

Social conditioning for the self-harm behaviour in adolescence

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Abstract

The most common causes of **self-harm in adolescents** are related to family (abuse, arguments with parents, poor communication), school (bullying), and behaviour (cyberbullying, illicit substance use, rejection by a boy or girl friend). Adolescents self-mutilate because of difficulty talking about their feelings, of peer contagion, of peer pressure, of suicidal thoughts; out of anger / desperation to seek attention, to show their hopelessness, to show their worthlessness; to be accepted, to rebel, to reject their parents' values, to state their individuality, or to take risks. Adolescents who self-harm are, usually, adolescents with multiple problems such as co-morbid psychiatric disorders (anorexia nervosa, anxiety state, Bipolar Disorder, conduct disorder, depression, hyperactivity, Post Traumatic Disorder, psychosis), educational failure (learning problems, school refusal), and impaired psychosocial functioning; who come from families with high psychopathology rates; and who may have lived unhappy life events. Depressive disorder is less common among pre-adolescents, with no gender difference; mid-adolescence self-harm behaviour shows a female preponderance, which is also found in adult females.

Keywords: harm, self-harm, adolescence

Introduction

Terminological Issues and Definitions. **Self-harm** affects mainly **adolescents**, but it also occurs in inmates with a history of suicide attempts (Barton, 2014) and in soldiers with Post Traumatic Stress Disorder (Neyshabouri, Dolatshahi & Mohammadkhani, 2020). The majority of self-mutilators are adolescents or young adults, aged in middle to late adolescence at the first episode of self-harm, angry and anxious (Sarbu, 2015), mostly female, often underemployed and are single; they have a lower vocational achievement in spite of equivalent education and more extensive therapy histories than other patients with personality disorders; and they tend to have more past suicidal ideation and attempts no matter their self-harm (Sarbu, 2017a; Sarbu, 2017b; Panescu & Sarbu, 2019; Sarbu, 2016b).

Deliberate self-harm (DSH) ("intentional self-injury or self-poisoning, irrespective of type of motivation or degree of suicidal intent" – Hawton *et al.*, 2008) (Hawton *et al.*, 2002; Polk & Liss, 2007; Garisch & Wildon, 2010; Nock, 2010; Greydanus & Apple, 2011; Muehlenkamp *et al.*, 2012; Barton, 2014; Olfson *et al.*, 2018;

