two groups.

		Sought help		Total
		No	Yes	
Desire to stop DSH	No	68 (30.6%)	44 (19.8%)	112 (50.5%)
	Yes	71 (32%)	39 (17.6%)	110 (49.5%)
Total		139 (62.6%)	83 (37.4%)	222 (100%)

the group who did not, as seen in Table 5.

The main category presented by the group who sought help was the fear of being exposed/discovered (18.1%). SA (10.8%) was another category; some participants said that someone had seen them and took them to the emergency services (e.g., “My mother took me to the hospital after I attempted suicide”; “I told someone” (9.6%), and “I told a friend what was happening and she took me to see someone”). In some cases (4.8%), people started to notice behavioral changes (e.g., “I was losing a lot of weight and my parents noticed”; and “People around me were concerned because I looked sad”). Several participants (3.6%) knew they needed health care because of one or more DSH episodes (e.g., “I cut myself and got infected, I was in a lot of pain and it was looking bad”).

Other help-seeking categories showed that the participants were scared and intended to stop and find other ways of dealing with their DSH. This applied in 16.9% of responses (e.g., “I was losing control/I was afraid it would get worse or I would die,” “I couldn’t control it anymore. I was doing it obsessively at every place and time because there was no one present”; and “I was afraid I would try to kill myself at some point”); and despair (14.5%; e.g., “I hit rock-bottom”). While 10.8% of the answers related to an inability to stop (e.g., “At some point I knew I couldn’t stop by myself”). Others (9.6%) expressed negative feelings (e.g., “I was in such despair that it felt like my chest was exploding” and “I was going into a spiral of deep sadness, despair, and loneliness”). DSH behaviors perceived as unhealthy coping mechanisms accounted for 3.6% of the answers (e.g., “I know it’s bad for me”).

For the group who did not seek help, the main reason presented shows a devaluation of DSH phenomena, with 18.5% of the answers saying, “It was only a few times and I didn’t leave any scars.” Shame, fear of the consequences, stigma, and fear of disappointing, hurting, or worrying the people they love altogether represent 41.5% of the categories found. A total of 5.4% of the categories refer to the ability to successfully stop DSH behaviors by themselves, while 3.1% expressed feelings of being misunderstood.

### 3.4. Discussion

The present article aimed to describe and differentiate young people who sought or did not seek help in terms of the diversity and severity of DSH, SI, family conflicts, desire to stop DSH, age, and gender. In addition, qualitative data concerning the barriers to and facilitators of help-seeking were collected. The second study aimed to provide information about the expectations young people have about the person they asked or thought about asking for help, as well as what they expect from professional healthcare practitioners.

Our findings revealed differences between groups regarding SI, with

**Table 5**

Percentage of responses according to category in the two groups.

Sought help	%
Fear of DSH being exposed/discovered “I couldn’t hide the marks”/“Someone saw the marks”	18.1
DSH severity worsen “I was afraid it would get worse, or I would die”	16.9
Despair “I couldn’t take it anymore”	14.5
Suicide attempt(s) “I attempted suicide”	10.8
Inability to stop DSH “I couldn’t stop on my own”	10.8
Unburden/Disclosure “I told someone”	9.6
Experiencing negative feelings “I felt miserable, alone, and sad”	9.6
Behavioral changes perceived by others “People around me started to notice that something was wrong”	4.8
Perceiving DSH as an unhealthy coping strategy “It’s not healthy for me”	3.6
Health care was needed because of DSH episodes “I went to the hospital because one of the cuts in my thigh got infected”	1.2
Did not seek help	%
DSH devaluation “I just did it a few times and I didn’t leave any marks. I always thought that it was normal thing during adolescence”	18.5
Shame “I am embarrassed to reveal what I’m going through and what I do to cope with my problems”	16.9
Fear of the consequences “I was afraid I was getting expelled from school”	11.5
Keep it secret “I didn’t want to talk about it or anyone to know what was happening”	7.7
Disappointing, hurting or worrying other people “I thought my family and friends would be disappointed with me and I didn’t want them to be worried”	7.7
No need for help “I didn’t think I needed help”	6.9
Successfully coping with DSH behaviors “I stopped by myself”	5.4
Stigma “I was afraid of being labeled as ‘crazy’”	5.4
Courage “I didn’t have the courage to disclosure any of my thoughts or behaviors”	3.9
DSH behaviors perceived as coping strategies “Self-harm behaviors calm and relieve me”	3.1
Feeling misunderstood “No one would understand me”	3.1
DSH not perceived as a health or mental health problem “I didn’t know who to ask or where to go. I thought about going to the teachers but I didn’t know if they could help and I never thought about going to the hospital because it wasn’t an emergency”	3.1
Desire to die “I wanted to die”	2.3
Costs “I didn’t have any money”	2.3
Difficulties in self-disclose/explanation “I find it hard to explain what I feel or what is happening to me”	1.5
Avoidance of formal sources of help “I didn’t want to be seen by professionals”	0.8

