



## Self-Harm Classification System Development: Theoretical Study

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### ABSTRACT

In the last decades there has been a visible increase in self-harming behaviour. Although this fact could have been influenced by the increased interest of specialists in researching this phenomenon and the related development and specification of adequate diagnostic tools, it is certain that this specific behaviour, until recently considered highly pathological, is becoming a norm to such an extent that a significant number of individuals try it at least once in their life or even practice it for an extended period of time. Despite the preliminary establishing of self-harm as an isolated symptom in the diagnostic manual DSM-VTM, we cannot find its unified and generally acknowledged definition in relevant specialised literature because it is a complex phenomenon and its exact description entails a number of disunities in terms of terminology resulting from the various ways of understanding it.

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### 1.0 Self-harm classification system development

Self-harm seemingly appears to be a rather new phenomenon of the current age. However, the truth is that similarly to, for example, mental anorexia, its manifestations can be traced to the distant past<sup>1</sup>, portrayed in a number of works of art and bibliographical references. The term self-harm itself was first used in the case study by L. E. Emerson *The Case of Miss A: a Preliminary Report of a Psychoanalytic Study and Treatment of a Case of Self-Mutilation* (Emerson, 1913). Emerson refers here to this behaviour as “self-mutilation”, building his study on psychoanalytical basis and recognising self-cutting as a symbolic substitution of masturbation. Menninger (1935, 1938) is another important author in this context. He uses the same term in his studies and further distinguishes between suicidal and self-harming behaviour. However, he considers self-harm a partial suicide. In his view, this behaviour has a specific purpose and occurs under various circumstances and conditions. He defines it as a certain “weakened” wish to die and therefore introduces the term “partial suicide” into specialised literature (Menninger, 1935, p. 460). Menninger states 6 types of self-mutilation: 1) neurotic (biting nails, picking off scabs, excessive hair pulling out, unnecessary cosmetic procedures), 2) religious (self-whipping, etc.), 3) maturity ceremonies (circumcision, hymen removal), 4) psychotic (eyes, ears, genitals

<sup>1</sup> The history of mankind is full of references to self-harm. The Greek playwright, Sophocles, around 500 B.C. wrote a story of Oedipus, who gauged his eyes after realising the horrid fact that he had had a sexual intercourse with his own mother. The Holy Bible contains a great number of references to self-torture. Vincent van Gogh cut off the lower part of his left ear with a razor in 1888. The poets of the 60s and the 70s of the 20<sup>th</sup> century wrote about self-harm without the intention of dying (Messer & Fremouw, 2008) and the works of contemporary artists portray it in full openness as a common part of coping with an inner crisis.

removal, extreme amputation), 5) based on organic damage (where repeated head banging and biting and breaking fingers occur, etc.) and 6) conventional (cutting nails and hair and shaving). Despite these first efforts to define and classify self-mutilation, relatively little attention has been paid to this behaviour by specialists until the late 70s of the 20<sup>th</sup> century (Yates, 2004). Specialised literature on this topic appeared very sporadically and to a great extent focused on self-harm only as on a symptom of some of the clinical diagnoses (e.g. personality disorder, mental retardation, etc.).<sup>2</sup> However, in spite of this fact, we can still trace several important milestones, which formed the understanding of self-harm as a unique phenomenon throughout history.