Sarbu, 2017a), **focal suicide** (“self-mutilation and self-destructive acts” – *The Medical Dictionary*) (Openshaw, 2008), **intentional self-harm** (“self-inflicted physical harm, such as cutting, that is not suicidal and is usually a response to stress or trauma” – *The Free Dictionary*) (Brooks *et al.*, 2017), **nonsuicidal self-harm** (“[behaviour] involving socially unacceptable, self-inflicted harm to one’s body without intent to die” – Peterson, Freedenthal & Coles, 2010; Sarbu, 2011), **nonsuicidal self-injury** (“[behaviour] involving socially unacceptable, self-inflicted harm to one’s body without intent to die” – Peterson, Freedenthal & Coles, 2010) (Muehlenkamp *et al.*, 2012; Jantzer *et al.*, 2015; Blasco-Fontecilla *et al.*, 2016; Chin, 2016; Raitt, 2018; Huang, Ribeiro & Franklin, 2020; Raffagnato *et al.*, 2020), **parasuicide** (“attempted suicide, emphasizing that in most such attempts death is not the desired outcome” – *The Medical Dictionary*) (Brooksbank, 1985; Nock, 2010; Oliveira & Graça, 2013), **self-abuse** (“the deliberate infliction of damage or alteration to oneself without suicidal intent, in particular by those with eating disorders, mental illness, a history of trauma and abuse – e.g., emotional or sexual abuse – or mental traits such as low self-esteem or perfectionism; any act of intentional physical injury to oneself” – *The Free Dictionary*) (Openshaw, 2008), **self-destructive behaviour** (“any behaviour that is harmful or potentially harmful towards the person who engages in the behaviour” – *Wikipedia*) (Gavriliă-Ardelean, 2016; Nock, 2010; Sarbu, 2017b), **self-harm** (“intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent” – cf. Royal College of Psychiatrists, 2010) (Dace *et al.*, 1998; Harrington, 2001; Poppe, 2001; Wood, 2009; Maharajh & Seepersad, 2010; Nock, 2010; Fisher *et al.*, 2012; Harvey & Brown, 2012; Hawton, Saunders & O’Connor, 2012; Oliveira & Graça, 2013; McAndrew & Warne, 2014; O’Connor, Dooley & Fitzgerald, 2014; Townsend, 2014; Baker *et al.*, 2015; Del Bello *et al.*, 2015; Hawton *et al.*, 2015; Lawrence *et al.*, 2015; Ferrey *et al.*, 2016; Grech & Axiak, 2016; Tørmoen, 2016; Marchant *et al.*, 2017; Shanahan, Brennan & House, 2019; Hetrick *et al.*, 2020; Raffagnato *et al.*, 2020), **self-harm / harming behaviour** (“the intentional physical harming of one’s own body (injuring, cutting the skin, wound-excoriation, and so on) without suicidal intention, social amusement purpose, or alcohol and drug overdose” – Oktan, 2017) (Openshaw, 2008; Jantzer *et al.*, 2015; Blasco-Fontecilla *et al.*, 2016), **self-inflicted violence** (“self-inflicted physical harm, such as cutting, that is not suicidal and is usually a response to stress or trauma” – *The Free Dictionary*) (Alderman, 1997; Openshaw, 2008; Sarbu, 2011), **self-injurious behaviour** (“deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned” – cf. Whitlock, 2010) (Herpertz, 1995; Sarbu, 2011), **self-injury** (“a behaviour in which a person causes deliberate harm to his or her body without suicidal intent” – Polk & Liss, 2007, 568) (Tantam & Whittaker, 1992; Openshaw, 2008; Peterson *et al.*, 2008; Nock, 2010; Lyons-Ruth *et al.*, 2013; Hawton *et al.*, 2015; Daelman, Bloch-Torricco & Gagnon, 2017; Sarbu, 2017a), **self-mutilation** “a direct, socially unacceptable, repetitive behaviour that causes minor to moderate physical injury; when self-mutilating, the individual is in a psychologically disturbed state but is not attempting suicide or responding to a need for self-stimulation or a stereotypic behaviour characteristic of mental retardation or autism” (Suyemoto, 1998, 532) (Poppe, 2001; Ross & Heath, 2002; Openshaw, 2008; Nock, 2010), **self-mutilative behaviour** “deliberate damage to one’s own body tissue without suicidal intent” (Nock & Prinstein, 2004), **self-wounding** (“harming oneself where there are no underlying psychological

problems related to the self-injury, but where the injurer wanted to take advantage of being injured” – *Wikipedia*) (Brooksbank, 1985; Tantam & Whittaker, 1992; Openshaw, 2008), **suicidal self-harm** (“[behaviour] involving intent to end one’s life and including ideation and actions” – Peterson, Freedenthal & Coles, 2010), and **wrist-cutting syndrome** (“repeated cutting of the wrists” – Rosenthal *et al.*, 1972) are just some of the labels applied to this disorder.

Self-destructive behaviour has for synonyms, according to Openshaw (2008, 111): **antisuicide, carving, delicate cutting, indirect self-destructive behaviour, nonfatal suicide, parasuicidal behaviour, self-attack,** and **wrist slashing,** terms unfortunately not defined.

No matter the term used, **self-injury** has its place in the hierarchy of self-injurious thoughts and behaviours, where there are self-injurers with and without intent to die (Nock, 2010; Del Bello *et al.*, 2015) (Figure 1).

Self-harm in Adolescents

Self-harm behaviours are compulsive, episodic, purposeful, repetitive, ritualistic, and sometimes accompanied by anxiety and/or depression (Whitlock, 2010; Panescu & Sarbu, 2019). It is imperative to identify and control these behaviours because self-harm has short- and long-term consequences such as distress, mental ill health, physical ill health, poor educational, vocational & economic participation outcomes, poor treatment outcomes, repeated self-harm and suicide attempts, suicide & premature mortality, substance misuse, and traffic accidents (Gavrila-Ardelean, 2018a; Hetrick, 2017). Though self-harm is not suicide, it eventually becomes suicide (Figure 2).