a higher score for those who sought help. For the diversity of DSH, the group who sought help had a higher mean of methods used. Higher severity scores were recorded amongst the group who sought help. Significant differences were found for both diversity and severity of DSH behaviors between groups. These results are in line with previous research, since higher severity behaviors are most likely to be in need of medical care, noticed easily, infect or leave more scars, so having more severe behaviors could lead young people to the emergency services and therefore to getting help to stop and control DSH their behaviors (e.g., Owens et al., 2003). These results are also in line with the contents of the qualitative analysis where 12% of the motives for seeking help were related to severe DSH behaviors or SAs that needed health-care

assistance.

The group who did not seek help had a higher range and mean of DSH methods. As was pointed out above, a higher diversity of DSH methods used is associated with a significantly higher suicide risk (Duarte et al., 2020; Gouveia-Pereira et al., 2022; Pompili et al., 2015). It is also important to note that the group who sought help engaged in more severe methods of self-harm; no one reported using light means of self-harm, and few participants reported engaging in moderate behaviors.

The quality of family relationships has been associated with the maintenance, cessation and severity of DSH behaviors (e.g., Turner et al., 2022), therefore, we expected a positive association between family conflicts and the severity of DSH. However, in the present study the association between DSH severity and family conflicts was negative – in other words, more family conflicts were associated with lighter methods of DSH. Other authors (e.g., Tatnell et al., 2014; Turner et al., 2022) reported the same results and proposed that being exposed to a conflictual environment for a long period of time can lead to a desensitization and a decreasing in the need to self-punish and this can explain the negative association found between family conflicts and the severity of DSH. As family relations tend to deteriorate, DSH behaviors persist (or worsen) and may lead to desensitization and a decreasing in the need to self-punish (Tatnell et al., 2014; Turner et al., 2022).

Within the group who sought help, more family conflicts were mentioned by participants who did not want to stop the behaviors. Usually, when parents know about their children’s DSH behaviors, this leads to help-seeking from formal help sources even when the young person wishes to maintain the behavior, which could consequently increase family conflicts and may explain our results (Hasking et al., 2015). Helping parents to build better relationships with their children would facilitate young people’s comfort in disclosing their DSH behaviors and asking healthcare practitioners for help. Moreover, schools may have an important role promoting parent support groups, spreading information, and giving useful contacts for both parents and their children (Thorslund et al., 2017).

It is also common for parents to show negative reactions to disclosure about DSH, increasing family conflicts and therefore the desire to maintain the behavior (e.g., Gray et al., 2022). The fear of disappointing, hurting, or being a burden to loved ones is one of the motives presented for not seeking help in our study and is in line with the findings published by O’Brien et al. (2021), in which perceived burdensomeness (the assumption that one’s existence implies excessive burden to the closest people) is present for 20% of the adolescents. At the same time, it is known that not all the people who engage in DSH have the desire to stop doing so (Gray et al., 2022), which was reported by half of our sample.

Two questions remained after this study: “What do young people expect from the person they ask or intend to ask for help?” and “What do they expect from healthcare practitioners?”. Therefore, the main goal for the second study was to characterize what the participants were looking for in the person they asked (or were thinking about asking) to help them and to expand our knowledge about what these informal and formal sources could focus on.

Study 2: The Expectations of Young People Regarding (a) Those They Asked (or Thought of Asking) for Help and (b) Healthcare Workers.

The purpose of the second study was to describe (1) the expectations of the participants when they asked someone in their social network or a healthcare worker to help them and (2) for those who did not seek help, what would they expect from both their social network and a healthcare worker. The main aim of the study was to determine what the participants were looking for in the person to whom they went for help (or were thinking about it) and to distinguish requests for assistance from simple unburdening (e.g., to friends).

