Self-harm & Non-suicidal Self-Injury (Nssi) Tendencies Among Children: Effect of an Intervention Program

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The Asian Conference on Education 2021
Official Conference Proceedings

Abstract
Self-harm according to research is an increasing global concern, which is not just of today. It has begun to be alarming that in the recent generation self-harm and Non-Suicidal Self-Injurious (NSSI) behavior have been rampant especially in the younger ages. This study aims to determine the prevalence of self-harm and non-suicidal self- injury tendencies and the common form of self-harm among those who are in late childhood up to the earlier years of adolescence. Moreover, this action research also gauges the overall psychological distress of the respondents in the dimensions such as subjective well-being, problems and symptoms, life functioning and, risk and harm. It was participated by 301 school-going adolescents under ages 9 to 11 years old and employing a standardized self-report questionnaire (Clinical Outcomes Result Evaluation). The findings indicate that the most common form of self-harm is cutting (71.43%). Results also show that the dimension risk and harm determines an individual being at risk to themselves or others by having thoughts of hurting oneself. Findings suggest that prevention program such as wellness intervention can be developed and implemented to promote skills to minimize risk-taking behavior such self-harm and self-injury.

Keywords: Self-harm, Non Suicidal Self-injury (NSSI), Psychological Distress, Social-emotional Learning, Psychological Well Being

Introduction

Stress is not just a problem of adults but rather it is already a concern of the younger generation. According to Goodman et al. (2005), stress refers to a stimulus generating psychosocial and physiological demands requiring action on the part of the individual. As it is normal having some stress in life, young people are already experiencing both physical and emotional manifestation of such experience. Teenagers experience feeling of stress, confusion, pressure to succeed, self-doubt, and other fears while navigating their way to adulthood (Miller, 2010). For some of them, it has become part of their system and life yet there is also repercussion when the stress level reaches an overwhelming state.

Adolescence is a period characterized by substantial emotional and behavioral challenges that correspond with important brain developmental changes. When they experience strong negative emotions, they tend to experiment with a range of coping behaviors, some of which may be maladaptive, such as substance use, disordered eating patterns, and non-suicidal self-injury. Eight ways of coping according to Lazarus are the following: confrontive, distancing, self-controlling, social support seeking, accepting responsibility, escape-avoidance, planful problem solving, and positive reappraisal. One could attempt to discover how self-harming early adolescents categorize self-harm as a way of coping. Some early adolescent may constantly categorize self-harm in one or more categories of coping, whereas others may be more inconsistent, fluid, and flexible with their perceptions of functions that self-harm performs. Although Lazarus' categories of coping could assist one in defining the function that self-harm, it cautions that coping is complex process that changes across time and across stressors. Beyond the ways of coping, one could further examine the outcomes of early adolescent self-harm (Lazarus, 1993).

The act of harming one's own body tissue without the intent to die is known as non-suicidal self-injury (NSSI). Self-injury has been identified as a coping mechanism to deal with emotional distress. Non-suicidal self-injurious behavior is mostly manifested through cutting, burning or hitting oneself, scratching oneself to the point of bleeding and interfering with healing (Grandclerc, De Labrouhe, Spodenkiewicz, Lachal & Moro, 2016). It is a relatively frequent behavior in adolescents and young adults. Its principal risks will evolve toward other forms of self-injurious behavior such as suicide attempts and may eventually become chronic.

Framework

This study is based on the concept 'Social and Emotional Learning' also known as SEL by Collaborative for Academic, Social and Emotional Learning (2007) and the Model of Psychological Well-Being by Carol Ryff (1995).

Social and Emotional Learning (SEL)

Social and Emotional Learning involves the processes of developing social and emotional competencies in children. SEL programming is based on the understanding that the best learning emerges in the context of supportive relationships that make learning challenging, engaging, and meaningful. Social and emotional skills are critical to being a good student, citizen, and worker.

SEL uses positive youth-development and the promotion of social and emotional competencies to prevent the development of emotional and behavioral problems (Benson, 2006; Guerra & Bradshaw, 2008). This concept has developed from the research related to prevention and resilience (Zins, Bloodworth, Weissberg, & Walberg, 2004). Different risky behaviors like drug use, violence, bullying, and dropout, can be prevented or reduced when multi-year, integrated efforts develop students' social and emotional skills. This is best done through effective classroom instruction, student engagement in positive activities in and out of the classroom, and broad parent and community involvement in program planning, implementation, and evaluation (Bond & Hauf, 2004; Hawkins, Smith, & Catalano, 2004; Weare & Nind, 2011).