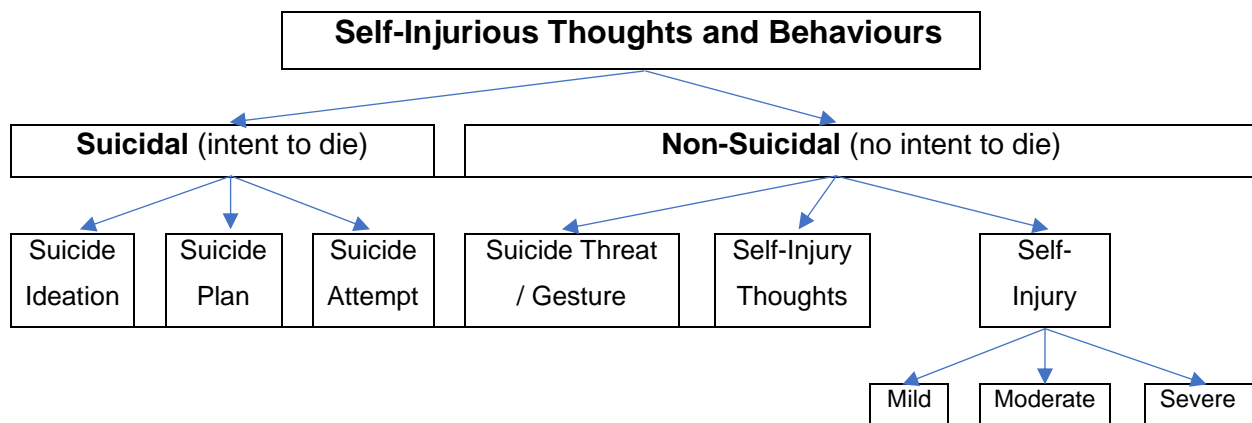
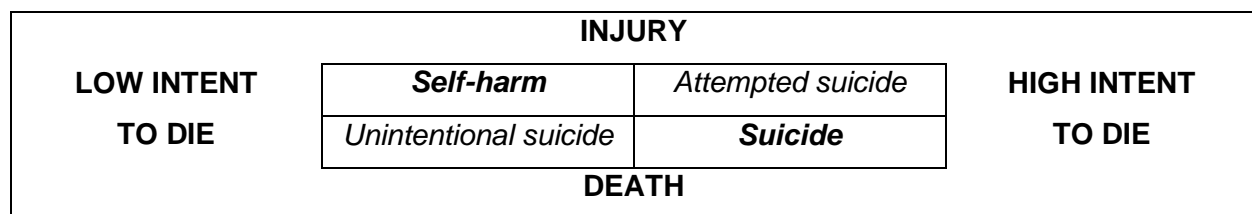


Figure 1. Self-Injurious Thoughts and Behaviours (after Nock, 2010, 341)



**Figure 2. Relationship between self-harm and suicide
(after Centre for Suicide Prevention, 2016)**

The **purpose of self-harm** may be one of several of the following: change emotional pain into physical pain, create a reason to physically care for themselves, escape traumatic memories, express something that is hard to put into words, express suicidal feelings and thoughts but do not take their own life, have a sense of being in control, have something in life that they can rely on, punish themselves for their feelings and experiences, reduce overwhelming emotional feelings or thoughts, stop feeling numb, disconnected or dissociated, or turn invisible thoughts or feelings into something visible.

Pattison & Kahan (1983, in Dace *et al.*, 1998, 7) provide a **classification of self-harmful behaviours** depending on the degree of lethality (Table 1).

