doi.org/10.36689/uhk/978-80-7435-960-6.007

FUNCTIONS AND RISK FACTORS OF SELF-HARM IN ADOLESCENTS

FUNKCIE A RIZIKOVÉ FAKTORY SEBAPOŠKODZOVANIA U ADOLESCENTOV

Simona Dulovics Sámelová (Slovak Republic)

Abstract

In today's society, which faces constant technological and social changes, there is a growing number of threats to the physical and mental health of children, adolescents and adults. These challenges, including pressure to perform, the influence of social media and the consequences of the COVID-19 pandemic, contribute significantly to social isolation and an increase in mental health problems, particularly self-harm, especially among children and young people. The aim of this paper is to analyse the phenomenon of self-harm, its characteristics, causes, functions and manifestations. We understand self-harm as a maladaptive strategy for coping with intense emotional tension and emptiness, which differs from suicidal behaviour. Adolescence is considered a critical developmental period characterised by the search for identity and is most often cited as the initial period of self-harm. Other risk factors include the family environment and the influence of digital technologies, including the phenomenon of online self-harm. The article also lists typical signs that can be used to identify self-harm in adolescents from the perspective of parents or members of the school support team. Understanding the emotional triggers and functions of this behaviour is key to effective identification, support and assistance.

Keywords: Self-harm. Adolescent. School support team.

Abstrakt

V dnešnej spoločnosti, ktorá čelí neustálym technologickým a sociálnym zmenám, rastie počet hrozieb pre fyzické a duševné zdravie detí, adolescentov a dospelých. Tieto výzvy, vrátane tlaku na výkon, vplyvu sociálnych médií a dôsledkov pandémie COVID-19, významne prispievajú k sociálnej izolácii a nárastu problémov duševného zdravia, najmä sebapoškodzovania, a to hlavně u detí a mladých ľudí. Cieľom tohto príspevku je analyzovať fenomén sebapoškodzovania, jeho charakteristiky, príčiny, funkcie a prejavy. Sebapoškodzovanie

chápeme ako maladaptívnu stratégiu na zvládanie intenzívneho emocionálneho napätia a prázdnoty, ktorá sa líši od suicidálneho správania. Adolescencia je považovaná za kritické vývinové obdobie charakterizované hľadaním identity a je najčastejšie uvádzaná ako počiatočné obdobie sebapoškodzovania. Medzi ďalšie rizikové faktory patrí rodinné prostredie a vplyv digitálnych technológií, vrátane fenoménu sebapoškodzovania online. Článok tiež uvádza typické príznaky, ktoré môžu slúžiť na identifikáciu sebapoškodzovania u adolescentov z pohľadu rodičov alebo členov školského podporného tímu. Porozumenie emocionálnym spúšťačom a funkciám tohto správania je kľúčom k efektívnej identifikácii, podpore a pomoci.

Kľúčové slová: Sebapoškodzovanie. Adolescent. Školský podporný tím.

Introduction

In today‘s dynamic and changing society, facing constant challenges and threats, we encounter influences that significantly endanger the physical, mental and social health of children, adolescents and adults. As a result of the COVID-19 pandemic, social isolation, the shift to online learning and the cancellation of extracurricular activities, mental health has deteriorated. Stress and anxiety have significantly affected people‘s personalities, relationships and lives. One of the alarming consequences is an increase in mental illness and self-harm, especially among children and young people.

Despite constant efforts and emphasis on the importance of mental health care, we still encounter stigmatisation of mental disorders. Significant differences in coping strategies mean that what is manageable for one person may trigger self-harm in another as a reaction to unmanaged emotional tension or a difficult life situation. We note that the emotional climate in the family is key to the healthy development of the individual.

Children learn coping strategies from an early age in the family, which, even in a changing world, remains the primary environment for optimal development. Emphasis should be placed on healthy and quality emotional relationships that provide a sense of basic security and safety. However, we often observe a crisis in the parent-child relationship, especially during puberty and adolescence, which is one of the fundamental developmental crises of human beings (Langmeier, 2006, p. 142).