## 4. Methods

### 4.1. Participants and procedure

A total of 110 young Portuguese adults between the ages of 18 and 25 participated in this study, with a lifetime history of DSH. The sample used for this study is not the same as that presented in the first study. The sample was divided into two groups: the first comprised those who asked for help (46 participants, 41.8%;  $M_{age} = 21.30$ ;  $SD_{age} = 2.25$ ) and the second, those who did not (64 participants, 58.2%;  $M_{age} = 20.98$ ;  $SD_{age} = 2.14$ ). The first group consisted of 60.9% females and the second 73.4%.

The study data were collected online during 2021 and the link was shared among university students. Participants were guaranteed privacy and anonymity. They all gave their informed consent.

### 4.2. Measures

The research team designed a sociodemographic questionnaire that included questions about gender and age and a help-seeking questionnaire based on the instruments used by Rickwood et al. (2005) and Wilson and Deane (2001) in their studies concerning young people’s help seeking behaviors for mental health problems. These studies proposed similar categories. The questionnaire contained closed questions using a 7-point self-response scale ranging from one (*nothing*) to seven (*a lot*). These questions covered issues relating to support (e.g., “I don’t want to feel alone”), feeling understood and trusted (e.g., “I don’t feel judged”), problem-solving (e.g., “I know they will help solve the problem”), unburdening/relief (e.g., “I just want to talk to someone”), and confidentiality (e.g., “I know they’re going to keep it a secret”). The study also comprised the Inventory of Deliberate Self-Harm Behaviors (Duarte et al., 2019). The participants who responded “never” for all the behaviors presented in the Inventory of Deliberate Self-Harm Behaviors (Duarte et al., 2019) were not included in the present sample. Both groups answered the same questions.

## 5. Results

Table 6 summarizes the results for each group. Problem-solving was the highest scoring expectation for those who sought help from their social network, followed by confidentiality, understanding and trust,

**Table 6**  
Descriptive statistics and differences between groups regarding expectations from social network and healthcare workers.

		Sought help	Did not seek help	Test statistic (U)	Sig.
Social network	Problem-solving	$\bar{x} = 5.75$ ( $\pm 1.42$ )	$\bar{x} = 5.10$ ( $\pm 1.60$ )	1426.00	0.023
	Confidentiality	$\bar{x} = 5.72$ ( $\pm 1.56$ )	$\bar{x} = 5.71$ ( $\pm 1.77$ )	1335.00	0.235 <i>ns</i>
	Understanding and trust	$\bar{x} = 5.42$ ( $\pm 1.59$ )	$\bar{x} = 4.90$ ( $\pm 1.72$ )	1339.00	0.111 <i>ns</i>
	Support	$\bar{x} = 5.03$ ( $\pm 1.69$ )	$\bar{x} = 4.64$ ( $\pm 1.78$ )	1258.50	0.324 <i>ns</i>
	Unburdening	$\bar{x} = 5.00$ ( $\pm 1.86$ )	$\bar{x} = 4.89$ ( $\pm 1.86$ )	1184.00	0.669 <i>ns</i>
Healthcare Workers	Problem-solving	$\bar{x} = 5.62$ ( $\pm 1.67$ )	$\bar{x} = 5.31$ ( $\pm 1.87$ )	1246.00	0.362 <i>ns</i>
	Understanding and support	$\bar{x} = 5.09$ ( $\pm 1.71$ )	$\bar{x} = 4.61$ ( $\pm 2.19$ )	1251.00	0.353 <i>ns</i>

support, and unburdening. Regarding the healthcare workers, the main theme was problem-solving followed by understanding and support. The group who did not seek help expected confidentiality from their social network first, followed by problem-solving, understanding and trust, unburdening, and support. They expected primarily problem-solving, understanding, and support from health-care practitioners. The expectations were different for the groups regarding social networks, but not healthcare professionals, from whom they expected problem-solving capabilities.

A difference-between-groups test was conducted for each category. We provide an alternative methodology since the assumptions for the use of parametric tests failed ( $p < .05$ ) for at least one of the groups. The Mann–Whitney U test revealed significant differences for the problem-solving category regarding social networks only ( $U = 1426.00$ ;  $p = .023$ ). All the other expectations showed nonsignificant differences ( $p < .05$ ) for both social network and healthcare workers.