In 1967, Graff & Mallin carried out a research study focused on self-harm, especially on wrist cutting, aiming to trace the causes of this behaviour. At that time, the impact of psychoanalytical theories had already decreased (Dominique & Roe-Sepowitz, 2005) and the influence of behaviourism was on the rise. Due to this influence, we can encounter new classifications of self-harm based on the description of the given behaviour. The above-mentioned authors described self-mutilation as follows: "In the past several years wrist slashers have become the new chronic patients in mental hospitals, replacing the schizophrenics" (Graff & Mallin, 1967, p. 74). In most respondents, the research found difficulties in communication and behaviour resulting from early deprivation. Self-harm was also the subject of the study titled *The Syndrome of Delicate Self-Cutting* by Pao in 1969, where he distinguished between self-harming individuals who harm themselves in a delicate way (delicate) and those who harm themselves in a rather coarse way (coarse). In his opinion, in the first group of individuals one cannot assume a suicidal aim. However, he noted this behaviour as relatively repetitive. In the second group of individuals, he observed the usual suicidal aim, which can even result in death. The author finds that the "delicate cutters" were usually young people who suffered from multiple attacks of self-harming surface cutting and were often diagnosed as suffering from a borderline personality disorder. In contrast, "coarse cutters" were usually older and often psychotic. At the turn of the 70s and 80s, Ross & McKay (1979) introduced their classification of self-harm and highlighted the necessity to distinguish between direct self-harm (cutting, biting, excessive rubbing, cutting off parts, inserting objects, burning, swallowing or inhaling, hitting oneself and strangling) and indirect self-harm (overeating, drug abuse, etc.). Subsequently, Pattison & Kahan (1983) described in their work the typical characteristics of intentional self-harm – repetition, long-term nature, low mortality, and the intention to harm oneself – and suggested that intentional self-harm should be distinguished as a unique diagnostic syndrome. The authors also distinguished three basic elements of self-harm – the so called "self-harming acts" – which are: *directness or indirectness of self-harming behaviour* (referring to whether the behaviour is caused by a direct or indirect intention to mutilate oneself – some of the indirect acts are e.g. smoking, alcoholism, or not following medical treatment), *frequency of repeating* (the act can be one-time or repeated) and *high or low mortality* (among the acts with high mortality is a suicidal attempt, or a suicide). By combining these elements, eight additional groups were created, which the authors used to classify all forms of self-harming behaviour from smoking to premature ending of treatment of serious illnesses or even to suicide.

In 1987, the ground-breaking monograph *Bodies under Siege: Self-Mutilation in Culture and Psychiatry* by Armando Favazza is published. Favazza, in his work, uses the term "self-mutilation" and distinguishes between culturally accepted self-mutilation (e.g. piercing) and deviant self-mutilation, which he further classifies. Despite various gradual changes in his original conception that the author made throughout his lifetime research, he always strictly separated self-harm from suicidal behaviour and highlighted different motivation behind both acts. He was drawing on an assumption proven by practice that an individual who attempts suicide wants to end his or her life, while a person who intentionally harms oneself has the opposite aim – to feel better. In his study from 1990, he proposes a new taxonomy system of self-harm (Favazza & Rosenthal, 1990), which is used and respected to this day.

Another, very clear, classification system appears in the publication by Walsh & Rosen (1988), *Self-Mutilation: Theory, Research and Treatment*. Based on their research in specialised literature, its authors postulate and support Favazza's innovative thought that self-harming behaviour should be strictly separated from suicidal attempts and both phenomena should be understood as separate clinical units in clinical practice. In their classification, the authors use four degrees, which they define by the level of physical mutilation, mental state of the individual, and the extent of social acceptance of the given behaviour. Intentional self-harm, as understood by the majority of authors, should be closest to the third type in their classification system.

Later on, Favazza and Simeon revised their taxonomical system of self-harm and laid the basis for currently its most frequently used division. In the last and most up-to-date version of their classification, they distinguished four categories of self-harming behaviour and considered the first three categories pathological: *Stereotypical*

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<sup>2</sup> Self-harm was actually viewed this way until the recent past.

*self-mutilation*<sup>3</sup>, which typically occurs in individuals with pervasive developmental disorders and other illnesses (e.g. autism, mental retardation, etc.) – such behaviour does not consider social context (e.g. the presence of onlookers), does not have affective content and it is repeated and rhythmical; *Serious self-mutilation*, which includes serious mutilation of the body (e.g. auto-castration or gauging one's eyes) resulting in permanent damage and often occurs as a unique event in the course of a psychotic attack; *Compulsive self-mutilation*, manifested by repeated or ritual behaviour, which often occurs several times per day (e.g. pulling out hair, biting nails, scratching)<sup>4</sup>; and *Impulsive self-mutilation*, defined as direct, socially unacceptable damage of tissue, which occurs without the intention of killing oneself and without pervasive developmental illness or psychosis. Such behaviour can be rare or repeated – when rare, it includes individual episodes of self-mutilation (e.g. cutting, burning, hitting oneself), which are usually caused by the preceding feeling of tension and after the act of self-mutilation the tension reduces and the person feels better. Isolated incidents can grow with time and the particular behaviour can gradually turn into an addiction (Simeon & Favazza, 2001)<sup>5</sup>. Unfortunately, all the subsequent classification systems significantly lack unified terminology, which is caused mainly by the fact that for some authors, self-harming behaviour includes manifestations of behaviour with the intention to die behind it. Moreover, very often the unity of terminology by various authors does not mean the unity of content<sup>6</sup>.

