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Case report

NON-SUICIDAL SELF-INJURY IN ITALIAN SECONDARY SCHOOLS: 5 CASE REPORTS

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SUMMARY

By definition, adolescence is an age of transition, full of numerous small and major crises. Over the past few years, various data underscore the prominence of adolescent distress. In some cases, the malaise manifests through acting out and self-destructive behaviours. During adolescence, young people may experience a range of physical, emotional and social changes that can increase the risk of non-suicidal self-injury.

Non-suicidal self-injury is a complex behaviour of intentionally inflicting pain or injury on oneself, frequently as mechanism to handle stress, anxiety, or other negative emotions. The scientific literature on self-injury is complex and multifactorial, encompassing several psychological, social, and biological factors. This paper describes the risk factors, the prevalence of the phenomenon, and its potential psychological meanings. Furthermore, 5 case reports are presented, involving female adolescents aged 15 to 18 who exhibit non-suicidal self-injury. Anamnestic data and each adolescent's own life history were collected through in-person and online interviews in school-based listening services. Non-suicidal self-injury is a significant problem which requires an integrated prevention approach among the various stakeholders in the school system. Network synergy between school, family and social workers is crucial in order to promote the adolescent well-being.

Key words: *self-injury – adolescence - non-suicidal self-injury*

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INTRODUCTION

Adolescence has always symbolised a period of rapid physiological, psychological, cognitive, social and emotional changes. Adolescence has its roots in the Latin term “adolescere” meaning “to grow”. Sometimes, minors struggle to effectively manage the developmental challenges typical of their age. An adolescent is simultaneously a child and an adult: on one hand, there is a kind of relinquishment of their childhood, and on the other, there is a frenetically research of the adult status. The intricate nature of the challenges makes it difficult to delineate the border between normal and psychological, since adolescents are experiencing strong growth and changes. The ongoing challenges are numerous, encompassing the search for one's identity and autonomy, while the peer group assumes immense importance. In this process of transformation and change, adolescents can be fragile and can be exposed to certain psychological and emotional difficulties.

DISSEMINATION OF SELF-INJURY ACT

Among the various manifestations of adolescent distress, a very frequent phenomenon is emerging today: non-suicidal self-injury to one's own body. Each adolescent employs distinct method and targets specific body areas for self-inflicted cuts and burns. The intention is to intentionally damage the body as a means of suppressing internal distress. This behaviour starts from puberty and continues during all the adolesce (Klonsky & Muehlenkamp 2007; Muehlenkamp et al. 2012).

Over the past few years, there has been a frequent observation of students inflicting in silent self-injury; this phenomenon seems to be proliferating rapidly. In fact, data compiled by the Italian Society of Paediatrics (2017) indicate that 8 out of 10 adolescents exhibit emotional difficulties, and 15% have experienced at least one self-injury incident. A recent study has revealed the possibility of social contagion of the self-injury phenomenon through the peer group or the use of social networks, all of which contribute to the emergence of the disorder or its maintenance (Jarvi et al. 2013).

The self-injury phenomenon is a rather widespread behaviour among young people and adolescents; it is aggression directed towards oneself in the form of cuts, scratches, burns. Self-injury is more prevalent among girls (Andover et al. 2012). In addition, high percentages (30-40%) of non-suicidal self-injury are found in adolescents with psychiatric disorders (Jacobson et al. 2008).

RISK FACTORS FOR SELF-INJURY

The self-injury act does not present a linear randomness but depends on multiple factors. Among socio-environmental factors, for example, the adolescent may be influenced by peer pressure, lack of social support and one’s own history of abuse or trauma. Certainly, environmental factors encompass family history and the relationships the adolescents form with their environment. A hostile, judgmental, critical, ironic in a negative sense climate may be present in the family context, that limits the emotional development and emotional regulation of the adolescent. Many studies

highlight the presence of one or more mental disorders in the family, verbal or physical violence, or use of substances or suicidal acts.

Numerous are the psychological, relational and affective factors: self-injury may be associated with mood disorders, depression, anxiety, or even borderline personality disorder and post-traumatic stress disorder.

In addition, biological factors encompass neurochemical imbalances, specifically involving serotonin and dopamine within the serotonergic system (Giaanakopoulos et al. 2025). Actually, the relationship between self-injury and biological factors is complex; nevertheless, it is evident that a significant neurochemical component underlies self-injurious behaviours in psychiatric adolescents.

The aggressivity against yourself can be associated to other self-destructive behaviour such as eating disorders, alcohol and substance abuse (Murray et al. 2011).