### 5.1. Discussion

This study aimed to enrich our understanding of help-seeking behaviors by mapping the participants' expectations when deciding to seek help from their social networks and healthcare professionals. We distinguished the two groups (participants who sought for help and those who did not seek help) to see if there were any differences in what each one favored. No significant differences were found, except for problem-solving regarding social network. For the group who did not seek help, confidentiality was the higher scored category for social network and problem-solving capabilities was the higher scored category for healthcare practitioners. For the group who sought help, problem-solving scored highest for both social network and healthcare practitioners. Biocalti et al. (2018) indicated that, for young people, confidentiality and trust were important to promote help-seeking behaviors. Even though confidentiality is one of the higher scored categories, it is only the main theme for those who did not seek help regarding their social network. Young people seem to favor the capacity of their social network or health-care practitioner to solve the problem – in other words, primarily to help them cease their DSH behavior.

## 6. General discussion

### 6.1. Help-Seeking facilitators

Firstly, we would like to highlight the percentage of extremely high severity methods in the group who did not seek help, with 16.5% saying that they attempted suicide at least once. It's possible that higher scores of SI combined with SAs (extremely high severity methods of DSH) contribute to healthcare seeking, which facilitates getting help to stop these behaviors. In addition, reporting more severe DSH methods can lead to emergency services and facilitate getting help (Owens et al., 2003). Considering that 16.5% of the participants who did not seek help reported at least one SA, and the reasons presented for seeking help (e.g., "Someone saw the marks"), it is important to note that having attempted suicide per se or engaging in severe methods of DSH does not mean getting help for some young people.

The desire to stop DSH behaviors is pointed to as a facilitator for getting help (e.g., Mummé et al., 2017), but it is not sufficient alone for asking for help (Gray et al., 2022). As our results presented, a third of the participants who wanted to stop their DSH behaviors did not ask for help. The same applies to the quality of family relations, since having a caring and supportive family, with space to talk about problems, and DSH specifically, was identified as a facilitator for getting help and ceasing these behaviors (Duarte et al., 2020a; Muehlenkamp et al., 2013; Mummé et al., 2017). On the other hand, a conflictual family environment was associated with SAs in adolescence. Furthermore, the perceived burdensomeness about oneself in the family context, aligned with intrapersonal conflicts, can compromise help-seeking behaviors,

even though the family is supporting and caring (Tatnell et al., 2014; Turner et al., 2022).

The recognition that these behaviors are not healthy and can lead to severe outcomes represented altogether 38.6% of the motives presented for seeking help and constitutes one of the main facilitators for getting help. In addition, when we asked young adults what they prefer when they asked for help or think about doing so, the ability of their social network and healthcare workers to solve the problem, together with confidentiality regarding their behaviors are the higher scored categories, meaning these are facilitators to seeking help.

### 6.2. Help-seeking barriers

One of the most common functions of DSH is affect regulation (Duarte et al., 2018; Hasking et al., 2015; Klonsky, 2007). In the present study, the feeling of relief experienced by young people after DSH is seen as a barrier to seeking help for only a few participants. This may be an important reason for engaging in several DSH methods, as pointed out by the participants, but it does not seem to be a main motive for not seeking help. Conversely, the devaluation of the severity of DSH or the inability to recognize them as maladaptive is identified as one of the main barriers to seeking help, accounting for 18.5% of the motives.

One of the most significant barriers is the stigma, shame, and fear of negative reactions, which encourages secrecy, increases feelings of isolation, and erodes levels of perceived support (Hasking et al., 2015; Gray et al., 2022; Maple et al., 2020). In the present study, fear of consequences, shame, and perceived burdensomeness represented a third of the motives for not seeking help. Another barrier to seek help is the absence of the desire to stop with half of the participants saying they didn't want to stop DSH behaviors.

### 6.3. Implications

The results presented and discussed above underline the importance of understanding help-seeking facilitators and barriers in the context of DSH behaviors as multifactorial and as a complex phenomenon. The qualitative results of the study are consistent with recent literature (e.g., Mudge et al., 2008; Gray et al., 2022; Turner et al., 2022). They represent a major step towards our understanding of what drives help-seeking and help-negation behaviors amongst young adults with DSH and enriches the knowledge about what facilitates or mitigates against asking for help.

Furthermore, several misapprehensions that appeared regarding DSH highlight the urgent need to properly inform and talk about these behaviors. Schools – as a meeting point for peers, family, and teachers – should be the ideal environment to address the severity of these behaviors and to disseminate accurate information, sharing helpful contacts for those in need and providing support groups for young people and parents (Krysinska et al., 2020; Smith, 2004; Thorsund et al., 2017; Townsend et al., 2021).

Practitioners would benefit from knowing what specifically drives the group of young people who want to stop DSH behaviors but do not ask for help. As reported by other authors (e.g., Gray et al., 2022), this group may have specific needs that we need to better understand.

