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Self-harming behaviour among university students: A South African case study

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This study investigated the prevalence of self-harming practices among South African university students. Respondents were 201 students attending a small university of technology in South Africa (females = 55%; males = 45%). The students completed a survey on their self-harming behaviours by type, frequency, and context of occurrence. The data were used to descriptively profile self-harming behaviours among the students. Secondary analysis considered any group differences by gender. In total, 19.4% of the respondents reported deliberate self-harm. Mental pain was reported as the most prevalent category of behaviours, at 23.4% of the sample. Most of the types of deliberate self-harming behaviour were engaged in only once. Statistically significant associations were found between gender and substance abuse and risky general behaviour, respectively, where females were at higher risk of engaging in both self-harming behaviours.

Keywords: self-harm, deliberate self-harming behaviour, mental pain, South Africa, students

Introduction

Self-harming practices among the youth are on the rise, although the reasons for their occurrence remain unclear. Self-harm is defined as ‘self-destructive behaviors that are undertaken to damage or harm oneself, but not to intentionally end life’ (Sansone & Sansone, 2010, p. 16). Previous studies investigating the reasons individuals engage in self-harming behaviour have found that potential motivators of self-harm are intrinsic, such as an intention to die, to escape, or to find relief (Scoliers et al., 2009). People engaging in self-harming behaviour often do so with the purpose of alleviating psychological and emotional distress or pain (Hicks & Hinck 2008; Shamos, 2007). Because psychological and emotional pain can vary in intensity, the outcome thereof will also vary. Research has shown that when a person thinks about self-harm over a long period of time, the type of self-harm that is engaged in will be more severe (such as self-poisoning), and the consequences will also be severe (i.e. needing to be admitted to hospital) (Rodham, Hawton & Evans, 2004).

Most studies are in agreement that emotions (either positive or negative) are experienced before, during, and after the incident of self-harm (Laye-Gindhu & Schonert-Reichl, 2005). Negative behavioural dispositions, feelings, and emotions associated with self-harm include hopelessness, disappointment, loneliness, stress, sadness (Laskite & Laskene, 2011), guilt, embarrassment, aggression (Woldorf, 2005), shame, self-hate (Hicks & Hinck, 2008), anxiety, low self-esteem, impulsivity (Hawton, Harriss & Rodham, 2010), and depression (Laye-Gindhu & Schonert-Reichl, 2005). Adolescents suffering from any of the aforementioned negative feelings or emotions often find relief, or escape, by hurting themselves, and thus self-harm has become for them a way of coping with emotional distress (Laye-Gindhu & Schonert-Reichl, 2005).

Measuring the prevalence of self-harming behaviour

The procedures used for measuring the prevalence of self-harming behaviour vary across studies, which makes it

difficult to establish the prevalence of this typically hidden practice. Although some will disclose incidents of self-harm to others, others will prefer to keep such incidents private. Self-harm is often not reported, and the reasons that have been cited for this are, among others, no access to support, unwillingness to seek help, and cognitive, attitudinal and practical factors (Fortune, Sinclair & Hawton, 2008). Friends are the main source of support for adolescents, which would seem to be normal for the developmental stage of adolescence (Fortune et al., 2008). The data suggest that individuals with family members with a history of self-harm are also likely to self-harm, or to harm others (Fortune et al., 2008; Hawton et al., 2010).

Scholars (e.g. Laskite & Laskene, 2011; Laye-Gindhu & Schonert-Reichl, 2005; Martin, Rotaries, Pearce & Allison, 1995; Ross & Heath, 2002; Swenson, Spirito, Dyl, Kittler & Hunt, 2008) have reported conflicting results regarding the association between gender and self-harming behaviour. Some studies have found no significant correlation between these two variables (e.g. Martin et al., 1995), while other studies have found that more females than males engage in self-harming behaviour (e.g. Laskite & Laskene, 2011; Laye-Gindhu & Schonert-Reichl, 2005; Ross & Heath, 2002; Swenson et al., 2008). However, most of the studies cited were conducted with adolescents in developed countries, such as Europe and America. The current study sought to determine the prevalence and correlates of self-harming practices among university students in a developing country, namely South Africa.