Favazza's work broadened awareness of self-mutilation by including not only professional but also non-professional audience. Subsequently, this type of behaviour was considerably publicised in media by personal testimonies of celebrities, like Angelina Jolie and Lady Diana Frances Spencer, etc. Following their example, a number of teenagers admitted such behaviour (Messer & Fremouw, 2008) and self-harm gradually gained the attention of psychologists, doctors, pedagogues specialising in the education of children with behavioural disorders and broader professional and non-professional public. The last important milestone in the development of classification of professional public attitude to self-harm was the year 2013 when the term Non-Suicidal Self-Injury was introduced into the American Psychological Association Manual DSM-VTM.

### 1.01 Definition of terms

Despite the preliminary establishing of self-harm as an isolated symptom in the diagnostic manual DSM-VTM, we cannot find its unified and generally acknowledged definition in relevant specialised literature because it is a complex phenomenon and its exact description entails a number of disunities in terms of terminology resulting from the various ways of understanding it. Therefore, in specialised literature, we can find various terms for self-harm, which very often have more or less the same meaning. The most common terms are: Self-Harm, Self-Injury, Self-Mutilation, Parasuicide, Self-Battery, Deliberate Self Harm (DSH), Local Self-Destruction, Self-Cutting, Focal Suicide, Self-Inflicted Violence, Delicate Cutting, Self-Abuse, Self-Injurious Thoughts and Behaviour and other. Using these terms in research and clinical practice is very often given by particular region. The terms Self-Harm and Deliberate Self-Harm are used especially in Great Britain, whereas the terms Self-Injury, Self-Mutilation, Self-Inflicted Violence and Self-Injurious Behaviours are used rather in the USA (Sutton, 2005). Very frequent terms, which are used especially in research studies, are Non-Suicidal Self-Injury (NSSI) (Brausch & Gutierrez, 2010) and Repetitive Self-Mutilation Syndrome (RSM). Lieberman (2004) states that this term includes activities which can be identified as self-injurious behaviour, parasuicidal behaviour and deliberate self-harm. Based on the form of self-harm, more specified terms, like Symbolic Wounding, Slashing, Scaring and other, appear.

The frequency of using various terms and changeability of their content meaning can also be observed in the historical context, which shows the progress in perceiving self-harm: from a type of behaviour closely connected with suicidal behaviour (Kreitman, 1977) to realising the importance of mechanisms through which self-harm actually prevents suicide (Ross & McKay 1979; Simpson, 1975; 1980) to perceiving self-harm as a type of behaviour which completely lacks suicidal motivation.

<sup>3</sup> In clinical symptoms, this behaviour can have the form of stereotypical self-harm, which is usually repeated monotonously, sometimes even rhythmically. Mostly, it has the form of hitting oneself in the head or other parts of one's body, biting oneself, pulling out one's teeth, dislocating one's joints, etc. It can appear in mentally retarded or autistic people. However, it can also be connected with acute psychosis, schizophrenia, Lesch-Nyhan syndrome, Cornelia de Lang syndrome, Rett and Tourett syndrome.

<sup>4</sup> Current psychiatric taxonomy diagnostically classifies it as an impulsive disorder (e.g. trichotillomania).

<sup>5</sup> This classification is significant because it distinguishes the category of impulsive self-mutilation (it distinguishes this category from stereotypical self-mutilation), serious self-mutilation (which occurs in psychotic people) and compulsive self-mutilation (which is a symptom of other possible psychiatric diagnoses). When most of the current studies mention self-mutilation, they are talking about Favazza's impulsive self-mutilation. It is the first big step to distinguish self-harm as a separate phenomenon as opposed to 'mere' symptom of other mental illnesses.

<sup>6</sup> E.g. the term "Deliberate Self-Harm" is understood by Tantom & Whittaker (1992) in their study as the most general term for the type of behaviour that entails the intention to harm one's body, and which therefore also includes a suicidal attempt. In contrast, Sutton (1999) does not include the type of behaviour directly aiming to end one's life under this term.