Owens et al. (2003) found that three quarters of those who died by suicide were not receiving specialist healthcare before they killed themselves. This might also be the case for Portuguese young adults, since the majority of the participants with DSH behaviors did not ask for help. Finally, we stress the high score of SI for both groups, especially for those who did not seek help.

### 6.4. Limitations and future directions

The present study has several limitations. For instance, the samples were not uniform, and the data were collected during quarantine. This fact compromises the generalization of results since we need more

studies to confirm if the same results are found nowadays. It would therefore be interesting to know whether there were any changes in the nature and degree of DSH during that time and whether it would have impacted the SI scores. Also, collecting data online is another limitation as it is impossible to control the respondents of the survey, even though it was shared with university students, and also to manage the environment in which data is collected. Additionally, this collection method does not allow to control absence and to access the magnitude of selection bias.

Moreover, several additional variables could be included in future studies, such as to whom young adults prefer to disclose their DSH behaviors, their possible psychopathology, parents' psychopathology, and the age of the first and last DSH behavior. Also, regarding cultural characteristics, it is not possible to know the participants' cultural background since we did not ask for this information and the inclusion criteria was that participants should be Portuguese speakers.

Both studies herein present new knowledge about the role of DSH diversity and severity in the context of help-seeking and help-negation behaviors. It would be useful to ask openly what do those who did not ask for help need in order to do so and also to explore what help do young people need to ask from formal sources and what help they can provide themselves. Furthermore, the studies highlight how parents, teachers, peers, and healthcare professionals might respond when confronted with DSH and suicidal behavior. Schools offer a privileged intervention setting because they can be a meeting point for both adolescents, parents, and teachers (Biocalti et al., 2018; Fortune et al., 2008). More information is also needed about the motives and reasons for not wanting to stop DSH behaviors of those 50.5% who fall into this category. Finally, the second study provides an insight into the expectations young adults have of social networks and health-care practitioners when they ask for help to stop DSH. Future research should also focus on what are the characteristics of family relations that could be barriers to or facilitators of help-seeking.

## Funding

This work was supported by Applied Psychology Research Center Capabilities and Inclusion (APPsCI), ISPA – University Institute and by a grant from the Science and Technology Foundation/Fundação para a Ciência e Tecnologia [20200925.BD]

## Declaration of Competing Interest

All authors declare that they have no conflicts of interest to disclose.