During adolescence, young people undergo not only biological maturation but also significant psychological changes, such as emotional instability and the onset of mature thinking. There is also a new social classification, accompanied by societal expectations, changing self-perception and a shift away from the authority of parents and teachers towards friends. The weakening influence of the family is gradually replaced by the influence of peers, which tests

the quality of emotional relationships with parents. If these relationships are of poor quality, problems with forming one's own identity may arise. It is during this period that peer groups become important.

From the perspective of Erikson's (1999) theory of development, this is a period characterised by the formation of the ego, i.e. identity. The family recedes into the background and peer groups, role models from the environment, gain in importance. The necessary psychosocial modality is to achieve the quality of being oneself, of sharing. Mastering this developmental period means acquiring reliability, loyalty and forming a cohesive identity. Failure to master this developmental task can manifest itself in fanaticism, non-recognition, the creation of a diffuse identity, i.e. one that is incoherent, confusing, full of contradictions, characterised by unclear roles, and ambiguities regarding self-image and the image in the eyes of others. Pretending, incoherence and ambiguity become typical.

Říčan (2004) states that adolescents are almost mature from a biological point of view, their cognitive functions are at their peak, but in terms of emotions, they are not yet fully mature; they are equipped for life rationally, but not emotionally.

In agreement with Lipanová (2023), we state that adolescence is a challenging period accompanied by a number of stressful situations that adolescents' current coping strategies are insufficient to handle because they lack experience. They have not had the opportunity to learn about other possible ways of coping. In this context, we encounter self-harm, which is often part of experimenting with coping with stress as one of the maladaptive mechanisms.

It is precisely this imbalance in the maturation process in adolescents, where rational thinking lags behind the emotional side, that may be one of the causes of self-harm. Many difficult life situations are more difficult for adolescents to cope with because their coping strategies are not sufficiently developed. They typically make decisions based on emotions and impulsive behaviour. Significant risk factors for self-harm in this age group include changes associated with adolescence: high emotionality, withdrawal in connection with negative feelings, increased importance of reference groups and the pressures they exert on individuals.

Self-harming individuals also often experienced childhoods in which their parents had problems satisfying their basic needs, providing basic security, emotional involvement and reassurance (Conterio et al., 1998).

The present era brings a great deal of frustration, but it is qualitatively and quantitatively disproportionate and different from the experience formed over several thousand years. It also brings about a deterioration in the quality of relationships – they are less personal, focused on performance, and isolate family members in their micro-spaces (Lipanová, 2023, p. 9).

Self-harm, characteristics, prevalence

Self-harm, also known as self-mutilation, is an act of physical violence that a person inflicts on themselves. It is an expression of psychological pain through physical pain (Nagyová, 2022).

It is an act of autoaggression, physical violence against oneself. It is deliberate and conscious behaviour that lacks the specific intention to die (Nagyová, 2022).

Favazza (1999) distinguishes between actual self-harm and certain culturally determined acts of self-harm, which include various trends such as body decoration in the form of piercings or tattoos. Another form of this culturally conditioned act is indigenous rituals, which in certain cultures celebrate the transition from childhood to adulthood. Self-harming behaviour must be characterised by the following features:

a) intentionality;
b) damage to tissue without the intention of dying;
c) social unacceptability; repetition of the act.

We agree with Kitty Širilová's (2014) view that self-harm can be characterised as behaviour in which a person hurts themselves. It usually occurs in situations that are challenging and characterised by insufficient coping mechanisms. The goal is usually the need to feel inner pain, to vent it, to get it out of oneself. From this perspective, physical pain can be understood as more easily comprehensible, concrete, visible or easy to imagine, while psychological pain is unmanageable in a given situation. At that moment, physical pain, which becomes an outlet, a release of psychological pain, can temporarily numb psychological pain, but soon feelings of guilt, and shame of failure, which subsequently increase the psychological pain and the individual finds themselves in a vicious circle in which the psychological pain intensifies. This cycle is very close and similar to substance addiction. (Kitty Širilová, 2014, p. 148)

Kast (2010) also states that this is a human effort to start feeling and perceiving one's body again after losing touch with it and with oneself. This destructive behaviour can be understood as an effort to regain contact with oneself.