Currently, the umbrella term Self-Destructive Behaviour is being used in a number of studies for self-harming behaviour (see [Sutton, 2005](#); [Duffy, 2006](#)). It covers all the types of behaviour which lead to deliberate self-harm with any level of lethality. This term includes previously used labels, like Self-Mutilation (auto-mutilation or self-mutilation), Self-Harm, Self-Battery, Deliberate Self-Harm (one-time or periodical behaviour with direct intention to physically harm oneself but without the intention to die, deliberate self-harm, self-injury), suicidal behaviour most often denoted by the term Suicide, Parasuicide (suicidal attempt), Attempted Suicide, which is connected with direct intention to die or with the expression of the intention to end one's life. However, this term also newly includes Risk-Taking (which is a term for long-term behaviour without a direct intention to harm oneself or die – it includes smoking, alcohol and drug abuse, performing risky sport activities, etc.) and it also acknowledges the categories of Self-Poisoning/Overdosing and Self-Injury. In its broadest meaning, the term Self-Destructive Behaviour can therefore cover any injury aimed against oneself. In this context, Sutton uses the term Self-Inflicted Violence (2005). Under this perspective, the spectrum of activities, which could be included under the term Self-Destructive Behaviour, is broad. On the one side of this spectrum, there would be phenomena as frequent in today's society as, for example, drinking alcohol or smoking cigarettes, restriction in food intake or, on the other hand, overeating, excessive amount of exercise and even broadly culturally accepted body decorating in the form of various types of piercing and tattoos or even less accepted creating of decorative scars (so called scaring). Although these body-modifying techniques are not generally understood as deliberate self-harm because of their primarily decorative character, some writers put them in this category<sup>7</sup>. On the other side of the spectrum of activities which are seen as self-destructive, we can find very rare extreme behaviour, which includes significant and coarse injury of body tissue<sup>8</sup> occurring in some psychiatric patients in connection with acute psychotic states<sup>9</sup>, or suicide.

Despite its inconsistency, the currently used terminology most often takes into account the criterion of a certain level of directness of this behaviour and the seriousness of the damage consequently caused, or the aforementioned level of lethality. Another traditionally stated differing criterion is repetition of such behaviour. In spite of certain differences, we can therefore find the same elements in a number of currently used definitions of self-harm, which unfortunately does not prevent the contents of the terms from overlapping. Nevertheless, most writers describing this behaviour agree on its basic components: an individual performs the acts on himself/herself, deliberately and with a purpose in mind, at various levels of physical violence. However, according to most authors, this behaviour is not suicidal and does not include sexual or decorative intention.

One of the most popular and most frequent definitions in specialised literature is the following: "Self-mutilation (SM) refers to the deliberate, direct destruction or alternation of body tissue without conscious suicidal intent" ([Favazza, 1998, p. 259](#)). Many more authors (e.g. [Ross & Heath, 2002](#)) use this definition as the basis for their own research. [Hawton & Harris \(2007\)](#) define "Deliberate Self-Harm" as an act with non-fatal consequences in the form of behaviour causing damage (cutting oneself, jumping from high places), use of a drug which exceeds the prescribed limit, eating non-edible matter or an object, or taking illegal or recreational drugs with the intention to harm oneself. [Skegg \(2005\)](#) describes Self-Harm as a broad scale of behaviour and intentions including attempted hanging, surface self-cutting or impulsive self-poisoning carried out in response to an unmanageable burden. In foreign literature, the most frequent definitions describe self-harm in the meaning of a deliberate act of destructing of one's own tissue with the aim of shifting unbearable emotional pain to physical pain, which is more manageable for the individual ([Janis & Nock, 2008](#); [Hicks & Hinck, 2008](#)). These authors claim that in an extreme interpretation of self-harm, it can be defined as a visual demonstration of extreme emotional anxiety and in their writing we can encounter the broadening term "Self-Injurious Thoughts and Behaviour".

More recent surveys and comparative studies (see [Ougrin et al., 2012](#)) use the term "Self-Harm" relatively broadly, regardless of the intention of such behaviour. In Great Britain and Europe, suicidal attempts are also often included under this term. In contrast, in the US it is much more common to distinguish self-harming behaviour based on its intention, and thus the term Non-Suicidal Self-Injury (NSSI) is more frequently used here. According to [Lloyd et al. \(2007\)](#), NSSI is perceived as intentional behaviour which results in mutilation or alternation of body tissue without a conscious suicidal intention. With regard to the aim of this publication and the above mentioned facts, the term Self-Harm will be used primarily from now on.

## 1.02 Differentiation from suicidal behaviour

In recent years, the research in the area of self-harm repeatedly highlighted the necessity to specify the theoretical paradigm of self-harm, which would, among other things, also contribute to its more precise

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<sup>7</sup> Laye-Gindhu & Schornert-Reichl (2005) observes more frequent occurrence of tattoos in people who mutilate themselves.