Table 1. Self-harmful behaviours depending on the degree of lethality (after Pattison & Kahan, 1983, in Dace *et al.*, 1998, 7)

	Direct	Indirect
High lethality	<ul style="list-style-type: none"> • <i>Suicide attempt</i> (single episode) 	<ul style="list-style-type: none"> • <i>Termination of vital treatment such as dialysis</i> (single episode)
Medium lethality	<ul style="list-style-type: none"> • <i>Suicide attempts</i> (multiple episodes) • <i>Atypical deliberate self-harm syndrome</i> (single episode) 	<ul style="list-style-type: none"> • <i>High-risk performance</i> (e.g. stunts) (multiple episodes) • <i>Acute drunkenness</i> (single episode)
Low lethality	<ul style="list-style-type: none"> • <i>Deliberate self-harm syndrome</i> (multiple episodes) 	<ul style="list-style-type: none"> • <i>Chronic alcoholism</i> (multiple episodes) • <i>Severe obesity</i> (multiple episodes) • <i>Heavy cigarette smoking</i> (multiple episodes)

Ten years later, Favazza & Rosenthal (1993, 134), grouped *self-harm* into three types – *major self-harm*, *stereotypic self-harm*, and *moderate / superficial self-harm*: **major self-harm** is an “infrequent act in which a significant amount of body tissue is destroyed” associated with acute and chronic encephalitis, acute intoxications, congenital sensory neuropathy, mental retardation, psychotic states, schizoid personality disorder, the residual phase of schizophrenia, transsexualism; **stereotypic self-harm** is an “act that has a fairly fixed pattern of expression, seems to be devoid of symbolism, and is often rhythmic” associated with acute psychotic states, autistic disorder, Lesch-Nyhan syndrome, obsessive compulsive disorder, schizophrenia, Tourette syndrome; **moderate / superficial self-harm** is an “act of low lethality that

results in relatively little tissue damage and that occurs sporadically or repetitively” associated with posttraumatic stress disorder after combat and rape.

Are **forms of self-harm**: *biting, bone breaking, branding, bruising, castration, derma abrasion / abuse / contusion or self-inflicted epidermal damage (skin banging, skin burning, skin carving with designs, words, or other symbols, skin cutting, skin piercing, skin picking, self- / skin punching), excessive body piercing, excoriations, eye enucleation, eyeball pressing, finger biting, food refusal / restriction, hanging, head banging, exercising excessively, getting into fights where one gets hurt, hitting, inserting objects into body, interference with wound healing, jumping from a high point, jumping in front of a car / train / metro train, limb amputation, marking, needle sticking, pinching, promiscuity, pulling hair, pulling skin, scratching, self-cutting, self-hitting, self-poisoning (with alcohol; overdosing with drugs / medicines such as antidepressants, non-opiate analgesics, paracetamol, sedatives, tranquillisers; non-ingestible substances such as household bleach, recreational drugs), shooting, stabbing, swallowing objects, tattooing, wrist slashing, self-destructive behaviours (drinking, over-eating, smoking, under-eating).*

Suyemoto (1998, 537) identified **six functions of self-harm** grouped into four major types (affect regulation, drive, environmental, and interpersonal) and six specific functional models (affect regulation, antisuicide, boundaries, dissociation, environmental, and sexual): “**Environmental Model** [rooted in behavioural and systemic theory]: *environmental*: self-mutilation creates environmental responses that are reinforcing to the individual while simultaneously serving the needs of the environment by sublimating and expressing inexpressible and threatening conflicts and taking responsibility for them; **Drive Models** [rooted in psychoanalytic theory]: *antisuicide*: self-mutilation is a suicide replacement, a compromise between life and death drives. *sexual*: self-mutilation stems from conflicts over sexuality, menarche, and menstruation; **Affect Regulation Models** [rooted in ego and self-psychology]: *affect regulation*: self-mutilation stems from the need to express or control anger, anxiety, or pain that cannot be expressed verbally or through other means; *dissociation*: self-mutilation is a way to end or cope with the effects of dissociation that results from the intensity of affect; **Interpersonal Model** [rooted in self-psychology and object relations]: *boundaries*: Self-mutilation is an attempt to create a distinction between self and others. It is a way to create boundaries or identity and protect against feelings of being engulfed or fear of loss of identity.”