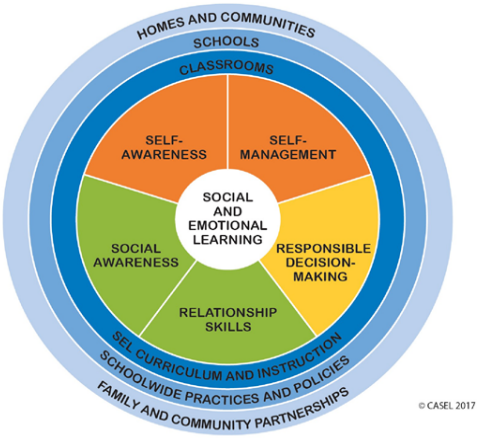

Figure 1. The Five Social and Emotional Learning Core Competencies

Model of Psychological Well-being: The Six Criteria of Well-Being (Ryff, 1995)

Model of Psychological Well-being differs from past models in one important way: well-being is multidimensional and is beyond a simple positive-negative dichotomy. Well-being is best characterized as a profile of indicators across multiple domains, rather than a single factor. It is not merely about happiness or positive emotions.

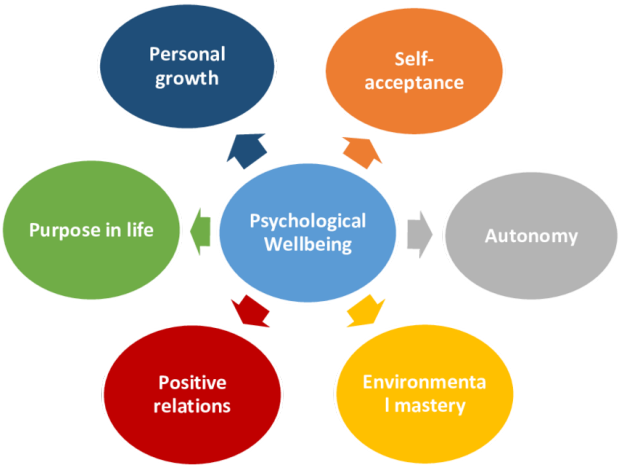

Figure 2. Model of Psychological Well-being: The Six Criteria of Well-Being

Forms of Self-Harm

In a 2010 study in the Journal of Abnormal Psychology, Franklin and colleagues investigated one of the central questions of why people report feeling better after hurting themselves. They used a task that measured people's defensive eye-blink responses before and after they dipped their hands into ice-cold water. The results indicated that self-injurers do in fact feel better afterward. Healthy controls showed exactly the same degree of physiological defensiveness and subsequent physiological relief as those who engaged in self-injury. In a 2013 paper in Clinical Psychological Science, Franklin's team replicated the finding and also showed that most people had equivalent changes in positive emotions in response to shocking stimuli. He discovered something described by psychologists 70 years ago: a phenomenon called pain offset relief. According to this concept, virtually everyone experiences an unpleasant physical reaction to a painful stimulus. Removing the stimulus does not return the individual to their pre-stimulus state, however. Rather, it leads them into a short but intense state of euphoria.