## References

- Arbuthnott, A., Lewis, S.P., 2015. Parents of youth who self-injure: a review of the literature and implications for mental health professionals. *Child Adolesc. Psychiatry Mental Health* 35 (9), 1–20. <https://doi.org/10.1186/s13034-015-0066-3>.
- Barrocas, A., Giletta, M., Hankin, B., Prinstein, M., Bela, J., 2015. Nonsuicidal self-injury in adolescence: longitudinal course, trajectories and intrapersonal predictors. *J. Abnorm. Child Psychol.* 43 (2), 369–380. <https://doi.org/10.1007/s10802-014-9895-4>.
- Biddle, L., Donovan, J., Owen-Smith, A., Potokar, J., Longson, D., Hawton, K., Kapur, N., Gunnell, D., 2010. Factors influencing the decision to use hanging as a method of suicide: qualitative study. *Br. J. Psychiatry* 197 (4), 320–325. <https://doi.org/10.1192/bjp.bp.109.076349>.
- Bijl, R.V., Ravelli, A., 2000. Psychiatric morbidity, service use, and need for care in the general population: results of the Netherlands mental health survey and incidence study. *Am. J. Public Health* 90 (4), 602–607. <https://doi.org/10.2105/ajph.90.4.602>.
- Biolcati, R., Palareti, L., Mameli, C., 2018. What adolescents seeking help teach us about a school-based counseling service. *Child Adolesc. Soc. Work J.* 35 (1), 45–56. <https://doi.org/10.1177/0272431613494006>.
- Bland, R.C., Newman, S.C., Orn, H., 1997. Help-seeking for psychiatric disorders. *Can. J. Psychiatry* 42 (9), 935–942. <https://doi.org/10.1177/070674379704200904>.
- Castellví, P., Lucas-Romero, E., Miranda-Mendizábal, A., Parés-Badell, O., Almenara, J., Alonso, I., Blasco, M.J., Cebrià, A., Gabilondon, A., Gili, M., Lagares, C., Piqueras, J. A., Roca, M., Rodríguez-Marin, J., Rodríguez-Jimenez, T., Soto-Sanz, V., Alonso, J., 2017. Longitudinal association between self-injurious thoughts and behaviours and suicidal behaviour in adolescents and young adults: a systematic review with meta-analysis. *J. Affect. Disord.* 215, 37–48. <https://doi.org/10.1016/j.jad.2017.03.035>.
- Cipriano, A., Cella, S., Cotrufo, P., 2017. Nonsuicidal self-injury: a systematic review. *Front. Psychol.* 8 (8) <https://doi.org/10.3389/fpsyg.2017.01946>. Article 1946.
- Duarte, E., Gouveia-Pereira, M., Gomes, H., 2019. Development and validation of the inventory of deliberate self-harm behaviours for Portuguese adolescents. *Psychiatry Q.* 90, 761–776. <https://doi.org/10.1007/s11226-019-09660-1>.
- Duarte, E., Gouveia-Pereira, M., Gomes, H.S., Sampaio, D., 2018. How do families represent the functions of deliberate self-harm? A comparison between the social representations from adolescents and their parents. *Arch. Suicide Res.* <https://doi.org/10.1080/13811118.2018.1545713>. online.
- Duarte, E., Gouveia-Pereira, M., Gomes, H.S., Sampaio, D., 2020a. Social representations about the functions of deliberate self-harm: construction and validation of a questionnaire for Portuguese adolescents. *J. Pers. Assess* 102 (3), 405–414. <https://doi.org/10.1080/00223891.2018.1557667>.
- Duarte, T., Paulino, S., Almeida, C., Gomes, H., Santos, N., Gouveia-Pereira, M., 2020b. Self-harm as predisposition for suicide attempts: a study of adolescents' deliberate self-harm, suicidal ideation, and suicide attempts. *Psychiatry Res.* 287. <https://doi.org/10.1016/j.psychres.2019.112553>.
- Ferreira, J., Castela, M., 1999. Questionário de ideação suicida (QIS) [Suicidal Ideation Questionnaire]. In: Simões, M.R., Gonçalves, M.M., Almeida, L.S. (Eds.), *Testes e Provas Psicológicas Em Portugal [Tests and Psychological Evidence in Portugal]*. Sistemas Humanos e Organizacionais, Lda, pp. 129–130.
- Fortune, S., Sinclair, J., Hawton, K., 2008. Help-seeking before and after episodes of self-harm: a descriptive study in school pupils in England. *BMC Public Health* 8 (1), 1–13. <https://doi.org/10.1186/1471-2458-8-369>.
- Frey, L.M., Higgins, G.E., Fulginiti, A., 2018. Testing the psychometric properties of the self-harm and suicide disclosure scale. *Psychiatry Res.* 270, 134–142. <https://doi.org/10.1016/j.psychres.2018.09.016>.