Are associated with **self-harm** the following **personality disorders** (“*In psychiatry, deeply ingrained patterns of behaviour of a specified kind that deviates markedly from the norms of generally accepted behaviour, typically apparent by the time of adolescence, and causing long-term difficulties in personal relationships or in functioning in society*” – *Lexico*): **adjustment disorder** (“*In psychology, a disorder considered to be a maladaptive reaction to a recent, specific stressful event or situation, accompanied by various mental and physical symptoms that often include anxiety or depression*” – *Lexico*) (Ross & Heath, 2002), **borderline personality disorder** (“*In psychiatry, a personality disorder characterized by severe mood swings, impulsive behaviour, and difficulty forming stable personal relationships*” – *Lexico*) (Löff *et al.*, 2018), **chemical / substance abuse** (“excessive, inappropriate, or illegal use of a substance, such as a drug, alcohol, or another chemical such as an inhalant, especially

when resulting in addiction” – *Medical Dictionary*), **dissociative identity disorder** (“*In psychiatry, a rare psychological disorder in which two or more personalities with distinct memories and behaviour patterns apparently exist in one individual*” – *Lexico*), **eating disorder** (“any of a range of psychological disorders characterized by abnormal or disturbed eating habits (such as anorexia nervosa [binge-eating disorder, bulimia nervosa, obesity]” – *Lexico*), **generalized anxiety disorder** (“*In psychiatry, a disorder characterized by excessive or unrealistic anxiety about two or more aspects of life (work, social relationships, financial matters, etc.), often accompanied by symptoms such as palpitations, shortness of breath, or dizziness*” – *Lexico*), **major depression** or **major depressive disorder** (“*In psychiatry, a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts*” – *Lexico*) (Harrington, 2001; Ross & Heath, 2002), **minor depression** (“a mood disorder lasting at least 2 weeks in which fewer symptoms of depression are present than in major depression (two to five symptoms as opposed to more than five)” – *Medical Dictionary*) and other substance abuse, **obsessive-compulsive disorder** (“*In psychiatry, a disorder in which a person feels compelled to perform certain stereotyped actions repeatedly to alleviate persistent fears or intrusive thoughts, typically resulting in severe disruption of daily life*” – *Lexico*), **schizophrenia** (“*In psychiatry, a long-term mental disorder of a type involving a breakdown in the relation between thought, emotion, and behaviour, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation*” – *Lexico*), etc.

There are correlations between **self-harm** and **antisocial behaviour** (“behaviour that is inimical to the rights of others, or to the rules of society, but not necessarily severe enough to incur a legal penalty” – *The Medical Dictionary*), **depressive symptomatology** (“fatigue or loss of energy almost every day, feelings of worthlessness or guilt almost every day, impaired concentration and indecisiveness, insomnia or hypersomnia (excessive sleeping) almost every day, markedly diminished interest or pleasure in almost all activities nearly every day (anhedonia), recurring thoughts of death or suicide, restlessness or feeling slowed down, significant weight loss or gain (a change of more than 5% of body weight in a month” – *The Medical Dictionary*), **dissociation** (“*In psychiatry, separation of normally related mental processes, resulting in one group functioning independently from the rest, leading in extreme cases to disorders such as multiple personality*” – *Lexico*), **physical complaint** (appetite change, back pain, chronic joint pain, fatigue, gastrointestinal problems, limb pain, sleep disturbance), **physical illness** (asthma, poliomyelitis, rheumatic disease, etc.), **sexual behaviour at high risk for HIV** (illicit drug use, multiple sex partners, penile-anal sex, unprotected intercourse, use of alcohol), and **sexual dysfunction** (“inability to fully enjoy sexual intercourse” – *Medical Dictionary*).

Several variables seem to **predict self-harming behaviour**: **alexithymia-like symptomatology**, **depression**, **dissociation**, **emotional and physical neglect**, **peer victimization symptomatology**, **sexual abuse**, and **trauma** (Gavrila-Ardelean, 2014; Polk & Liss, 2007, 568; Garisch & Wilson, 2010; Oliveira & Graça, 2013; O'Connor, Dooley & Fitzgerald, 2014; Löf *et al.*, 2018; Raffagnato *et al.*, 2020) also suggest **musical preferences** (Rock/Grunge, New metal/Punk, Metal/Hard rock, Rock/Pop, and

