



Exploration of the Phenomena of Resisting Urges to Self-harm in Adolescence

Zuzana Rojková^{1*}, Josef Kunderát², and Jakub Ladecký¹

¹ Faculty of Arts, University of Ss. Cyril and Methodius, Slovakia

² Faculty of Arts, University of Ostrava, Czech Republic

Abstract

The paper deals with the topic of self-harm in adolescence with a focus on the phenomena of resisting the urge to physical self-harming behaviour. In the study, data obtained within the project solved on a representative sample of Slovak adolescents are handled, in the current study the following aspects were observed in self-harming adolescents younger (12-15 years; n = 498) and older (16-18 years; n = 387) groups: the age of the first self-harm, the time since the last self-harm, the time that usually elapses from the urge to the self-harm itself, and the reasoning if resistance occurs (ie. the time interval between the above). The aim is to clarify the process between the urge for self-harm and self-harm itself based on the time data and qualitative data and its comparison between age cohorts. The questionnaire with open questions was used to data collection. Data were processed by frequency and thematic analysis (of over 200 statements). The results show several patterns of reasoning the postponing self-harm, the most common of which are deliberation, waiting for the fitting opportunity, rational rejection, and rejection respecting the loved ones. The time between urge and self-harm is most often within 1 hour or more than 24 hours. The results are beneficial for revealing resistance as a process of finding or using urges management resources as strategies useful in preventing self-harm or recurrence.

Keywords: self-harm, adolescence, resistance, urge, coping

1. Introduction

Self-harm (SH) is a serious and relatively common type of risky behaviour that has recently seen changes in prevention, comorbidities and forms of SH (Démuthová & Démuth, 2019). In general, SH is defined as deliberately harming one's own body, with the aim of inducing pain, which does not involve suicidal tendencies (Krieglová, 2008). In foreign literature, the term is defined as self-injurious behavior, without suicidal tendencies (Brausch & Guttierrez, 2010). The prevalence of SH has been on the rise over the years, with an incidence of 21.2% in the Czech population (Vaníčková et al., 2010), similar results were brought by a Slovak study,

where 29.7% is registered (Démuthová & Démuth, 2019). After the COVID-19 pandemic, the prevalence in the Slovak population doubled to 45.2% (Démuthová & Démuth, 2022).

According to sources, the beginnings of self-injurious behavior vary among individuals. According to Klonsky (2007), SH has an onset in adolescence, however, foreign sources report an average age of onset at 13 years (Gillies et al., 2018), some from 12 years (Geulayov et al., 2018; Brager-Larsen et al., 2022). The possible causes of SH are varied, the most common being the desire to release psychological pain with physical pain, which eliminates negative emotions (Nock et al., 2010). A possible motive is also an effort to gain control over one's own life (Glassman et al., 2007), or a search for a sense of security, or a desperate cry for help (Chapman et al. 2006). The developmental aspect of SH is the period of adolescence, which are challenging for individuals in terms of turbulent physical and mental changes, and the given developmental needs in combination with young age often lead to the search for maladaptive forms of coping strategies, such as self-harm in an extreme form (Démuthová & Démuth, 2022).

Primary prevention of SH consists in using the potential of addressing problems at the national level, with the aim of reducing prevalence. Prevention of self-harm has an impact on the percentage of suicidal behavior in the population (Gunnell et al., 1995). Hawton et al. (2002) recommend focusing on socio-economic problems such as unemployment, alcoholism, or low parental income. A key aspect of prevention is to focus on areas and institutions that the actors themselves consider to be the primary source of assistance. The main sources of help for many adolescents are family, friends, and school (Fortune et al., 2008). According to the authors, support or the creation of school programs for the development of mental health leads to increased orientation in helping services, such as helplines, and this leads to a reduction in the incidence of risky behavior.

Providing psychological help is the basic pillar of self-harm prevention or intervention. Currently, the most common form of treatment is cognitive-behavioral therapy (CBT). CBT is one of the most commonly used therapies in the treatment of self-harm, helping clients identify grasp negative thoughts and maladaptive behavior patterns that lead to self-harm (Hume & Platt, 2007). Another sought-after form of therapy is dialectical-behavioral therapy (DBT). It represents a therapeutic approach that has been specially created for people with severe emotional dysregulation and is therefore suitable for people who self-harm (Ougrin et al., 2012). According to Hume and Platt (2007), clients report a combination of pharmacological treatment with psychotherapy as an ideal form of therapy, also seeking out different support groups and group therapies to obtain different opinions.