- Gouveia-Pereira, M., Duarte, E., Gomes, H.S., da Silva, C.T., Santos, N., 2022. Exploring the suicidal continuum: deliberate self-harm diverseness and severity as predictors of suicidal ideation and suicide attempts. *Psychiatry Res* 309. <https://doi.org/10.1016/j.psychres.2022.114400>.
- Gouveia-Pereira, M., Gomes, H.M., Roncon, F., Mendonça, R., 2016. Impulsivity mediates the relationship between future orientation and juvenile delinquency. *Deviant Behav.* 38 (1), 34–46. <https://doi.org/10.1080/01639625.2016.1190591>.
- Guerreiro, D., Sampaio, D., Figueira, M., Madge, N., 2017. Self-harm in adolescents: a self-report survey in schools from Lisbon. *Arch. Suicide Res.* 21 (1), 83–99. <https://doi.org/10.1080/13811118.2015.1004480>.
- Gray, N., Hasking, N., Boyes, M., 2022. Cognitive and emotional factors associated with the desire to cease non-suicidal self-injury. *J. Clin. Psychol.* 78 (9), 1896–1911. <https://doi.org/10.1002/jclp.23336>.
- Hamza, C., Stewart, S., Willoughby, T., 2012. Examining the link between nonsuicidal self-injury and suicidal behaviour: a review of the literature and an integrated model. *Psychol. Rev.* 32, 482–495. <https://doi.org/10.1016/j.cpr.2012.05.003>.
- Hasking, P., Rees, C.S., Martin, G., Quigley, J., 2015. What happens when you tell someone you self-injure? The effects of disclosing NSSI to adults and peers. *BMC Public Health* 15 (1). <https://doi.org/10.1186/s12889-015-2383-0>. Article 1039.
- Henderson, S., Andrews, G., Hall, W., 2000. Australia's mental health: an overview of the general population survey. *Aus. N. Z. J. Psychiatry* 34 (2), 197–205. <https://doi.org/10.1080/j.1440-1614.2000.00686.x>.
- Klineberg, E., Stansfeld, S.A., Bhui, K.S., 2013. How do adolescents talk about self-harm? Findings from a qualitative school-based study in England. *J. Adolesc. Health* 52 (2), S78–S79. <https://doi.org/10.1016/j.jadohealth.2012.10.183>.
- Klonsky, E.D., 2007. The functions of deliberate self-injury: a review of the evidence. *Clin. Psychol. Rev.* 27 (2), 226–239. <https://doi.org/10.1016/j.cpr.2006.08.002>.
- Klonsky, E.D., Glenn, C., May, A., 2012. The relationship between nonsuicidal self-injury and attempted suicide: converging evidence from four samples. *J. Abnorm. Psychol.* 121 (1), 231–237. <https://doi.org/10.1037/a0030278>.
- Klonsky, E.D., Victor, S., Saffer, B., 2014. Nonsuicidal self-injury: what we know, and what we need to know. *Can. J. Psychiatry* 59 (11), 565–568. <https://doi.org/10.1177/070674371405901101>.
- Krysinaka, K., Curtis, S., Lamblin, M., Stefanac, N., Gibson, K., Byrne, S., Thorn, P., Rice, S.M., McRoberts, A., Ferrey, A., 2020. A parent's experience and psychoeducation needs when supporting a young person who self-harms. *Int. J. Environ. Res. Public Health* 17. <https://doi.org/10.3390/ijerph17103662>.
- Luoma, J.B., Martin, C.E., Pearson, J.L., 2002. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am. J. Psychiatry* 159 (6), 909–916. <https://doi.org/10.1176/appi.ajp.159.6.909>.
- Madge, N., Hewitt, A., Hawton, K., Wilde, E.J.D., Corcoran, P., Fekete, S., van Heeringen, K., De Leo, D., Ystgaard, M., 2008. Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) study. *J. Child Psychol. Psychiatry* 49 (6), 667–677. <https://doi.org/10.1111/j.1469-7610.2008.01879.x>.
- Maple, M., Frey, L., McKay, K., Coker, S., Grey, S., 2020. Nobody hears a silent cry for help": suicide attempt survivors' experiences of disclosing during and after a crisis. *Arch. Suicide Res.* 24 (4), 498–516. <https://doi.org/10.1080/13811118.2019.1658671>.
- Meltzer, P.B., Brugha, T., Farrell, M., Jenkins, R., Lewis, G., 2000. The reluctance to seek treatment for neurotic disorders. *J. Mental Health* 9 (3), 319–327. <https://doi.org/10.1080/0954026021000046038>.
- Michelmores, L., Hindley, P., 2012. Help-seeking for suicidal thoughts and self-harm in young people: a systematic review. *Suicide Life-Threat. Behav.* 42 (5), 507–524. <https://doi.org/10.1111/j.1943-278X.2012.00108.x>.
- Muehlenkamp, J.J., Claes, L., Quigley, K., Prosser, E., Claes, S., Jans, D., 2013. Association of training on attitudes towards self-injuring clients across health