Scratching or pinching is a behavior that includes severely scratching or pinching with fingernails or objects to the point that bleeding occurred, or marks remained on the skin (Whitlock et al., 2006). This method of self-injury was seen in more than half of all students who reported participating in self-harm. Impact with objects is a self-harm behavior included banging or punching objects to the point of bruising or bleeding. This way of self-harm was seen in just over 37 percent of the self-harming students. While cutting is often considered synonymous with self-harm, this way of self-mutilation only occurred in just over 1-in-3 students who reported demonstrating self-harm. The impact with oneself is a self-injury method includes banging or punching oneself to the point of bruising or bleeding. This way to self-injure was seen in almost 25 percent of the students who reported self-harming behaviors. Ripped skin as a way of self-mutilation includes ripping or tearing skin. This type of self-injury was seen in just under 16 percent of those who admitted to self-harming behaviors. Carving as a way of self-harm is when a person carves words or symbols into the skin. This is different from cutting. This method of self-mutilation was identified by just under 15 percent of those who self-harm. Interfering with healing as way of self-mutilation and is often in combination with other types of self-harm. In this case, a person purposefully hampers the healing of wounds. This method of self-harm was used by 13.5 percent of respondents. Burning skin is a way of self-mutilation. Burning as a way of self-injury was seen in 12.9 percent of students who harmed themselves. Rubbing objects into the skin is type of self-harm that involves the rubbing of sharp objects, such as glass, into the skin. Twelve percent of responding students used this way to self-harm. Hair-pulling, another way to self-harm is medically known as trichotillomania. In trichotillomania, a person feels compelled to pull out their own hair and, in some cases, even ingest that hair. This type to self-injury was seen in 11 percent of students who self-harmed (Whitlock et al., 2006).

Subjects

Table 1: Gender Distribution of Study Sample

Gender	Number of Respondents (N)	Percentage (%)
Male	158	52.67
Female	143	47.33
Total	301	100

Instrument

CORE (Clinical Outcomes in Routine Evaluation) Outcome Measure developed by the CORE System Trust (CST), a not-for-profit company that holds and protects the copyright on the CORE instruments. It is a self-report questionnaire, where respondents were asked to answer 34 questions about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'. It addresses global distress and is therefore suitable for use as an initial screening tool and outcome measure; like most self-report measures, it cannot be used to gain a diagnosis of a specific disorder. The mean of all 34 items can be used as a global index of distress, the main design intention.

Four Dimensions of the CORE Outcome Measure:

- Subjective well-being (4 items)
- Problems/symptoms (12 items)
- Life functioning (12 items)

Discussion of Results

This action research aims to answer the following queries:

1. What is the occurrence of self-harm among the respondents?

Table 2: Self-harm Occurrence

Grade 6 AY 2017-2018	Male		Female		Total	
	F	P (%)	F	P (%)	F	P (%)
Self-Harm Related Cases	8	5.06%	6	4.19%	14	4.65%
Total Number of Respondents	158		143		301	

This table shows that out of a population size of 301, 14 were identified and referred to the counseling office due to self-harm related cases. Of these, 8 or 5.06 percent are female while 6 or 4.19 percent are male. 4.65 percent of the population was reported to engage in self-harm or possible NSSI behavior.

2. What is the most common form of self-harm among the respondents?

Table 3: Forms of Self-harm

Forms of Self-Harm	Frequency	Male	Female	P (%)
Cutting	10	3	7	71.43%
Scratching	2	1	1	14.29%
Poking	1	1	0	7.14%
Choking	1	1	0	7.14%
Total	14	6	8	100%

Table 3 above shows that out of the 14 identified self-harm cases, majority of respondents attempted to mutilate by cutting, 10 respondents or 71.43 percent of the population, 3 are males and 7 are females. Cutting is a form of self-injury – the person is literally making small cuts on his or her body, usually the arms and legs. The usual tool or object used in this form of self-harm are cutters, blades, knives, scissors and any other available pointed objects like rulers. It is usually done at home especially during times when their parent is not around and done in private places such as restroom and bedroom. There are also reports that this sometimes occur in the school's bathroom and is being inflicted on arms, legs or ankle.

According to the result, the next common form of self-injury and self-harm is scratching of oneself. This form of self-harm is being practiced by 2 of the respondents or 14.29 percent, wherein 1 of them is male and 1 is female. Scratching is known to be deliberately inducing scratches in a person's own body to inflict tissue damage and simply leave a mark with the use of sharp objects like pen, scissors, knife or any other sharp object. This act is done inside the classroom whenever they feel the need to express internal feelings in an external way. The injury is commonly inflicted on arms, legs or ankles.

3. What is the Psychological Distress distribution of the respondents in terms Subjective well-being, Problems and Symptoms, Life functioning, and Risk and harm?