Hip/Trip-hop) as predictors of self-harming behaviour. The relationship between causes and outcomes in deliberate self-harm is not a linear one: it is rather a combination of constitutional factors predisposing to self-harm arising from **genetic endowment** (family history of suicidal behaviour, parental psychopathology) or **earlier experience** (broken family, disaffection, emotional / physical / sexual abuse in childhood, experience of loss, family discord, family dislocation, learning difficulties, marginalization, maternal withdrawal in infancy, neglect in childhood, not attending education, “not fitting in”, parental deprivation resulting in emotional distancing and inconsistent parental warmth, social isolation, social-related difficulties) and **precipitating stressful events** (bullying, competition, contagion, new media, normalization, portrayal of deliberate self-harm on television, triggering,)” (Fond-Harmant & Gavrilă-Ardelean, 2016; Harrington, 2001, 47; Wood, 2009, 436; Fisher *et al.*, 2012; Hawton, Saunders & O’Connor, 2012; Lyons-Ruth *et al.*, 2013; Jantzer *et al.*, 2015; Shanahan, Brennan & House, 2019; Panescu& Sarbu, 2019; Bordas-Mohorea & Sarbu, 2020). However, **words** may also be predictors of self-harm in adolescents. Harvey & Brown (2012) analysed a corpus of 1.6 million words from health-related messages posted on a UK-hosted adolescent health Web site, and identified a range of keywords relating to both health themes (Table 2) and self-harm. Closely connected to these health-related words are 10 self-harm-related words whose frequency ranges between 314 to 7 (Harvey & Brown, 2012, 323): *cut* (314), *self-harm* (175), *cutting* (122), *self-harming* (61), *cuts* (55), *slit* (18), *harm* (16), *harming* (12), *self-harmer* (10), and *slitting* (7). It is interesting to note that, if we group these words under their allomorphs (an *allomorph* points to the concept associated with a group of words), their frequency changes: CUT (314 *cut* + 122 *cutting* + 55 *cuts*) ranks first with 491 occurrences, HARM (175 *self-harm* + 61 *self-harming* + 16 *harm* + 12 *harming* + 10 *self-harmer*) ranks second with 274 occurrences, and SLIT (18 *slit* + 7 *slitting*) ranks third with 25 occurrences. In close connection with *cut* and *harm* are the following collocates (and their frequencies): *help* (81), *stop* (60), *friend* (46), *started* (45), *feel* (28), *depressed* (19), *years* (16), and *blood* (12). Such an analysis – which clearly shows that the most frequent self-harm behaviours are **self-harming**, in general, and **cutting** and **slitting**, in particular – supports the idea of discrete monitoring of children and adolescents’ activities, in general, and Internet activities, in particular, for a **timely identification of self-harm ideation and/or action** (Jantzer *et al.*, 2015; Marchant *et al.*, 2017).

Table 2. Keywords related to health themes in adolescent e-mails (after Harvey & Brown, 2012, 322)

Theme	Keywords
Body weight/image	<i>anorexia, anorexic, BMI, bulimia, calories, diets, eat, eating, exercise, fat, KG, KGS, kilograms, obese, overweight, size, skinny, thin, underweight, weight</i>
Drugs/alcohol	<i>addict, alcohol, cannabis, cigarettes, cocaine, crack, dope, drinking, drugs, drunk, ecstasy, heroin, LSD, marijuana, mushrooms, pills, poppers, stoned</i>
Medication	<i>antibiotics, antidepressants, medication, medicine, pill, pills, prescribed, Prozac, tablets</i>
Mental health	<i>addict, addiction, ADHD, angry, antidepressants, anxiety, crying, cut, cuts, cutting, depressed, depression, die, harm, mad, mental,</i>

	<i>moods, overdose, paranoid, personality, Prozac, sad, scars, self-harm, stress, stressed, suicide, unhappy, wrists</i>
Minor conditions	<i>acne, blackhead, cystitis, dandruff, mumps, pimples, scabies, spots, worms, zits</i>
Serious conditions	<i>AIDS, anthrax, cancer, diabetes, epilepsy, HIV</i>
Sexual health	<i>abortion, AIDS, balls, bisexual, chlamydia, clitoris, condom, contraception, erection, fanny, foreplay, foreskin, gay, genitalia, glans, herpes, HIV, intercourse, labia, lesbian, masturbate, miscarriage, oral, orgasm, ovaries, ovulation, period, pill, PMS, pregnancy, pregnant, scrotum, sex, sperm, STD, STI, tampon, testicles, thrush, unprotected, vagina, Viagra, virgin, vulva</i>