Currently, the field of research and therapy focuses on the postponement phase of intentional SH (Marchand et al., 2013). Procrastination has a positive benefit for the individual and opens up coping possibilities. By postponing SH, the client gains time to consider, during which he can think about the consequences of his behavior and find possible alternatives, including adaptive strategies. In addition, he gains time to seek support, which can lead to gaining perspective for coping with his difficult situation (Milleret al., 2021).

Resisting urge to SH is the time and processes that take place in the time between the appearance of the urge to SH and the act of SH. This time can last from an hour to several days and during it both emotional and cognitive processes take place, such as the processes of coping, regulation, but also hesitation or just waiting for a suitable opportunity. This phenomenon of resistance is an opportunity for helping workers when to intervene, and understanding the processes is important for the targeting and nature of the intervention and its adaptation to the developmental period. The aim is to clarify the process between the urge for

SH and SH itself based on the time data and qualitative data and its comparison between age cohorts.

2. Methods

The research group consisted of adolescents aged 12 to 18 from different regions of Slovakia, and who were identified as a physical form of SH. The respondents were pupils of primary and various types of secondary schools, for which data was collected using the questionnaire method in 2018 and 2019 (in the total number of $N = 3313$). The questionnaire was administered following correct ethical principles (anonymity, parental consent, the formulation of questions in such a way as to avoid traumatising the respondents).

The questionnaire battery consisted of several standardized and non-standardized methodologies or sections with closed and open questions, which were focused on a wide range of aspects of SH within the large national project. For the purposes of the current research, data from the SHI questionnaire (Self-Harm Inventory – SHI, Sansone & Sansone, 2010) and from closed and open questions determining the time and motivational of postponing SH and the act of SH itself were used. Based on data from the SHI questionnaire, individuals with the presence of physical forms (burning, cutting, hitting, banging the head, scratching, injuring) of SH were identified in the entire cohort, which is operationalized as a history of repeated SH (rare occurrence in at least three of these forms, or repeated occurrence in at least one of the forms). According to this criterion, $N = 885$ respondents (26.7%) were assigned to the group with the incidence of self-harming behaviour (SHB). The research group was divided into two age groups with the aim of exploring developmental specifics. The age group of younger adolescence (12-15 years) consisted of $n = 498$ with an average age of 14.1 years; group of older adolescence (16-18 years) $n = 387$ respondents, mean age 16.6 years.

For this study, two items from the questionnaire clarifying SH were used:

A) How long does it usually take from the moment you feel the urge to hurt yourself to hurting yourself?

within one hour 1-3 hours 3-6 hours 6-12 hours 12-24 hours more than 1 day

B) Why are you postponing it? (explain briefly)

In both items, we recorded a significant percentage of missing data, despite the occurrence of SHB detected by the SHI questionnaire. For qualitative analysis, 114 statements in the group of 12-15-year-olds and 120 statements in the group of 16-18-year-old adolescents were valid.

2.1 Analyses

Bivariate frequency analysis and quantitative thematic analysis were used for examination. To identify and describe the mechanisms adolescents use to postpone the urge to SH, a qualitative approach was chosen. The research sample consisted of 224 respondents who provided valid answers to the open-ended question investigating the reasons for postponement ("Why do you postpone it?"). The obtained data took the form of short text segments, ranging from one-word expressions (e.g., "don't know", "fear") to complex sentences describing emotional states or external circumstances (e.g., "because there is still someone we care about and mainly so I wouldn't hurt my family").

Thematic analysis was chosen as the analytical framework, allowing for flexible yet systematic identification, analysis, and presentation of patterns in qualitative data. We drew inspiration from the phases of thematic analysis described by Braun and Clarke (2006), adapting the methodology to the specific nature of the data (short, semantically dense statements). The

analysis was conducted inductively, i.e., "bottom-up," meaning categories were not derived from pre-existing theory but allowed to emerge directly from the participants' statements.