Table 4: Psychological Distress Distribution

Scores	Subjective Well Being	Percentage	Problems and Symptoms	Percentage	Life Functioning	Percentage	Risk and Harm	Percentage	Overall Psychological Distress	Percentage
Healthy/ Mild Risk <1.25, or <1.0	140	46.5 %	209	69.4 %	171	56.8 %	193	64.1 %	223	74.1%
Moderate Risk 1.25/1.0 – 2.49	105	34.8 9%	83	27.6 %	119	39.5 %	100	32.2 %	72	23.9%
Severe/ Very Severe Risk >=2.50	56	18.6 %	9	2.9 %	11	3.6 %	8	2.7 %	6	1.9%
Total	301	100 %	301	100 %	301	100 %	301	100 %	301	100%

The table shows the distribution of the respondents in terms of the four dimensions (Subjective well-being, Problems and Symptom, Life Functioning and Risk and Harm). Based on the results of Table 4, almost half of the population or 140 respondents have high Subjective well-being, 105 respondents of the study have moderate risk and 56 are severe or severe risk. Subjective well-being seeks to measure an individual's feelings about oneself, feeling of crying, feeling of optimism in one's future and feeling of being overwhelmed by one's problems.

The Problem and Symptoms Dimension measures indicators of anxiety, depression, physical symptoms and trauma. Anxiety symptoms include tension, panic or terror, and nervousness. This dimension covers feelings of tension, anxiousness and nervousness that may also prevent a person in doing important things. This can be feelings of panic and terror; and inability to put to one side one's problems. This dimension also measures trauma by being disturbed having unwanted thoughts and feelings, and being distressed by unwanted images or memories. Results show that a seemingly high number of the respondents are on the

healthy to mild risk, 83 of which are at the moderate level and 9 are severe and very severe risk. This may mean that the participants have a healthy and appropriate response to life situations.

Life Functioning Dimension covers a general measure of close relationship and social relationship. It also measures the social support that an individual has and the extent of alleviation because other people. It gauges one's feelings of being able to cope when things go wrong; being happy with the things one has done and if one feels that he/she has achieved the things he/she wanted to. The results showed that more than half of the population, 171 have healthy to mild risk life functioning, 119 are in the moderate risk and 11 of them are severe to very severe risk. From these, it can be assumed that participants have good social support from other people, friends and family.

On the other hand, Risk and Harm Dimension measures an individual's being at risk to themselves or others by having thoughts of hurting oneself; have attempted hurting oneself physically or taken dangerous risks with a person's health; having thoughts and plans of ending one's life; being physically violent to others and threatened or intimidated another person. From the given table, the results of this study show that majority are in the healthy/mild group with 193 respondents, 100 are in the moderate risk and 8 are in the severe and very severe risk. This may mean that majority of the respondents may possess a healthy coping skill that enables them to regulate their own emotions and behaviors. Emotion regulation is the process by which behaviours, skills, and strategies, whether automatic or effortful, modulate, inhibit, and enhance emotional experiences and expressions (Gross & Thompson, 2007).

4. What activity could be proposed based on the results of the study?

The current study suggests development of preventative interventions, programs that could aid the students in dealing with difficult emotions and situations. This may include wellness program and social-emotional skills program to scaffold the development of effective and contextually appropriate strategies for the said population. It can be proposed that there may be activities and programs not limited to the students, but also require the collaboration with other stakeholders such as parents, teachers and the community in fostering mental wellness and well-being.

Mental wellness is vital in the promotion of an individual's holistic development in the aspect of self-care. This study intends to eventually create a program that will enhance the wellness of the individual to create awareness on the different factors that contribute to holistic well-being and learn different coping strategies in dealing with life's challenges.

Figure 3. The Pillars of Well-Being

5. What is the outcome of the program?

Majority of them highly rated the program as organized, interesting, helpful and highly relevant to their present concern. The participants suggested having more interaction and socialization, and present additional relevant videos.

Conclusion

The findings suggest that prevention program such as wellness intervention program to be implemented that promote skills to minimize risk-taking behavior such self-harm and self-injury. Schools must offer an accessible and convenient avenue for the delivery of self-harm prevention programs that could potentially be widely provided. Our results propose that schools should proactively focus upon reducing incidents of bullying and encouraging a positive and friendly environment particularly for those children and young adolescents who feel marginalized. Moreover, mental health awareness needs to be raised so that issues such as low mood, depression, anxiety and self-harm can be openly discussed.

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