In the context of this article, we perceive self-harm as behaviour directed towards oneself, but without suicidal intent. It is targeted, violent, deliberate behaviour, the essence of which is self-regulation of internal tension, gaining emotional control, an outlet, transforming psychological pain into physical pain.

The prevalence of self-harm among men and women is more balanced than that of suicidal behaviour (DSM 5, 2015).

Several professional studies (Favazza. 1989; Pattinson & Kahan, 1984, Kriegelová, 2008,

Whitlock 2009, Richardson 2006 Muehlenkamp 2004) point out that most adolescents began self-harming between the ages of 12 and 15, and that their behaviour tends to be repetitive.

The difference between the sexes can be found in the methods used. Boys are more likely to engage in self-biting, scratching, self-burning, self-biting and preventing wound healing, while girls are more likely to engage in self-cutting (Barrocas et al., 2015; Linderová et al. Hradečná et al., 2023, Glenn & Klonsky, 2013, Groschwitz et al., 2015; Poudel et al., 2022).

Most self-harmers use more than one method of self-harm (Groschwitz et al., 2015; Muehlenkamp et al., 2012, Carr-Gregg 2012).

Alderman (1997) lists cutting, burning, scratching, hair pulling, poking painful areas, banging the body against hard objects, drug overdose, and substance abuse among the most common methods of self-harm.

Kriegel (2008) also lists nail and finger biting, extremely risky behaviour (casual sex, careless driving, not wearing seat belts), participation in risky or high-contact sports, obsessive washing and cleaning (to the point of bleeding), remaining in a violent relationship, preventing wounds from healing (picking at scabs), deliberate starvation, smoking, and others.

Sutton (1999 in Kriegelová, 2008) states that when individuals do not have their usual tools at hand and find themselves in a so-called crisis, they are capable of using anything as a tool. The most commonly used tools for self-harm are razor blades for cutting and cigarettes or lighters for burning.

Triggers of self-harm

The triggers of self-harm cannot be strictly defined and identified. It is a multidimensional conditioned act, a subjective emotional experience. For some, it is strong emotions, emptiness, anger, fear, boredom, or indifference from those around them that trigger impulsive behaviour.

It can also be a certain pattern of reducing any tension, not only distress but also eustress. Even self-harm out of boredom and in an attempt to provoke attention should not go unnoticed. It has its own significance and could escalate into other auto-aggressive or even suicidal thoughts and later actions. In this case, not paying attention will not lead to the extinction of the child‘s undesirable behaviour pattern. (Lipanová, 2023, p. 11).

Platznerová (2009, p. 37) lists the characteristics of individuals who are prone to self-harm:

- *poorly managed stress*
- *sensitivity to rejection*
- *anger towards oneself*
- *suppressed anger and aggression*
- *impulsiveness, problems with self-control*
- *chronic anxiety*
- *tendency to be swayed by current mood*
- *feelings of weakness, helplessness*
- *depression, self-destruction*
- *suicidal thoughts*

Sutton (2005) lists long-term abuse in childhood, rape, gender identity issues, separation or alcoholism of a caregiver, parental divorce, and loss of a significant person as risk factors for self-harm.

Currently, there is growing evidence (Nock, 2004; Prinstein, 2005) that self-harm is associated with problematic emotional experiences and emotional regulation. Kamphuis, Ruyling, and Reijntjes (2007, in Slee et al., 2008) report that the most negative emotions are experienced immediately before self-harm, with a significant decrease occurring after the act and a recurrence of these emotions usually one day after.

Chapman and Dixon-Gordon (2007) cite anger (45.16%), anxiety (16.13%), boredom (12.90%), sadness (9.68%), and guilt (6.45%) as the most common triggers for self-harm. The subsequent emotions include relief (25.80%), calmness (16.13%), sadness (12.90%), indifference (9.68%), anxiety (6.45%), and anger (6.45%).