The coding and categorization process was carried out in MS Excel, which enabled efficient handling of a large volume of data. The analysis proceeded in several iterative steps, beginning with open coding. In this first phase, each statement was analyzed line by line, and respondents were assigned initial codes capturing the semantic content of their message (e.g., "fear of scars", "parents at home", "waiting for solitude"). A single statement could be assigned multiple codes if it contained multiple layers of meaning. Following this initial step, the process moved to constant comparison and revision. Coding did not proceed linearly but cyclically; throughout the analysis, emerging codes were constantly compared with existing ones. In the final phase of creating categories, individual codes were grouped into overarching semantic themes representing the main patterns of behavior and experience of the respondents (e.g., categories *Family*, *Pain*, *Coping*). Special attention was also paid to negative cases, i.e., statements where postponement does not occur (category *Does not postpone*).

Missing data were not imputed and analyses were conducted using available-case analysis. Given the sensitive nature of self-harm-related questions, non-response was interpreted cautiously and considered a meaningful phenomenon rather than a random omission. To enhance the credibility of the qualitative findings, the thematic analysis followed an iterative coding process with continuous comparison of emerging categories. The coding scheme was repeatedly reviewed and refined to ensure internal consistency and conceptual coherence of themes. The result of this process is the structure of categories presented below, which vividly describes the motivations and strategies of adolescents in managing the urge to SH.

3. Results

First, we present the results of the frequency analysis of the categories of the length of time of postponing SH (Figure 1). Of all respondents with SHB, 42.5% lacked an answer (similarly in both groups). Of the other answers, we record the shortest interval between compulsion and SH in 23.1% of older (16-18y.) and 19.7% of younger (12-15y.) respondents. The answer "More than 1 day" occurred approximately as often, with 20% of older and 22.7% of younger respondents. Of the other options, the 1-3h category was represented in 7.5–8.7% across groups.

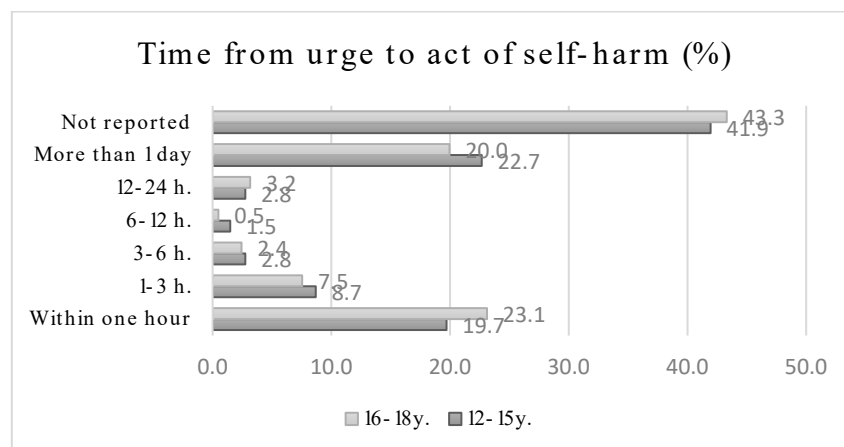


Figure 1: Illustration of the percentage of categories of Time from urge to act of SH

Secondly, through thematic analysis, we identified eight key categories representing recurring semantic patterns in the respondents' statements (Figure 2).

Deliberation: Rational Consideration: One of the most frequently cited reasons for postponing SH is the rational consideration of the act, re-evaluation of the situation, and reflection on the meaning of such behavior. We designated this pattern with the collective term **deliberation**. The respondents' statements in this category did not contain assertions that the respondent was decided not to carry out the SH act; rather, it was stated that they postpone the act to think it over or to gain time for a decision.

This process of internal hesitation is evident in numerous statements where respondents explicitly mention the need for cognitive processing of the situation. For example, a respondent stated that they postpone the act "because I am thinking about whether what I want to do is good" or "I wonder if it's worth hurting myself." Similarly, other participants described an effort to gain distance "to think over whether it is really necessary," or simply stated that at that moment, they are "thinking about whether to do it or not" so that they "can change my mind." This phase of deliberation thus serves as a buffer zone between the impulse and the act, providing space for potential re-evaluation.

Rational Rejection of SH: A significant and specific pattern, qualitatively different from mere deliberation, is the **rational rejection of SH**. While in deliberation the individual hesitates, in this category, respondents actively use cognitive processes and argumentation to reject the urge. Postponement here is not just a pause but a conscious strategy aimed at preventing the act. Within this category, we identified three key sub-themes.

The first sub-theme involves the realization of the pointlessness of the act. This represents a moment of intellectual insight, where respondents describe a kind of "awakening." In these moments, they view their urge with detachment and evaluate it as illogical or absurd. Emotional pressure is directly confronted with rational judgment, which devalues the act. Typical statements label SH as "stupidity" or "nonsense." For example, respondents stated: "I realize it is sick and that I don't have to do it," or declared self-control with the words: "I have enough sense not to do it."