- professionals. *Arch. Suicide Res.* 17 (4), 462–468. <https://doi.org/10.1080/13811118.2013.801815>.
- Mummé, T.A., Mildred, H., Knight, T., 2017. How do people stop non-suicidal self-injury? A systematic review. *Arch. Suicide Res.* 21 (3), 470–489. <https://doi.org/10.1080/13811118.2016.1222319>.
- Nock, M.K., 2010. Self-injury. *Annu. Rev. Clin. Psychol.* 6, 339–363. <https://doi.org/10.1146/annurev.clinpsy.121208.131258>.
- O'Brien, K.H.M., Nicolopoulos, A., Almeida, J., Arguinaldo, L.D., Rosen, R., 2021. Why adolescents attempt suicide: a qualitative study of the transition from ideation to action. *Arch. Suicide Res.* 25 (2), 269–286. <https://doi.org/10.1080/13811118.2019.1675561>.
- Owens, C., Booth, N., Briscoe, M., Lawrence, C., Lloyd, K., 2003. Suicide outside the care of mental health services: a case-controlled psychological autopsy study. *Crisis* 24 (3), 113–121. <https://doi.org/10.1027/0227-5910.24.3.113>.
- Owens, C., Lambert, H., Donovan, J., Lloyd, R., 2005. A qualitative study of help seeking and primary care consultation prior to suicide. *Br. J. General Pract.* 55, 503–509.
- Parra, A., Oliva, A., Reina, M., 2015. Family relationships from adolescence to emerging adulthood. *J. Fam. Issues* 36 (14), 2002–2020. <https://doi.org/10.1177/0192513X13507570>.
- Pompili, M., Goracci, A., Giordano, G., Erbutto, D., Girardi, P., Klonsky, E.D., Baldessarini, R.J., 2015. Relationship of non-suicidal self-injury and suicide attempt: a psychopathological perspective. *J. Psychopathol.* 21, 348–353.
- Reynolds, W. (1988). Suicidal Ideation Questionnaire. *Psychol. Assess. Resour.*
- Rickwood, D., Deane, F.P., Wilson, C.J., Ciarrochi, J., 2005. Young people's help-seeking for mental health problems. *Aust. E-J. Adv. Mental Health* 4 (3), 218–251. <https://doi.org/10.5172/jamh.4.3.218>.
- Rowe, S.L., French, R.S., Henderson, C., Ougrin, D., Slade, M., Moran, P., 2014. Help-seeking behaviour and adolescent self-harm: a systematic review. *Aust. N. Z. J. Psychiatry* 48 (12), 1083–1095. <https://doi.org/10.1177/0004867414555718>.
- Singleton, N., 2000. *Psychiatric morbidity among young offenders in England and Wales*. Office for National Statistics.
- Smith, M., 2004. Parental mental health: disruptions to parenting and outcomes for children. *Child Fam. Soc. Work* 9 (1), 3–11. <https://doi.org/10.1111/j.1365-2206.2004.00312.x>.
- Tatnell, R., Kelada, L., Hasking, P., Martin, G., 2014. Longitudinal analysis of adolescent NSSI: the role of intrapersonal and interpersonal factors. *J. Abnorm. Child Psychol.* 42, 885–896. <https://doi.org/10.1007/s10801-013-9837-6>.
- Teodoro, M.L.M., Allgayer, M., Land, B., 2009. Desenvolvimento e validade fatorial do Inventário do Clima Familiar (ICF) para adolescentes. *Anál. Psicol.* 11 (3), 27–39.
- Thorslund, K., Hanse, J.J., Axberg, U., 2017. Do parents of adolescents request the same universal parental support as parents of younger children? A random sample of Swedish parents. *Scand. J. Public Health* 45, 492–502. <https://doi.org/10.1177/1403494817705233>.
- Townsend, M.L., Miller, C.E., Matthews, E., Grenyer, B.F.S., 2021. Parental response style to adolescent self-harm: psychological, social and functional impacts. *Int. J. Environ. Res. Public Health* 18 (24). <https://doi.org/10.3390/ijerph182413407>.
- Turner, B., Robillard, C.L., Ames, M., Craig, S.G., 2022. Prevalence and correlates of suicidal ideation and deliberate self-harm in Canadian adolescents during the coronavirus disease 2019 pandemic. *Can. J. Psychopathol.* 67 (5), 403–406. <https://doi.org/10.1177/07067437211036612>.
- Whitlock, J., Muehlenkamp, J., Eckenrode, J., 2008. Variation in nonsuicidal self-injury: identification and features of latent classes in a college population of emerging adults. *J. Clin. Child Adolesc. Psychol.* 37 (4), 725–735. <https://doi.org/10.1080/15374410802359734>.
- Whitlock, J., Muehlenkamp, J., Eckenrode, J., Purington, A., Abrams, G., Barreira, P., Kress, V., 2013. Nonsuicidal self-injury as a gateway to suicide in young adults. *J. Adolesc. Health* 52 (4), 486–492. [10.1016/j.jadohealth.2012.09.010](https://doi.org/10.1016/j.jadohealth.2012.09.010).
- Wilson, C.J., Deane, F.P., 2001. Adolescent opinions about reducing help-seeking barriers and increasing appropriate help engagement. *J. Educ. Psychol. Consult.* 12 (4), 345–364. [https://doi.org/10.1207/S1532768XJEP1204\\_03](https://doi.org/10.1207/S1532768XJEP1204_03).
- World Health Organization, 2014. *Preventing Suicide: A Global Imperative*. World Health Organization.