Warma, Murray and Fox (2003) found that 96.7% of self-harmers use self-harm to express psychological pain, 89.6% to express anger, 87.6% to maintain self-control, and approximately 4% to attract the attention of others (Nock, 2004; Prinstein, 2005).

The most common functions of self-harm include relief from negative feelings and release of emotional pressure (Albores & Gallo et al., 2014; Fischer et al., 2014; Kaess et al., 2012; Zetterqvist, 2014; Kaess et al., 2012; Klonsky, 2011; Sim, Adrian & Zeman, 2009; Nagyová,

2022; Gámez, Chmielewski, Kotov, Ruggero & Watson, 2011; Klonsky, 2011). Glenn and Klonsky (2013) refer to these functions collectively as influencing emotion regulation, which, according to the authors, is present in up to 98% of self-harmers.

According to the findings of Lindnerová and Hradečná (2023), emotion regulation was the most common function of self-harm (up to 84.7%), followed by self-punishment (67.1%) and dissociative function (48.1%).

Physical pain in self-harm is important in terms of the frequency of self-harm and also the number of suicide attempts, as pointed out by Ammerman et al. (2015), according to whom the less pain a person feels when self-harming, the more the frequency of self-harm and suicide attempts increases.

It follows from the above that physical pain is important in terms of the frequency and severity of self-harm; it acts as a kind of brake that should protect against more fatal injuries and life-threatening situations.

The course and comorbidity of self-harm

Self-harm has a typical course. A stressful event triggers unpleasant emotions and increased tension. Anxiety and irritability increase to an unbearable intensity, leading to a persistent need for regulation, relief, and release from tension. The strength of emotions is extraordinary and can escalate to a state similar to panic and dissociation. At the peak of this active phase, self-harm occurs and a short-term feeling of relief (short-term positive effect) is experienced. This is immediately followed by negative thoughts and emotions, with feelings of shame and disappointment, self-contempt, even disgust, and feelings of guilt, i.e. strong, negative and unpleasant emotions (Kukučová, 2022, p. 5).

Self-harm is rarely an isolated problem. Most often, we find links to eating disorders, substance abuse, mood disorders, and personality disorders – most commonly borderline and emotionally unstable personality disorder, post-traumatic stress disorder, panic disorder, and anxiety disorder (Lipanová, 2023, p. 11).

Lipanová (2023) states that 75% of participants would like to stop self-harming and 25% would not. Hooley et al. (2020) express a similar view, stating that people who self-harm are not always convinced that they want to stop this behaviour. Gray et al. (2022) report that 20% of university students do not want to stop self-harming.

Places of self-harm

Young people initially cleverly hide evidence of self-harm on their bodies (under long-sleeved T-shirts, sweatshirts – even in summer, under long trousers). Parents or teachers should focus their attention on unexplained wounds on the forearms, shoulders and legs. The cuts often take the form of „linear lines", parallel to each other, resembling a „ladder". Some adolescents „carve" letters or words. A sign that this is deliberate self-harm may also be that it is on the hand with which the child does not write. Some wounds look more like scratches than cuts. After scars on the body are discovered, e.g. by parents, they find other places on their body that parents do not usually check, e.g. the inner thighs, stomach, breasts, etc. Not every cut can be considered intentional self-harm. When determining the severity of the problem of self-harm, the following should be assessed in particular (Nagyová, 2015, p. 84):

- the severity of physical damage;
- the mental state of the individual during the act;
- the level of acceptability of the behaviour.

The basic warning signs that indicate that a child or adolescent is deliberately harming themselves include (Ferková, 201, p. 87):

- unexplained wounds, cuts, bruises, burns, usually on the wrists, arms, thighs or breasts;
- bloodstains on clothing, towels, bed linen;
- sharp objects or cutting tools such as razors, knives, needles, glass shards or bottle caps;
- covering wounds and cuts by wearing long sleeves or long trousers, even in hot weather;
- injuries, e.g. fractures; hair loss;
- changes in behaviour, isolation and irritability.