A low socioeconomic background and difficult living circumstances constitute major risk factors for self-injury (Taylor et al. 2004). Self-injurious behaviour appears to be more prevalent in economically disadvantaged segments of the population. Moreover, experiences of bullying and cyberbullying can contribute to the risk of engaging in self-injurious conduct.

Nevertheless, there are instances in which none of these risk factors are evident: the adolescent experiences internal distress and derive a sense of relief from self-injurious behaviour.

POSSIBLE MEANINGS OF SELF-INJURY ACT

The self-injurious behaviour seems to reduce, even if only momentarily, negative thoughts and unpleasant emotions: it is a behaviour without lethal intention (Nock 2010). The adolescent obtains temporarily relief from the harmful act; in this way he manages to ignore the internal pain focusing on the physical one. Self-injurious behaviour appears to represent, at some level, a form of acting out for regulating stress, anxiety, or other negative emotions. In any case, non-suicidal self-injury is a behaviour that demands serious attention, as the adolescent at that moment is experiencing intense emotions and profound distress. In some cases, the behaviour occurs sporadically; conversely, it can evolve into a repetitive pattern that is negatively reinforced through habituation to pain.

Various scientific studies reveal that acts of self-injury can possess multiple meanings and serve diverse intrapsychic functions, such as an attempt to regulate emotions, control intense anguish, externalize pain, or even as a form of self-punishment or a means to counteract dissociation and suicidal ideation. At an individual level the self-injury act seems to signify a search for autonomy, a definition of one’s own boundaries, a search of strong external sensation, or even a form of emotional redemption or an extreme attempt at group identification (Klonsky et al. 2015).

The adolescent often presents relational difficulties with peers, an important role is played by social stresses such as with the class group, In some cases, the adolescent presents a low level of sociability and tends to self-isolate from the group.

The consequences of self-cutting affect the body and leave scars, infections or otherwise more or less extensive physical injuries. In general, the damaging act increases social isolation and intensifies relationship difficulties.

When the injurious act is repeated it worsens the symptoms, in the case of a specific mental disorder, and increases the risk of suicide. The structuring of the self-injury act can be an alarm bell; the pain becomes unbearable so that the adolescent may make suicide attempts.

In fact, further studies show that the act of self-injury or self-cutting correlates with several psychiatric diagnostic categories, however it does not present specific links with a particular psychopathological category, with elements of impulsivity, relational difficulties, alexithymia predominating. The possibility of a suicidal act or suicide attempt cannot be excluded (Gatta et al. 2019). Young people who self-harm have a higher risk of attempting suicide in the future than those who do not harm themselves (Jacobson & Gould 2007).

It is difficult to understand the seriousness of the self-injury act; usually it is not a suicide attempt but an effort to cope with negative emotions and painful anguish crisis situations anyway. This behaviour probably constitutes an attempt to alleviate discomfort; the self-injurious act decreases tension. In fact, the adolescent involved is quite committed to life. Anguish is sporadic and is controlled through the behavioural acts of self-injury, providing immediate relief. Recent research highlights that many adolescent self-injurious gestures exhibit spontaneous remission by adulthood (Moran et al. 2012).

CLASSIFICATION OF NON-SUICIDAL SELF-INJURY ACT (DSM V, 2013)

Proposed criteria A

Over the past year, the individual has, for five or more days, intentionally caused damage to the body's surface, likely aiming to induce bleeding, ecchymosis, or pain (for example: cutting, burning, hitting, excessive skin rubbing), with the expectation that the injury will result in only mild or moderate physical harm (which means there is no suicidal intent).

Note: The absence of suicidal intent can be declared by the individual or inferred from the individual's repeated engagement in behaviour that they know, or have learned, is not likely to cause death.

Proposed criteria B

The individual commits act of self-injury with one or more of these expected consequences: to obtain relief from an adverse emotional or cognitive condition; to solve an interpersonal difficulty; to induce a positive emotional state.

Note: The desired relief or response is experienced during or immediately after the act, and the individual may exhibit behavioural patterns suggesting dependence and a need to repeat the act.

Proposed criteria C

Intentional self-injury is associated with at least one of the following phenomena: interpersonal difficulties, negative feelings or thoughts, such as depression, anxiety, tension, anger, generalised anxiety, or self-criticism, occurring in the period immediately preceding the self-injurious act.; before the self-injurious act, a period of worry about the intended behaviour, which is difficult to control; self-injurious thoughts occur frequently, even when no act follows.

Proposed criteria D

The behaviour is not socially approved (as in the case of piercings, tattoos, parts of a religious or cultural ritual) and is not limited to removing a scab or biting one's nails. The behaviour or its consequences cause clinically significant distress, interpersonal or school interference, or in other important areas of functioning.