Method

Participants and setting

The study was conducted within the positivist paradigm, and was quantitative in nature. The research design that was used was a quantitative cross-sectional design. The data were collected by means of a self-administered questionnaire from a sample of 201 students. The sample consisted of 91 males (45%) and 110 females (females = 55%; age range 19 to 24 years mean age). In terms of race, 197 respondents (98%) indicated that they belonged to the

black African population group.

Instrument

The students completed an abridged version of the Self-Harm Inventory (SHI) (Sansone, Wiederman & Sansone, 1998). The abridged SHI consisted of 22 items enquiring about self-harming behaviours, to which the respondents had to answer on a four-point Likert scale, where possible options were 'definitely yes', 'yes', 'no', and 'definitely no'. The respondents also had to indicate the number of times they had engaged in the particular type of self-harming behaviour.

The SHI explores respondents' history of self-harming behaviour. The questionnaire takes approximately five minutes to complete, and it includes questions such as 'Have you ever intentionally, or on purpose, cut yourself?' The SHI also measures the frequency of engagement in different types of deliberate self-harm. According to Sansone et al. (1998), the SHI may be regarded as a useful screening tool for researchers and clinicians. Although the SHI has mostly been used in a clinical environment, Latimer, Covic, Cumming and Tennant (2009) assert that this instrument may also be useful in a non-clinical environment. The internal consistency reliability of scores from the SHI with the current study on the SHI was 0.7.

Data analysis

The data were descriptively analysed using SPSS (version 20). Specifically, frequencies and correlation indices were applied to profile self-harming behaviours. A *t*-test was

used to assess between-group differences of gender in self-harming practices by the students.

Results

The types of self-harming behaviour identified by the SHI were put into five categories, namely mental pain, substance abuse, physical pain, risky sexual behaviour, and risky general behaviour (see Table 1).

Mental pain was reported as the most prevalent category of behaviours for the sample. This includes behaviours such as torture with self-defeating thoughts ($n = 47$; 23.4%), engaging in rejecting relationships ($n = 42$; 20.9%), engaging in emotionally abusive relationships ($n = 32$; 15.9%), and distancing oneself from God as punishment ($n = 30$; 14.9%).

A total of 62 respondents (31%) indicated that they had never engaged in any type of self-harming behaviour, 30 respondents (15%) indicated that they had used one method to self-harm, and 109 respondents (54%) reported to have used more than one method to self-harm. Most of the types of deliberate self-harming behaviour ($n = 16$; 72.7%) were engaged in only once, and 11 of these listed behaviours (50%) were engaged in repeatedly. The behaviours that were engaged in repeatedly are listed in Table 2.

A Pearson product-moment correlation was performed to determine whether there was a relationship between the various manifestations of self-harming behaviour.

As can be seen from Table 3, there was a small positive correlation between mental pain and physical pain

Table 1: The frequency of different types of self-harm

Type of self-harm	Yes (n)	Yes (%)	No (n)	No (%)
Mental pain				
Torture with self-defeating thoughts	47	23.4	154	76.6
Setting yourself up in a relationship to be rejected	42	20.9	158	78.6
Engaging in emotionally abusive relationships	32	15.9	168	83.6
Distancing yourself from God as punishment	30	14.9	170	84.6
Substance abuse				
Alcohol abuse	46	22.9	155	77.1
Overdosing	25	12.4	174	86.6
Abuse of prescription medication	12	6	188	93.5
Physical pain				
Made medical situations worse on purpose	27	13.4	174	86.6
Hitting yourself	26	12.9	175	87.1
Head banging	24	11.9	77	88.1
Starving yourself	19	9.5	182	90.5
Cutting yourself	18	9	183	91
Scratching yourself	17	8.5	181	90
Exercised an injury on purpose	12	6	189	94
Prevented wounds from healing	10	5	191	95
Burning yourself	4	2	196	97.5
Abuse of laxatives to hurt yourself	3	1.5	197	98
Risky sexual behaviour				
Promiscuous behaviour	40	19.9	161	80.1
Engaging in sexually abusive relationships	8	4	189	94
Risky general behaviour				
Drove recklessly on purpose	21	10.4	179	89.5
Attempted suicide	17	8.5	184	91.5
Lost a job on purpose	12	6	189	94