Parents can be particularly helpful in intervening. School psychologists and teachers often do not have much chance of noticing cuts, especially if pupils wear long sleeves, which is often the case. Parents should focus their attention on unexplained wounds on the forearms, shoulders and legs (Ferková, 201, p. 87).

If parents notice a problem, they should focus primarily on open communication with their child. They should remain calm and not react hysterically or aggressively. Such an approach could cause fear and panic in the child, leading to concealment and downplaying of the situation. Children with such problems tend to lie, making excuses that the injury was caused by a pet, that they scratched themselves during training, etc.

Appropriate communication strategies when self-harm is discovered are as follows (Nagyová, 2022):

- communicate openly with the child, show empathy (which does not mean complete acceptance or approval of their actions)
- remain calm, do not react hysterically or aggressively
- try to assess the situation by asking direct questions
- try to find the causes of their actions.

Adults cannot punish the child for their actions. It is important to listen to them, provide support, and consider whether they themselves are contributing to the stressful situation in any way. Adolescents need to feel that we are not only concerned about their current injury, but that we are interested in them as a „whole"; it is important to take an interest in the various aspects of the child's experience. (Ferková, 2015)

Prevention in schools and the role of the school support team

In agreement with Emmerová (2018), we note that there are various programmes and projects aimed at preventing drug addiction, bullying and crime that are implemented in schools. However, little attention is paid to the prevention of self-harm. Narrowly specialised prevention of self-harm is problematic in schools. It is inappropriate to provide information about self-harm (e.g. its forms and methods); it is necessary to increase pupils' self-esteem, encourage the expression of emotions, prevent bullying and violence in the school environment, and communication based on mutual trust is also important. It is more effective to teach pupils to manage their emotions and stress in an appropriate manner and to teach them how to cope with stressful situations.

As Kriegelová (2008) points out, no official tool has yet been developed for diagnosing deliberate self-harm.

If a teacher or member of the school support team notices that a pupil is self-harming, it is necessary to respond with caution. It is crucial to realise that self-harming behaviour can be a cry for help or a way of drawing attention to oneself. When talking to the pupil, they should try to remain calm and avoid hysteria. The aim is to assess the situation by asking direct questions and trying to find the reasons for their behaviour.

Self-harming individuals fear the reaction of those around them and, above all, do not trust them. According to M. Kriegelová (2008), common reasons include fear of stigmatisation, embarrassment, shame, the belief that no one and nothing can help them, difficulty trusting

others, previous negative experiences, fear of breaking family rules, and a general lack of information about the issue. When contacting a professional, a large proportion of adolescents expect to be „labelled“, talked down to, have the problem trivialised and receive a generally hostile attitude. They fear that they will be forced to talk about something they would rather forget and that this will deepen their mental instability (Ferková, 2015).

Teachers should not underestimate the situation; they should seek help from the school support team, who will refer them to a specialist, psychologist or psychiatrist. The psychologist should assess the problem adequately or refer it to a child psychiatrist, who will choose the appropriate treatment, most often psychotherapy, pharmacological treatment, or, depending on the severity, hospitalisation and subsequent treatment in hospital (Ferková, 2015).

We are aware that teachers in particular often do not know how to deal with a student in the event of self-harm. They are not sufficiently prepared and informed about such problems. Our education system almost completely lacks educational programmes aimed at the prevention and intervention of self-harm for teaching and professional staff.

Teachers should be able to distinguish between suicidal behaviour and self-harm, know its forms and the basic causes that lead to such behaviour. It is very important that all school staff are familiar with the risk factors and warning signs. With this approach, it is important to keep in mind that:

- pupils can self-harm at any age, including younger children;
- children from different family backgrounds self-harm;
- both girls and boys are prone to self-harm;
- future suicidal behaviour by self-harming children cannot be ruled out.

Responding appropriately in such a crisis situation is challenging even for experienced professionals.

