Deliberate Self Harm among Adolescents. Where Do We Stand?

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Abstract

Deliberate self-harm (DSH) is distinguished from a suicide attempt. The person who self-harms him/herself does not necessarily have the intention to kill themselves, unlike a suicide attempt where the person has an intention to end their life. Studies have shown that DSH is prevalent among adolescents more than the rest of the population and the risk factors attributed to it are various. These risk factors comprise of mental health issues, family issues, relationship issues, and financial problems majorly. Childhood maltreatment also has been frequently associated with self-harm. The consequences of DSH can result in serious physical and mental injury to the person. A nurse who works with adolescents and especially in schools should be skilled with theoretical and practical skills and knowledge to deal with such patients.

ABBREVIATIONS

DSH: Deliberate Self Harm

INTRODUCTION

Deliberate self-harm (DSH) is a condition wherein individual purposely harms themselves. It is additionally renowned with the name of “parasuicide”, “self – mutilation”, “non-suicidal self-injury”, “self-misuse” and etc [1]. Rather than suicide attempts, which require suicidal expectation, self-harm alludes to nonfatal self-harming or self-injury without self-destructive aim [1,2].

LITERATURE REVIEW

Diagnostic and Statistical Manual of Mental Disorders, third edition includes self-mutilation as a diagnostic criterion. It estimates the prevalence of self-mutilation among the general populace to be 750 for each 100,000, or 1800 for each 100,000 people of 15 to 35 years of age. The frequency of self-mutilation in the mentally ill populace is a lot higher than in everyone else, extending from 4.3% to 20% of every mentally ill patient. In the event that the populace assessed is restricted to juvenile inpatients, the rate increases drastically, moving toward 40% in one investigation and 61% in another [3].

A study was conducted at Oxford University over a period of 30 years (1976-2006) to determine whether rates of suicide and self-harm in university students differ from those in other young people. The results showed that 48 students out of which 37 were in the age band of 18-25 years. In a similar period, a total of 602 students (383 women and 219 men) reported to the General Hospital after DSH. 90.7% were of 15–24 years of age, in which age bunch rates of DSH (per 100,000) during term-time were lower in contrast to other youngsters in Oxford City [4].

A cross-sectional study was conducted in Australia in 2002 in order to determine the prevalence and types of DSH in adolescents and its associated factors. 3757 out of 4097 students of year 10th and 11th (91.7%) from 14 high schools from the Gold Coast, Queensland were recruited for this study. The results showed that 233 students (6.2%) met the DSH criteria in the last 12 months. DSH was more frequent among females as compared to males. The main ways identified for self-harm included self-cutting (138 participants; 59.2%) and overdosing oneself with medicines (69 participants; 29.6%). The factors linked with DSH included alike kinds of acts in friends and families, self-blame, and prescribing medicines to oneself. Most of the participants who reported self-harm were not reported to seek help prior to or after the most recent self-harming incident. However, those who sought help, they did from their friends. It was concluded that DSH is common in youth in Australia and especially it was common among females [5].

Another cross-sectional study was conducted in Germany for determining the prevalence and the associated psychological and social factors of occasional and repetitive DSH behavior in adolescents. A sample of 5759 ninth standard students was recruited to be studied from a time period of 2004 to 2005. It was found that 630 (10.9%) students indulged in an occasional form of DSH within the last year and repetitive form of DSH was reported by 229 (4.0%) students; 14.8% teenagers in the study sample with occasional DSH and 27.1% teenagers in the study sample with repetitive DSH were receiving psychological treatment. The study suggested that there is an association between social factors and DSH, suicidal behavior and DSH and emotions and behavior issues and DSH [6].

A systematic review of 52 empirical studies from the year 2005 to 2011 was conducted that reported on the prevalence of DSH and non-suicidal self-injury in teenagers around the world. It was found that there is no statistically significant difference between...
non-suicidal self-injury (18.0% SD = 7.3) and DSH (16.1% SD = 11.6) studies. Assessment with single-item questions resulted in lower prevalence rates in contrast to assessment using specific behavior checklists and mean prevalence rates have not raised in the past five years which suggests stabilization [7].

A meta-analysis was done to provide estimates of self-harm derived from community-based studies of adolescents from the year 1990 to 2015, estimates about the risk of suicide, age, frequency, methods, reasons, and help-seeking behavior were also found. 172 sets that reported self-harm among 597,548 respondents from 41 nations were taken for the meta-analysis. The lifetime prevalence was 16.9% and rates were increasing by 2015. Females were more likely to indulge in self-harming activities. The mean age of beginning the self-harm was 13 years and 47% reported 1 or 2 incidents. Cutting was the most common method of self-harm (45%). The reasons for self-harm were reported to be relief from thoughts or feelings. A bit more than half looked out for help and friends were the most approached for help. Suicidal ideation (RR= 4.97) and suicide attempts (RR= 9.14) were significantly on the high side in adolescents who self-harmed. However, this was higher as the frequency of self-harming was increased by the participants [8].