5 CASE-REPORTS

Five cases are presented, of different age, different ethnic origin, same gender, all belonging to lower and middle social classes. The age group is adolescents, from 15 to 18 years. The situations were detected in a school environment, in secondary schools, amnestic information was gathered through face-to-face interviews and the use of psychological support chats.

1. A 17-year-old girl has conflicting relationships in the family, parents live apart at home, the climate is rather negative. The girl ha a terrible relationship with the father, who seems to prefer the sister. Jealousy and envy towards her younger sister are present. She feels mocked and denigrated by her father, seems not to have developed an adequate management and emotion regulation system. The relationship with the mother is amicable. The mother presents psychic fragility. The minor has been bullied in the past. She suffers a lot for her parents' relationship conflict, and as the family crisis deepens, she starts to cut herself with a razor blade. Feeling lonely to cope, she also starts using cannabis. She is mocked again in the school environment as a result of some of her attitudes, new episodes of bullying.

2. An 18-year-old girl has no enjoyable memories of her childhood. Family conflicts have always been present. The climate is cold and distant. She suffers from a mood disorder and problems with food restriction and control, panic attacks, when emotional crises escalate, she finds relief in burning her arms with a lighter. The dialogue and family communication are completely absent. She has a very low self-confidence. She has experienced trauma in the past with the male figure. She tends to establish dependent relationships and fears abandonment. At school she seems to isolate herself, few social relationships, school performance with significant fluctuations.

3. A 15-year-old girl experiences severe restrictions on her personal freedom in her family: it is not allowed to hang out with peers, to have a boyfriend, and she is systematically controlled on technological devices by her parents who adopt a rather strict and intransigent education. She lives isolated and feels a strong sense of loneliness. She has poor quality school performance and strong parental pressure for the school. She presents mood disorder, with anxiety and apathy. To weaken the pain, she cuts herself on the legs with a box cutter. There are constant conflicts in the parental couple with the father's sudden departure and his return at a later time. The father has problems with alcohol addiction.

4. An 18-year-old girl with major manifestation of mood swings and anxiety crises. She lives isolated in the family and has suffered trauma and abuse in the past. She isolates herself in class and has only one best friend with whom she has a symbiotic and strongly conflicting relationship. She reports brooding with presence of negative thoughts, depression, anxiety, insomnia, headaches. She has no meaningful social relationships and experiences boredom and loneliness. She experiences the class group in a persecutory manner, at times paranoid. She admits that she started to cut herself sporadically, following the viewing of some videos on social media, in which specific instructions for the self-injury act were given. She began to cut herself occasionally at first, then repetitively every day. She presents borderline personality and strong ambivalence.

5. A 15-year-old girl feels different in her family. She experienced sudden changes of residence in order to help her paternal family in a foreign country, loss of self-confident and of reference points in attachment relationship. She lived for 1 year during the COVID-19 pandemic in a foreign country alone with her mother. She had an imaginary friend in the pre-adolescence. Progressive departure from family affections: she isolates in her own room. She has a cold and distant relationship with the attachment figures. She lost a brother, and she has conflict with her mother. She tells of relieving herself with the self-injury act performed with a piece of glass. Then the pain returns, and she repeats the injurious act. She presents unstable mood and insomnia. She does not feel useful and recognised in the family, she would like to disappear.

CONCLUSIONS

In these 5 case-reports, certain risk factors for non-suicidal self-injury act are present: family conflicts, feelings of loneliness, mood disorders, anxiety disorders, previous traumas, lack of dialogue, hostile and rejecting climate, parents with psychic fragility, social contagion, bullying. Self-injury is a complex and varying phenomenon, difficult to intercept and understand. Within a sympathetic and empathetic listening climate, it is possible to carry out a first level of intervention and encourage the emergence of the difficulty. In recent years there has been increasing emphasis on the concept of adolescent well-being in the school and family context. The importance of developing relational, emotional and growth competencies with specific skills was widely noted. In this sense, the school can make the latter concept of well-being its own, both by realizing supervisions and interventions aimed at undertaking of the discomfort and by implementing projects to promote well-being. It is essential to realize prevention programmes and create social support networks between teachers, family and social workers. The school represents one of the contexts in which these phenomena emerge: support programmes for students, affective education projects with management and regulation of negative emotions, training of teachers and parents are useful and necessary.

A validating and affective family environment is quite important for the adolescent; when this is lacking, a fracture seems to be created that destabilises the adolescent. On the other hand, each adolescent has one's own personality structure and reacts differently to environmental stimuli.

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Contribution of individual authors:

Donatella Costa projected and designed the manuscript;

Giuseppe Tavormina supervised and reviewed it.

Both authors approved the final manuscript.

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