Conclusion

This paper highlighted the urgency of addressing the phenomenon of deliberate self-harm in adolescents, emphasising its importance for both professionals and the general public. Given that forecasts do not indicate a decline in the incidence of this behaviour, it is imperative to focus on comprehensive, research-based approaches. , the solution must include not only raising awareness of the aetiology and functions of self-harming behaviour, but also improving diagnostic procedures and expanding the therapeutic arsenal.

A key pillar is the implementation of effective strategic prevention in the school environment. This requires systematic training of teaching and professional staff on the issue of self-harm. It is also necessary to develop and implement preventive programmes that focus on strengthening self-confidence and developing adaptive coping strategies for managing stress. Only such an integrated approach, combining theory with practice in schools, can bring long-term and sustainable results in promoting the mental health of adolescents.

References

Albores-Gallo, L., Méndez-Santos, J. L., Luna, A. X. G., Delgadillo-González, Y., Chávez-Flores, C. I., & Martínez, O. L. (2014). Nonsuicidal self-injury in a community sample of older children and adolescents of Mexico City. *Actas Españolas de Psiquiatría*, 42(4), 159–168.

Alderman, T. (1997). *The scarred soul: Understanding and ending self-inflicted violence*. Oakland, CA: New Harbinger.

Ammerman, B. A., Burke, T. A., Alloy, L. B., & McCloskey, M. S. (2015). Subjective pain during NSSI as an active agent in suicide risk. *Psychiatry Research*, 228(3), 738–744.

Ammerman, B. A., Jacobucci, R., Kleiman, E. M., Uyeji, L. L., & McCloskey, M. S. (2018). The relationship between nonsuicidal self-injury age of onset and severity of self-harm. *Suicide and Life-Threatening Behavior*, 48(1), 31–37. https://doi.org/10.1111/sltb.12330

American Psychological Association. (2020). *Publication manual of the American Psychological Association* (7th ed.). Washington, DC: American Psychological Association.

Barrocas, A. L., Giletta, M., Hankin, B. L., Prinstein, M. J., & Abela, J. R. (2015). Nonsuicidal self-injury in adolescence: Longitudinal course, trajectories, and intrapersonal predictors. *Journal of Abnormal Child Psychology*, 43(2), 369–380. https://doi.org/10.1007/s10802-014-9895-4

Barrocas, A. L., Hankin, B. L., Young, J. F., & Abela, J. R. (2012). Rates of nonsuicidal self-injury in youth: Age, sex, and behavioral methods in a community sample. *Pediatrics*, 130(1), 39–45. https://doi.org/10.1542/peds.2011-2094

Caicedo, S., & Whitlock, J. L. (2009). *Top misconceptions about self-injury*. The Fact Sheet Series, Cornell Research Program on Self-Injury and Recovery. Retrieved from http://selfinjury.bctr.cornell.edu/documents/15_misconceptions.pdf

Carr-Gregg, M. (2012). *Mental health problems in adolescence*. Prague: Portál.

Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: The Experiential Avoidance Model. *Behaviour Research and Therapy*, 44(3), 371–394. https://doi.org/10.1016/j.brat.2005.03.005

Clarke, J. (1976). The Skinheads and the Magical Recovery of Community. In S. Hall & T. Jefferson (Eds.), *Resistance through rituals: Youth subcultures in post-war Britain* (pp. xx–xx). London: Hutchinson.

Conterio, K., Lader, W., & Blumenthal, S. (1998). *The social and psychological aspects of self-injury*. New York: Penguin Random House.

American Psychiatric Association. (2015). *Diagnostic and statistical manual of mental disorders* (5th ed.). Prague: Hogrefe-Testcentrum.

Emmerová, I. (2018). Self-harm in children and adolescents. *Paediatrics for Practice*, 19(2), 88–89. Retrieved from www.pediatriepropraxi.cz

Erikson, E. H. (1999). *The extended and completed life cycle*. Prague: Portál.