Data on self-harm conduct from Pakistan is scanty, particularly for youths. A retrospective descriptive study was conducted of all patients younger than 18 years (n = 69) presented with DSH to a hospital in Karachi, Pakistan. Females (63.8%) were more in numbers as compared to males by 1.7:1. The mean age of the sample was 16 years (± 2.2). The most successive method utilized was an overdose of benzodiazepine (30.4%). Conflicts in the family were the principle stressor addressed by 66.7%. Major depressive disorder was found in 18%. 76.8% communicated their plan to die. Multivariate logistic regression discovered the current stressor to be altogether connected with an aim to die [9].

The literature review suggests that studies on DSH among adolescents have been conducted in different parts of the world. However, data from Pakistan still lacks and therefore needs attention for study in order to make appropriate strategies to tackle the issue. From the literature review, it was found that DSH is prevalent among youths and the frequency keeps on increasing. It is associated with depression, bipolar disorder, drug abuse, alcoholism, family issues, and financial problems. DSH was more common in females than in men and self-cutting and overdosing were the most common methods of DSH. Furthermore, it was also found that teenagers do not seek professional help mostly, rather approach their friends for help in the situation of DSH. In the author’s opinion, studies exclusive to DSH should also be conducted in contrast to the current practice of the combined study of DSH and suicide attempts.

**DISCUSSION**

**Risk factors**

The risk factors or predictors of self-harm include physical and sexual abuse especially in childhood, insecure attachment, and childhood separation. [10] Recent studies have reported that self-harm is most prevalent among youths. Generally, identified with various mental issues, for example, depression, borderline personality disorder, and bipolar disorder, self-hurt has additionally been demonstrated to be common among non-clinical examples of teenagers and youths. As per a study, correlates of self-harm included: low financial status, poor family relationships, tranquilizer abuse, smoking, and alcohol [11]. Childhood maltreatment has been consistently mentioned in researches. Studies point out that individual factor like emotional in-expressivity is associated with self-harm. It is also suggested that sharing and communicating emotional experiences decrease self-harm behavior. However, studies are scarce for this association. Therefore this association of emotional in-expressivity and self-harm can be a further topic to study [12].

**Consequences**

The physical consequences of DSH are scars [13], serious injuries, bleeding, drug toxicity, and etc. The negative physical consequences of DSH can result in further in regret, guilt, shame, and greater isolation [13]. One another consequence that comes across as irrational is “relief from pain” but studies have reported that there is a dramatic and rapid reduction in tension after the act of self-harm [14]. This phenomenon was in fact demonstrated by a study. The urine cortisol levels of a woman who indulged in self-harm were assessed for consecutive 86 nights. It was found that whenever her cortisol levels would rise, she would perform DSH, and then her cortisol level would fall to her baseline levels which were usually low [15].

**Role of nurses**

All the nurses who deal with patients with self-harming behavior should be nonjudgmental in the first place. Judgments and preconceived notions about such patients create a barrier between the nurse and the client. The judgmental attitude can promote an environment for a patient that is not trusted and is rather uncomfortable which in turn will make them unable to share their experiences and reasons for self-harm. As per a qualitative study, mental health nurses’ “caring attitude towards the patient” was discussed. The nurses expressed the importance to know the person behind the suffering patient; they also cared to know what their patients did when they were on leave or after they were discharged. These nurses verbalized that they communicate with the patient and involve them in dialogues to understand what sign appears before the patients harm themselves. They mentioned how important it is to be sensitive toward patients during communications. The nurses sought to find out the triggers of the self-harm for their patients and looked out for the risk of potential self-harm events for example social isolation, scratching the body and etc [16]. Furthermore, school nurses can be a vital force to help adolescents with self-harming behavior. However, studies have pointed out that school nurses require training to fulfill this role. As per a study, it was reported that the nurses felt frustrated and inadequate while dealing with patients with self-harm. To combat this issue and help adolescents receive quality and standard care, nurses require theoretical and practical knowledge [17].

**CONCLUSION**

DSH among adolescents is a highly serious and prevalent concern around the globe. In fact, it is higher in adolescent population as compared to rest of the populace. However, recent studies from Pakistan lack to give us extensive information on
this topic, unlike Western countries. Therefore, more studies for this topic need to be taken up by researchers in order to know where Pakistan stands when it comes to DSH among adolescents. Studies and literature have identified that mental health problems like depression, bipolar disorder, personality disorder and financial issues, relationship problems, family issues can be a risk factor for DSH in teenagers and adolescents. Childhood maltreatment has been also frequently associated with DSH. DSH leads to physical and mental injuries. However, very distinguished evidence is that one of the consequences of DSH in a reduction in stress levels. However, more studies need to be conducted on this matter. Nurses and particularly mental health nurses who work with adolescents and especially those adolescents who self-harm should be adequately skilled, aware, and knowledgeable in terms of theory and practice to deal with such cases. Furthermore, nurses should be nonjudgmental when dealing with such patients otherwise they might end up not gaining their trust. An untrustworthy and uncomfortable environment acts as a barrier in communication with young patients who self-harm.

REFERENCES