There are three **main types of intervention in self-harm** (National Collaborating Centre for Mental Health, 2012, 202, 261): **psychological interventions**: cognitive behavioural therapy, dialectical behaviour therapy, group-based psychotherapy, interpersonal problem-solving skills training, mentalization-based therapy (see also Townsend, 2014; Löf *et al.*, 2018; Gavrilă-Ardelean & Gavrilă-Ardelean, 2017), problem-solving therapy, psychodynamic therapy; **psychosocial service-level interventions** (see also McAndrew & Warne, 2014): case management, chat room, compliance enhancement, continuity of therapist, counselling for own problems, worries, or stress, counselling on how to manage child's problems, counselling to help family relationships, emergency card interventions, general hospital admission or discharge to general practitioner, general practitioner letters, group counselling, help to meet people for company / support, home or outpatient interventions, individual counselling, information about problems, treatments, and services, intensive interventions, long- or short-term therapy, online personal counselling / support (Sarbu, 2014), postcard interventions, providing parenting skills courses, school counselling, special class / school, support group, telephone counselling (telephone supportive contact) (Sarbu, 2015), and temporary institutional care of a disabled, elderly, or sick person (to provide relief for their usual caregivers) (Sarbu, 2016b); **pharmacological interventions**. Unfortunately, "Interpersonal barriers and a lack of knowledge about where to go for help may impede help-seeking." (Gavrila-Ardelean, 2018b; Rowe *et al.*, 2014; Sarbu, 2014). Such **barriers** are (Lawrence *et al.*, 2015, 86): being concerned about what people might think, being not sure if child/adolescent needed help, being not sure where to get help, being incapable of affording it, being incapable of getting an appointment, being incapable of stigma self-managing, having a problem getting to a service that could help, lacking accessibility, not having mental health literacy, not turning up for appointment, preferring to handle by self or with family/friends, refusing help, thinking he/she does not have a problem, and thinking the problem would get better by itself.

Three main **categories of services** can be provided for self-harming adolescents: **non-statutory counselling services** such as counsellor therapists, family therapists, and occupational therapists, **primary health care services** such as general practitioners, nurses, paediatricians, school nurses, and social workers, and **specialist mental health services** such as nurses, psychiatrists, and psychologists.

Case Study

Between 1 and 30 of August, 2020, a 10-item questionnaire was applied to 276 subjects (adolescents and young people) from Romania about people with non-suicidal self-harming behaviour from their entourage. Using an indirect approach was considered a better way to reduce the social desirability factor associated with these issues. The questionnaire was anonymous distributed and the results do not include any reference to a particular participant to the study.

The group of respondents asked about people that self-harmed (N = 188) was divided into 2 sub-groups, those who did it once versus those who did it 2 or more times, and the following was found at the level of the investigated sample:

	Percentage		Gender = Female		Age 12-18 (most frequent)		Urban		Believer, but not a church-goer	
	n	%	n	%	n	%	n	%	n	%
once	30	16	21	11.2	18	9.6	22	11.7	16	8.6
2+	158	84	118	62.8	133	70.7	116	61.7	82	43.9

Based on these distributions, it is obvious that the most vulnerable group is represented by girls aged 12-18 years old, from urban areas, who believe in God but do not attend church on a regular basis, and, very important, when they start self-harming, they tend to relapse. The variable age is statistically significant associated with this type of behaviour (chi square = 10.129, sig; 0.017).

A very important aspect for the harmonious emotional development of adolescents is the social context, the relationship with one's family and friends. In this sense, a composite index was calculated from three distinct questions, the relationship with their father, with their mother, and with their siblings (if any), with values grouped on three intervals:

- **very distant relationships**, those who stated that there are extremely distant, very distant or distant relationships with all family members;
- **relatively tense relationships**, those located in the middle area (quite close);
- **very positive relationships**, those that indicated close or very close relationships.