Favazza, A. R. (1998). The coming of age of self-mutilation. *Journal of Nervous and Mental Disease*, 186(5), 259–268. https://doi.org/10.1097/00005053-199805000-00001

Favazza, A. R., & Conterio, K. (1988). The plight of chronic self-mutilators. *Community Mental Health Journal*, 24(1), 22–30. https://doi.org/10.1007/BF0075505

Ferková, Š. (2015). The role of the school psychologist in addressing the problem of self-harm among adolescents. *School Psychologist / Školní psycholog*, 16(1), 82–90.

Fischer, G., Ameis, N., Parzer, P., Plener, P. L., Groschwitz, R., Vonderlin, E., Kölch, M., Brunner, R., & Kaess, M. (2014). The German version of the self-injurious thoughts and behaviors interview (SITBI-G): A tool to assess non-suicidal self-injury and suicidal behavior disorder. *BMC Psychiatry*, 14(265). https://doi.org/10.1186/s12888-014-0265-7

Gámez, W., Chmielewski, M., Kotov, R., Ruggero, C., & Watson, D. (2011). Development of a measure of experiential avoidance: The Multidimensional Experiential Avoidance Questionnaire. *Psychological Assessment*, 23(3), 692–713. https://doi.org/10.1037/a0023240

Glenn, C. R., & Klonsky, E. D. (2013). Nonsuicidal self-injury disorder: An empirical investigation in adolescent psychiatric patients. *Journal of Clinical Child and Adolescent Psychology*, 42(4), 496–507. https://doi.org/10.1080/15374416.2013.794699

Gray, N., Hasking, P., & Boyes, M. (2021). The impact of ambivalence on recovery from non-

suicidal self-injury: Considerations for health professionals. *Journal of Public Mental Health*, 20(4), 251–258. https://doi.org/10.1108/JPMH-07-2020-0093

Gray, N., Hasking, P., & Boyes, M. (2022). Cognitive and emotional factors associated with the desire to cease non-suicidal self-injury. *Journal of Clinical Psychology*, 78(3), 441–455. https://doi.org/10.1002/jclp.23336

Groschwitz, R. C., Plener, P. L., Kaess, M., Schumacher, T., Stoehr, R., & Boege, I. (2015). The situation of former adolescent self-injurers as young adults: A follow-up study. *BMC Psychiatry*, 15(160). https://doi.org/10.1186/s12888-015-0555-1

Gutierrez, P. M. (1998). *Self-Harm Behavior Questionnaire (SHBQ)*. Unpublished manuscript, Northern Illinois University, DeKalb.

Hawton, K., Saunders, K. E. A., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *The Lancet*, 379(9834), 2373–2382.

Kahan, J., & Pattison, E. M. (1984). Proposal for a distinctive diagnosis: The deliberate self-harm syndrome (DSH). *Suicide and Life-Threatening Behavior*, 14(1), 17–35.

Kast, V. (2010). *Anger and its meaning: Stimuli for self-development*. Prague: Portál.

Širilová, Z. K. (2014). Self-care and self-harm. In L. Lováš, M. Hricová, B. Kováčová Holevová, M. Mesárošová, B. Ráczová, & K. Vasková (Eds.), *Psychological contexts of self-care* (pp. 145–173). Košice: UPJŠ.

Koenig, J., Rinnewitz, L., Warth, M., Hillecke, T. K., Brunner, R., Resch, F., & Kaess, M. (2017). Psychobiological response to pain in female adolescents with nonsuicidal self-injury. *Journal of Psychiatry & Neuroscience*, 42(3), 189–199. https://doi.org/10.1503/jpn.160074

Kriegelová, M. (2008). *Intentional self-harm in childhood and adolescence*. Prague: Grada.

Langmeier, J., & Krejčířová, D. (2006). *Developmental psychology*. Prague: Grada. ISBN 9788024712840.

Linderová, N., & Hradečná, Z. (2023). Functions and methods of self-harm in the clinical population of adolescents. *Československá Psychologie*, 67(6), 440–454. https://doi.org/10.51561/cspsych.67.6.440

Lipanová, L. (2023). Self-harm in children and adolescents. *Social Prevention*, 18(1), 4–9. ISSN 1336-9679.

