Deliberate self-harm in Swedish university students – onset and relationships with anxiety and mindfulness

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Deliberate self-harm (DSH) can be defined as intentional self-induced harming of one’s own body resulting in relevant tissue damage (Fox et al., 2006).

Some previous research has revealed much interest in research and in literature-reviews during recent years (Fox, 2008).

DSH typically has its onset in early adolescence and is strongly correlated with psychiatric symptoms, but occurs over many different disorders, as well as in non-clinical samples (J heure, 2005; Fox et al., 2008).

DSH is generally viewed as a dysfunctional coping mechanism or as a non-adaptive strategy to regulate tension and other negative emotions used by some people (Vorreyer, 2007).

Regrettably, the research in this field has been obstructed by methodological shortcomings, such as the lack of a unison definition of DSH and reliable instruments to measure such behaviors. One attempt to amend these methodological problems has been the development of the Deliberate Self-Harm Inventory (DSHI; Gratz, 2001).

To date no Swedish data on the prevalence of DSH in university students has been published. Therefore, this study was planned in two steps:

- First a shortened Swedish adaptation of the Deliberate Self-Harm Inventory (DSHI) (Bjärerehed & Johansson, 2008) that had previously been used with Swedish adolescents was administered to a second sample of university students. The reason for using the DSHI was that a shorter instrument would be easier and quicker for participants to answer.

- Second, a further shortened version of the instrument called the Deliberate Self-Harm Inventory short form version (DSHI9-r; Bjärerehed & Lundh, 2007) was used in a sample of university students. This version of the instrument screened for the lifetime prevalence of a broad range of different forms of DSH and was thus used to establish if these behaviors indeed were present in university students.

Frequencies of different forms of lifetime DSH in 512 university students

Frequencies of different forms of DSH during last 6 months in 187 university students

The results from Sample 1 suggests that some extreme forms of DSH, as reported by participants in Sample 1 and 2 respectively, have not been used to assess DSH in previous research.

- Cutting wrists, arms, or body areas
- Burning with cigarette, lighter or match
- Carving words, pictures, etc. into skin
- Severe scratching, causing bleeding
- Biting yourself, so that the skin is broken
- Sticking sharp objects into the skin
- Banged head/punching self, causing a bruise
- Preventing wounds from healing
- Rubber sandpaper on your body
- Dripped acid onto your skin
- Scrubbed skin with bleach, corne, or oven cleanser
- Rubber glass into your skin
- Broken your own bones

The results from Sample 1 suggests that some extreme forms of DSH, such as “rubbed sandpaper on your body”, “dripped acid onto your skin”, “used bleach, comet, or oven cleaner to scrub your skin”, “rubbed glass into your skin” and “broken your own bones” are rarely reported by a very small proportion of respondents in non-clinical samples.

For a to have suggested that DSH could be relatively untreatable over time (Bjärerehed & Lundh, 2008), and that DSH often start during early adolescence and then generally decrease over time lower prevalences would be expected when only recent DSH is asked for, DSH reported during the last 6 months, might therefore be more relevant as an estimate of the prevalences of commonly found forms of DSH in non-clinical populations.

The correlation between DSH and anxiety and the elevated level of anxiety in the group of self-harming participants is consistent with the view of DSH as a symptom of psychopathology. It would also be consistent with the view that DSH could be a dysfunctional strategy to regulate negative emotion (i.e. anxiety). The relationship with mindfulness also fits this model as high mindfulness related to more functional emotion regulation, and low mindfulness would be found correlating to both DSH and elevated anxiety in this model.

This is the first Swedish study reporting onset of DSH. Mean age of onset in Sample 1 was 16.1 years while the mean age of Sample 2 was lower, 13.5 years. One possible interpretation of this difference would be that warrant further investigation is that the group with recent DSH, as compared to the group with elevated level of anxiety, are more likely to engage in DSH, i.e. persons with a history of DSH, but no recent such behavior increase the mean age of onset for the group. This hypothesis should be explored in future studies as early onset of DSH might be indicative of pervasive DSH.

Instruments
- Deliberate Self-Harm Inventory (DSHI) (Gratz, 2001) asks respondents to report how many times they have engaged in a number of self-harming behaviors. In Sample 1 a version of the DSHI that asks for the lifetime occurrences of 16 different forms of DSH was used (Lundh et al., 2007). In Sample 2 a shortened version of the DSHI that asks for the occurrence of 9 forms of DSH during the last 6 months was used (Bjärerehed & Lundh, 2008).
- The Mindful Attention Awareness Scale. The MAAS (Brown & Ryan, 2003) measures dispositional mindfulness, i.e. awareness of and attention to events and experience in the present moment. The MAAS is composed of 15 self-report items that asks how often participants experience different day-to-day experiences like “I could be experiencing some emotion and not be conscious of it until some time later,” on a 6 (almost always) to 0 (almost never) scale where high scores represent high degree of mindfulness.
- The Hospital Anxiety and Depression Scale. The HADS (Zigmond & Snaith, 1983) is a commonly used measure to detect states of depression and anxiety. The scale consists of 7 items that measure anxiety, like “I feel tense or wound up” and 7 items that measure depression, like “I still enjoy the things I used to enjoy”.

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References