<sup>8</sup> It might be, for example, an eye enucleation, castration or limb amputation.

<sup>9</sup> Most often it is an acute psychotic episode, schizophrenia, mania, serious depression, or acute intoxication.



differentiation from suicidal behaviour (Jacobson et al., 2008). In the newest issue of DSM-5, Non-Suicidal Self Injury has been detached as a separate chapter in the part called Conditions for Further Study (DSM-VTM, 2013). This chapter includes areas which seem to be crucial for the clinical sphere. However, currently there is not enough data to include them among individual mental disorders<sup>10</sup>. At the same time, the chapter suggests criteria for independent diagnosis of NSSI (see attachment n°1), but along with the suggested diagnostic category they are a subject of further inquiry at the moment (In-Albon et al., 2013), despite the fact that their content is in accordance with the definition of NSSI commonly used in American research studies. Nevertheless, specialised literature more and more often highlights the need to diagnostically anchor self-harm in an appropriate way, not only for research purposes but also for the needs of common clinical practice. According to Nock (2012), it is necessary to work on its clear definition as well as on the correct use of given specialised terms in this context.

The level of lethality and motivations closely related to it has become one of the main diagnostic criteria for categorisation of self-harm as a separate clinical category. This helps distinguish such behaviour from suicidal attempts and suicidal behaviour. With regard to the frequency of its occurrence and even possible lethal consequences, it is necessary to pay increased attention to suicidal behaviour in this sensitive developmental stage<sup>11</sup>. Unfortunately, a number of research studies still examine suicidal attempts and self-harm together. Some of them use these terms inaccurately and then identify a suicidal attempt with self-harm (Wong, Brower & Zucker, 2011) – especially because a suicidal attempt is often difficult to identify (Claes & Vandereycken, 2007). However, a suicidal attempt is significantly different from self-harm in many ways, according to the results of a number of conducted research studies (Pattison & Kahan, 1983; Sabo et al., 1995; Motz, 2001; Brown, Comtois, & Linehan, 2002), and it is different in more than one category. A suicidal attempt is based on the intention to die and it is different in its aetiology, function of the behaviour, and also its frequency. This behaviour also differs from self-harm in the age when the first episode occurs. While suicidal behaviour hardly ever occurs before the age of 15, in case of self-harm this age limit is usually lower – around 12 years of age and it can occur in younger individuals as well (Bertolote & Fleischmann, 2002). Moreover, current definitions of self-harm (see above) mostly deny that any intention to die is directly related to this behaviour, which is also supported by a number of research claims (Brown, Comtois, & Linehan, 2002).

Most of the research conducted in this area also highlights the fact that self-harming behaviour brings the feeling of release. The moderation of inner pain, on the contrary, prevents suicidal tendencies (Lieberman, 2004). Great majority of individuals who harmed themselves state tension release, not ending their lives, as their primary aim. Therefore, it is possible to say that self-harm can be closely related to suicidal tendencies, but not directly or causatively. Also, according to Sutton (2005), self-harming behaviour does not have an explicit suicidal aim but represents a coping strategy used when dealing with psychological deprivation or when trying to regain a lost emotional balance. The invisible emotional pain thus transfers into a visible one in the form of physical injuries. In this context, Janis & Nock (2008) point to the fact that an individual planning a suicide is longing for death but a self-harming individual only wants to feel better. However, this presupposition does not exclude the fact that self-harming can precede a suicidal attempt and it relatively often does. Laye-Gindhu & Schonert-Reichl (2005) state in the results of their study that in self-harming individuals suicidal thoughts are present more frequently (83% as opposed to 29% of individuals who do not harm themselves). Similarly, they identified a majority of self-harming individuals in case of suicidal attempts (26% as opposed to 6% of individuals who do not harm themselves) and claimed that as high as 89% of adolescents who attempted suicide also harmed themselves. The occurrence of self-harm in personal anamnesis is also one of the most significant predictors of completed suicide, the risk of which grows up to ten times in self-harming individuals according to some authors (Hawton & Harris, 2007). According to Assarnow et al. (2011) self-harm in personal medical history is a more significant predictor of a suicidal attempt than a previous suicidal attempt<sup>12</sup>.