Muehlenkamp, J. J., & Gutierrez, P. M. (2004). An investigation of differences between self-injurious behaviour and suicide attempts in a sample of adolescents. *Suicide and Life-*

Threatening Behaviour, 34(1), 1–13.

Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health*, 6(10). https://doi.org/10.1186/1753-2000-6-10

Nagyová, A. (2022). Deliberate self-harm, or where can we find the roots of self-harm? *Nocka.sk*. Retrieved from https://www.nocka.sk/web/guest/zamery-seba-poskodzovania

Nixon, M. K., & Heath, N. L. (Eds.). (2009). *Self-injury in youth: The essential guide to assessment and intervention*. New York: Routledge.

Nock, M. K., & Prinstein, M. J. (2005). Contextual and behavioural functions of self-mutilation among adolescents. *Journal of Abnormal Psychology*, 114(1), 140–146.

Platznerová, A. (2009). *Self-harm*. Prague: Galén. ISBN 9788072626069.

Poudel, A., Lamichhane, A., Magar, K. R., & Khanal, G. P. (2022). Non-suicidal self-injury and suicidal behaviour among adolescents: Co-occurrence and associated risk factors. *BMC Psychiatry*, 22(96). https://doi.org/10.1186/s12888-022-03763-z

Richardson, C. (2006). *The truth about self-harm*. Mental Health Foundation. Retrieved from https://www.mentalhealth.org.uk/sites/default/files/truth_about_self[1]harm_NEW_BRAND_0.pdf

Ross, S., & Heath, N. (2002). A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence*, 31(1), 67–77.

Říčan, P. (2004). *The journey through life*. Prague: Portál. ISBN 9788026217831.

Sim, L. E., Adrian, M., & Zeman, J. (2009). Adolescent deliberate self-harm: Linkages to emotion regulation and family emotional climate. *Journal of Research on Adolescence*, 19(1), 75–91.

Slee, N., Spinhoven, P., Garnefski, N., & Arensman, E. (2008). Emotion regulation as mediator of treatment outcome in therapy for deliberate self-harm. *Clinical Psychology and Psychotherapy*, 15(3), 205–216.

Townsend, M. L., Barr, K. R., Miller, C. E., & Sanzone, G. (2024). Self-harm and suicidal behaviours in children: Perspectives of mental health clinicians. *Journal of Paediatric Psychology*, 49(8), 571–579. https://doi.org/10.1093/jpepsy/jsae044

Vágnerová, M. (2012). *Developmental psychology*. Prague: Karolinum. ISBN 9788024621531.

Whitlock, J. (2009). *The cutting edge: Non-suicidal self-injury in adolescence*. ACT for

Youth Centre of Excellence. Retrieved from http://www.selfinjury.bctr.cornell.edu/publications/2009_1.pdf

Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviours in a college population. *Pediatrics*, 117(6), 1939–1948. https://doi.org/10.1542/peds.2005-2543

World Health Organization. (n.d.). *International Classification of Diseases, 10th edition (ICD-10)*. Retrieved from https://mediately.co/sk/icd

Young, J. F., Sproeber, N., Groschwitz, R. C., Preiss, M., & Plener, P. L. (2016). The prevalence of nonsuicidal self-injury (NSSI) in a representative sample of the German population. *BMC Psychiatry*, 16(353). https://doi.org/10.1186/s12888-016-1060-x

Zetterqvist, M., Lundh, L. G., & Svedin, C. G. (2014). A cross-sectional study of adolescent non-suicidal self-injury: Support for a specific distress-function relationship. *Child and Adolescent Psychiatry and Mental Health*, 8(23). https://doi.org/10.1186/1753-2000-8-23

PaedDr. Simona Dulovics Sámelová, PhD.

Department of Psychology

Faculty of Education

Matej Bel University

Slovak Republic

simona.samelova@umb.sk

https://orcid.org/0000-0002-5177-911X