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 (Frey et al., 2006).

Such behaviors have received much interest in research and in literature-reviews during recent years (Heck, 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 (Heck, et al. 2008; Beck et al., 2000).

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 (Kovacs, 2007).

Regrettably, the research in this field has been obstructed by methodological shortcomings, such as the lack of a uniform 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 (DSH; Gray, 2001).

To date no Swedish data on the prevalence of DSH in university students.

Therefore, this study was planned in two steps:

First a shortened Swedish adaptation of the Deliberate Self-Harm Inventory - short (DSH9-r; Bjärehed & Lundh, 2008) used in a sample of university students. This version of the instrument screened for the life-time prevalence of a broad range of different forms of DSH and was thus utilized to establish if these behaviors indeed were present in university students.

Second, a further shortened version of the instrument called the Deliberate Self-Harm Inventory - short version-revised (DSH9-r; Bjärehed & Lundh, 2008), that had previously been used with Swedish adolescents was administered to a second sample of university students. The reason for using the DSH9-r was that a shorter instrument would be easier and quicker for participants to answer.

In this study data was collected on two separate occasions with about one year interval in two separate samples of university students at one Swedish University.

Participants

Sample 1 a total of 512 university students were recruited to respond to the questionnaire. After excluding participants with extensive missing data (504 (247 men and 252 women, 1 had not stated sex) remained. Age of respondents was between 18-49 years (mean age: 24.0, SD = 4.5).

Sample 2, a total of 187 university students (91 men and 95 women, 1 had not stated sex) between 19-49 years (mean age: 23.6, SD = 3.7) were recruited to answer the questionnaire.

Method

In both cases of data collection participants were approached on the University campus by research assistants. They were given general information about the study and asked to fill out the questionnaires.

Deliberate self-harm in Swedish university students

Onset and relationships with anxiety and mindfulness

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Previous research

The Deliberate Self-Harm Inventory - short version-revised (DSH9-r; Bjärehed & Lundh, 2008) that had previously been used with Swedish adolescents was administered to a second sample of university students. The reason for using the DSH9-r was that a shorter instrument would be easier and quicker for participants to answer.

Conclusion

As in several previous studies, DSH was found to be fairly common in the two separate non-clinical samples of university students studied here, and is similar to the prevalence found when similar methodology has been used to assess DSH in previous research.

The frequency of different forms of DSH during the last 6 months in 512 university students.

The number of behaviors asked for and also the time-period measured is consistent with the view that DSH could be a dysfunctional strategy to deal with negative emotions.

The relationship with mindfulness also fits this model as high mindfulness related to more functional emotional 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 there was a shortage of individuals who were more than 18 years old in Sample 2.