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<sup>10</sup> A major sign of NSSI is repeated creating of small but painful wounds on the surface of one's body. The most frequent cause of such behaviour is the effort to get rid of negative emotions, like tension, fear, or self-hate and/or solve an interpersonal problem. In some cases, the behaviour is understood as a deserved punishment. Individuals often talk about an immediate feeling of relief, which occurs during the act of self-harm. If the behaviour occurs regularly, it is often accompanied by the feeling of urge and desire, in its character similar to addiction. Self-inflicted wounds can be deeper and more frequent with time. The wounds are most often knife or razor blade wounds, needle sticks or sharp injuries. The usual places of self-inflicted injuries are the front part of thighs and the dorsal part of forearm. Other methods include stabbing (most often into the upper arm) with a needle or a sharp knife, burning by a cigarette, "burning" of skin by repeated rubbing with an eraser. Using more than one method is associated with more serious psychopathology, including suicidal attempts." (DSM-5, 2013, p. 803-804).

<sup>11</sup> According to Patton (2012), in the Western world, suicide is the second most frequent cause of death after accidents on the roads – in female adolescents aged 15-19 yrs. it is the most frequent cause of death and in male adolescents the third most frequent cause of death (after accidents on the roads and violence). Current research confirms that suicide is becoming an important cause of death in adolescents even in developing countries (Ougrin et al., 2012).

<sup>12</sup> The results of the study by Cooper et al (2005) highlight the importance of early intervention after an episode of self-harm in a suicide prevention strategy.

Whether self-harm changes into a subsequent suicidal attempt, or not, greatly depends on a number of significant intervening influences. Nevertheless, its occurrence can be in this context considered a significant risk factor. The risk factors of self-harm and of a suicidal attempt can in some cases be the same; however, some of them are exclusive for the given behaviour. In their study, [Hawton, Saunders & O'Connor \(2012\)](#) identify risk factors of self-harm, which are common for suicidal behaviour as well. These factors are low socioeconomic status, parental problems (divorce, separation, death of one of the parents, mental illness of parents), family history of suicidal behaviour, interpersonal problems, psychological disorder of the individual, addictive drug abuse, or feeling of deep hopelessness. In contrast, self-harm was different from suicidal behaviour in predominance of gender (female gender is predominant in case of self-harm and male gender is predominant in case of suicide). In case of self-harm, the authors state the following significant risk factors: other than heterosexual orientation, impulsivity, poor self-confidence, perfectionism, inability to solve problems, or experience of being bullied.

[Lloyd et al. \(2007\)](#) examined the differences between self-harming individuals who attempted to commit suicide and those who only harmed themselves. In the group with suicidal attempts, more frequent outpatient psychiatric treatment or hospitalisation and more frequent occurrence of suicidal thoughts were found in personal medical history. At the same time, individuals who carried out more serious types of self-harm and more differing ways of self-harm attempted to commit suicide more often. When examining the social context of self-harm, [Glenn & Klonsky \(2009\)](#) came to the conclusion that self-harming individuals who acted in this way on their own in privacy had a higher percentage of subsequent suicidal thoughts and suicidal attempts. [Swahn et al. \(2012\)](#) state that approximately 70% of repeatedly self-harming adolescents sometimes attempt to commit suicide. In their research study conducted on American adolescents, they found that 38.2% of those who had harmed themselves during the previous year attempted to commit suicide as well. Occurrence of both self-harm and suicidal attempts was more frequent in adolescents using alcohol and other drugs, in those who were abused during their childhood, and those who stated a higher level of depression and impulsivity and a lower level of self-efficacy and parental support. [Hawton et al. \(2012\)](#) state the existence of risk of potential suicidal behaviour especially in repeatedly self-harming adolescent boys (the risk is often higher in those who cut themselves than those who poison themselves). Also, the results of [Tormoen et al. \(2013\)](#) suggest that self-harming behaviour and suicidal attempts can have a common base. However, they also found that adolescents who, apart from harming themselves, attempt suicide show worse mental health, problematic lifestyle and more behavioural problems. [Brausch & Gutierrez \(2010\)](#) discovered other interesting difference between self-harming adolescents and those who attempted suicide. Those who only harmed themselves showed a lower level of depression and feelings of hopelessness and a higher level of parental support and self-respect than those who attempted suicide. These results suggest that with the increase of risk factors (e.g. depression, feelings of hopelessness, and other) and decrease of protection factors (e.g. parental support, self-respect, and other) an individual can go from healthy behaviour to self-harming and even to suicidal behaviour.

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