Table 2: Self-harming behaviours engaged in repeatedly

Type of self-harming behaviour	Respondents (n)	Percentage of sample
Hitting yourself	18	9
Promiscuous behaviour	15	7.5
Head banging	13	6.5
Overdosing	11	5.5
Reckless driving	8	4
Cutting yourself	8	4
Alcohol abuse	7	3.5
Scratching yourself	7	3.5
Suicide	2	1
Burning yourself	2	1
Emotionally abusive relationships	1	0.5

($r = 0.247$, $n = 197$, $p = 0.000$). Thus, as physical pain increases, so does mental pain, and vice versa. There was a medium positive correlation between substance abuse and physical pain ($r = 0.335$, $n = 197$, $p = 0.000$). This result suggests that with an increase in substance abuse, there is an increase in physical pain, and vice versa. Risky sexual behaviour had a medium positive correlation with mental pain ($r = 0.375$, $n = 197$, $p = 0.000$) and a small positive association with physical pain ($r = 0.205$, $n = 197$, $p = 0.004$). Thus, risky sexual behaviour will result in an increase in both mental pain and physical pain. Lastly, as is expected, risky general behaviour had a small positive association with substance abuse ($r = 0.188$, $n = 197$, $p = 0.008$). Thus, an increase in risky general behaviour can be expected as a result of an increase in substance abuse.

To determine whether gender had a statistically significant influence on the different types of self-harming behaviour, a t -test was performed. The results of the t -test are depicted in Table 4.

Statistically significant associations were found between gender and substance abuse and risky sexual behaviour respectively, where females were at higher risk of engaging in both behaviours ($p > 0.05$). There was no difference by age in self-reported self-harm ($p > 0.05$).

Table 3: Pearson product-moment correlation results

	MP	PP	SA	RSB	RGB
Mental pain (MP)	1				
Physical pain (PP)	0.000** 0.247	1			
Substance abuse (SA)	0.051 0.139	0.000** 0.335	1		
Risky sexual behaviour (RSB)	0.000** 0.375	0.004** 0.205	0.074 0.128	1	
Risky general behaviour (RGB)	0.057 0.136	0.123 0.110	0.008** 0.188	0.053 0.138	1

* $p \leq 0.05$; ** $p \leq 0.01$

Table 4: T -test results for gender and self-harming behaviour

Variable	Level of the variable	t -value	df	p -value
Self-harming behaviour	Mental pain	1.146	195	0.267
	Physical pain	0.001	195	0.696
	Substance abuse	15.285	195	0.000**
	Risky sexual behaviour	8.115	195	0.003**
	Risky general behaviour	0.041	195	0.060

** $p \leq 0.01$

Respondents were asked whether they knew of someone who had intentionally hurt themselves. Of the total sample, 42.35% of respondents ($n = 85$) indicated that they knew of someone that had intentionally hurt themselves.

Discussion

The results of the study show that respondents used mostly inwardly focused self-harming behaviour, such as torture with self-defeating thoughts, rather than acts that involve inflicting physical pain. In contrast, previous research has found that self-harm has been realised through behaviours that have involved self-infliction of physical pain, such as cutting, hitting, biting, burning, carving, interfering with wound healing, hair plucking, bone breaking, and recklessness (Hicks & Hinck, 2007; Laye-Gindhu & Schonert-Reichl, 2005). It is possible that adolescents in this sample are using inwardly focused methods to harm themselves, that is, methods that are not visible to other people.