At the level of the analysed subsample (those who know people who have self-harmed at least once), the distribution of the 3 groups is as follows:

	Frequency	Percentage
very distant relationships	107	56.9
relatively tense relationships	59	31.4
very positive relationships	21	11.2
no answer	1	.5
Total	188	100.0

Thus, in the case of more than half of the young people who self-harmed (56.9%), the relationships in their own families are very distant and, certainly, do not benefit from adequate emotional support from parents and possible siblings. Although the association between attempts at self-harm and family climate is not statistically validated (chi square = 1.078, sig; 0.583), it is quite obvious that a tense family climate can have serious repercussions on the emotional balance of adolescents. We mention that, even in connection with the number of friends, there was no statistically significant association with self-harmed behaviour (chi square = 1.754, sig; 0.416).

Self harmed experience (others) * Family relationship Crosstabulation

		Family relationship			Total	
		very distant relationships	relatively tense relationships	very positive relationships		
Self-harmed experience	only once	n	18	7	5	30
		% of Total	9.6%	3.7%	2.7%	16,0%
	2 or more	n	89	52	16	157
		% of Total	47.6%	27.8%	8.6%	84,0%
Total		n	107	59	21	187
		% of Total	57,2%	31.6%	11.2%	100.0%

Finally, regarding the reasons for self-harming, sentimental problems seem to be dominant in both categories of subjects, followed by the problems with the family members. To note that the share of this factor is much more pronounced in those who relapse, being almost as intense as with sentimental problems, compared to those who did it once, where family causes are half the value of sentimental problems. And this is absolutely natural, a degraded and tense climate within a family is often a constant over a longer period of time.

Self harmed experience (others) * Reasons Crosstabulation

Self-harmed experience		Q8. Regarding the reason why the person came to have a self-injurious behaviour, which statement do you think is closer to the real reason?						Total
		No answer	Sentimental problems	Problems with family members	Prolonged stress	Dissatisfaction with one's own physical appearance	Unpleasant memories of the past	
only once	n	2	16	7	2	1	1	29
	% of Total	1.1%	8.6%	3.8%	1.1%	0.5%	0.5%	15.7%
2 or more	n	16	48	46	6	18	22	156
	% of Total	8.6%	25.9%	24.9%	3.2%	9.7%	11.9%	84.3%
Total	n	18	64	53	8	19	23	185
	% of Total	9.7%	34.6%	28.6%	4.3%	10.3%	12.4%	100.0%

Conclusions

The following conclusions could be drawn from the literature review above:

- **Self-harm** affects mainly **adolescents**;

- There are 18 synonyms for **self-harm** and 8 synonyms for **self-destructive behaviour** alone, which points to the diversity of perceptions of this phenomenon;
- It is important to distinguish between **suicidal** and **non-suicidal self-harming thoughts and behaviours**;
- Self-harm has a **purpose** of its own;
- There are several **self-harm behaviours** depending on the *degree of lethality*;
- There are three **categories of self-harm**: *major, stereotypic, and moderate / superficial*;
- There are over 50 **forms of self-harm**;
- Self-harm has six **functions**;
- Self-harm is associated with a wide range of **personality disorders**;
- Self-harm correlates with a wide range of **behaviours**;
- Self-harming behaviour has a wide range of **predictors**;
- Self-harm ideation and/or action can be timely identified with the help of **self-harm-related words frequency**;
- There are three **main types of intervention in self-harm**: psychological, psychosocial, and pharmacological;
- There are three main **categories of services for self-harming adolescents**: *non-statutory counselling services, primary health care services, and specialist mental health services*.
- according to the result from the applied study, the most vulnerable group for the self-harmed behaviours is represented by girls between 12 and 18 years old, from urban areas who believe in God but do not attend church;
- if the adolescents start making self-harmed once, they tend to relapse
- a tense family climate can have serious repercussions on the emotional balance of adolescents
- regarding the reasons for such gestures, the sentimental problems seem to be dominant for both categories of subjects followed by the problems with the family members

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