The findings further suggest that self-infliction of mental pain, risky sexual behaviour, and substance abuse, as manifestations of self-harm, are related to self-infliction of physical pain. This implies that the more people abuse substances, such as alcohol and drugs, and engage in risky sexual behaviour, the more they are inclined to self-inflict physical pain, for example, self-mutilation. With regard to risky sexual behaviour, it has been established that this type of behaviour peaks at age 21 (Ramrakha, Caspi, Dickson, Moffitt, & Paul, 2000), and is related to other self-harming behaviour, such as intentional injuries and substance abuse (Bennett & Bauman, 2000).

In the current sample, it was found that females were more likely to engage in self-harming behaviour such as substance abuse and risky sexual behaviour. Tuchman (2010) asserts that gender differences exist in substance abuse, and that female substance abusers are increasing. This is particularly concerning if one takes into consideration that females engaging in substance abuse

often face multiple barriers that affect their access and entry to substance abuse treatment (Tuchman, 2010). They are also less likely to complete such treatment (Brady & Ashley, 2005).

The finding that females are more likely to engage in risky sexual behaviour is in line with the findings of previous research. Previous findings have indicated that risky sexual behaviour was significantly higher among females than males (Abruquah & Bio, 2008; Hartell, 2005). Fennie and Laas (2014) report that a national survey conducted in South Africa showed that women had a higher HIV prevalence than men. In this regard, the primary method of transmission of HIV in South Africa is heterosexual intercourse, which often includes risky sexual behaviour (Fennie & Laas, 2014). In a country such as South Africa, which has one of the highest HIV prevalences in the world, it is concerning that adolescents repeatedly engage in risky sexual behaviour, which increases their risk of death, not because such behaviour is self-harming, but because it increases the risk of contracting HIV, and ultimately dying of AIDS.

A significant minority of the students (42.4%) indicated that they knew of someone that had engaged in self-harming behaviour. Previous research has found an association between individual self-harm and peer self-harm, which suggests that if an adolescent has a friend (or a relative) that has self-harmed, thoughts of self-harm, or incidents of actual self-harm, in the adolescent increase (Fortune et al., 2008; Hawton et al., 2010). Thus, the mere fact that an individual knows of others that have harmed themselves can lead to self-harming ideation, which can manifest in the form of actual self-harm in later years. Another important consideration is that self-harm may become more prevalent when adolescents experience increased pressure and stress, for example during examination times, before important social events, or when experiencing relationship problems.

The study had some limitations. Firstly, it was limited to first-year students registered at a public university in South Africa. For this reason, the findings of the current study cannot be generalised to other populations and provinces. Secondly, the current study made use of a cross-sectional research design. It would be interesting to conduct a longitudinal study, to determine whether self-harming behaviour will change over time or fluctuate according to environmental influences.

Implications for research

The findings suggest that it is important that the concepts of deliberate self-harm and self-mutilation be regarded as two distinct concepts, and that they not be confused with each other. The concept of self-mutilation would seem to be defined more narrowly, while deliberate self-harm is a broader concept, as it includes failure to deal with emotional pain, which is manifested either physically or emotionally. Another implication for research is that self-harming behaviour in the form of self-infliction of mental pain and self-infliction of physical pain are related, and therefore a holistic approach should be followed when treating individuals that engage in self-harming behaviour.

Conclusion

The findings of the study indicate that a small proportion of students engage in self-harming practices. They mostly engage in behaviours such as torture with self-defeating thoughts, engaging in rejecting relationships, engaging in emotionally abusive relationships, and distancing oneself from God. Females appeared to be at higher risk of engaging in behaviours such as substance abuse and risky sexual behaviour. This finding may be of importance to educators and psychologists when designing counselling support interventions for university students.

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