The second group within this category consists of respondents who postpone or reject the act based on reflection on ineffectiveness or past experience. Rationalization here functions as a protective mechanism based on learning. The respondent realizes that relief in the past was only temporary or was followed by feelings of guilt that are not worth repeating. This experiential barrier is expressed in statements such as "because I realize immediately afterward that it was stupidity." A strong motive here is the prevention of regret, as evidenced by the statement: "Based on previous experience when I regretted it, I try not to do it."

Finally, the third sub-theme encompasses willpower and self-worth. This includes statements manifesting willpower and awareness of one's own worth. In these cases, postponement is not perceived as weakness or indecision, but as an active expression of self-respect and self-care. Respondents expressed this attitude with words like "I don't want to hurt myself" or "I don't need to hurt myself anymore." This positive relationship with oneself becomes a key protective factor, where the individual realizes the value of their life and health, noting "I've already stopped doing it, I was stupid then" or simply "I grew out of it."

Active Coping and Sublimation: A distinct category that emerged from the analysis is **active coping**, where the postponement is achieved through active distraction or sublimation of the urge into other activities. Unlike passive waiting, here the respondent engages in a specific behavior to manage the impulse.

Respondents describe efforts to redirect their attention, stating "I'm trying to switch to other thoughts" or "intentionally thinking about other, more pleasant things." Others engage in activities to occupy their minds, noting "I'm keeping myself busy with better things." This

category also includes active struggles against the urge, such as "trying to overcome myself" or "trying to fight it," as well as relaxation techniques ("I'm trying to relax").

Waiting for Suitable Circumstances and Healing: A frequent category represented waiting for suitable circumstances for SH. Respondents stated that it was not the right time for immediate action, or they were waiting to be alone. We designated this pattern as **waiting for suitable circumstances**. In these cases, postponement is not motivated by an effort to avoid harm, but rather by a pragmatic need for privacy or peace to perform the act, or fear of interruption by others.

This pragmatic motivation is evident from statements primarily concerning the presence of other people. Respondents often stated that "when I am not alone, I wait until they leave," or described a situation where "parents are home and watching me." An obstacle to realizing the urge was often the school environment ("I am at school") or a simple lack of opportunity ("to find a way and a place"). Additionally, a specific sub-group postponed the act to allow for physical recovery, stating they are "waiting to see if it heals" or waiting "so that my wounds disappear as quickly as possible."

Consideration for Loved Ones and Social Control: A strong motive for postponement is the social context, which we designated as **consideration for loved ones**. This pattern includes a wide range of emotions and motivations, from fear of discovery by parents to an altruistic effort not to cause pain to friends or family. Respondents often stated that they postpone the act because they do not want to disappoint their surroundings or fear that their actions would be exposed.

A significant role in this category is played by feelings of guilt and shame associated with the impact of the act on others. Respondents expressed concerns that "people around me would worry," or tried to hide their vulnerability with the words "I don't want them to see my fragility." A strong commitment preventing immediate action was in some cases a promise given to a loved one, for example: "Because I promised my boyfriend, I don't want to hurt him." The altruistic motivation is clearly expressed in statements like "I think about the people I love and who are worth not hurting."

Fear of Physical Consequences: A specific, strongly emotionally charged category is **fear**. Unlike rational rejection or social considerations, the primary brake here is the natural instinct for self-preservation, fear of pain, or concern about permanent consequences on the body.

Respondents explicitly mention fear of physical pain, for instance in the statement "because I am afraid it will hurt" or "so that I don't have to experience that pain again." Another significant factor is the fear of permanent marks on the body, where respondents are "afraid of scars." In extreme cases, existential fear appears, where a respondent stated "I don't have the strength to hurt myself to death," or fear of severe physical damage, such as bleeding out ("so that I don't bleed").

Passive Waiting and Suppression: A distinct coping strategy is **passive waiting** or suppression. Unlike active coping (doing something else) or rational rejection (deciding not to), here the respondent relies on the urge fading away on its own if they wait long enough, or simply tries to suppress it without a specific alternative activity.

This strategy is evident in statements where respondents express hope that "the desire to hurt myself will go away" or "maybe I'll get over it." It often involves waiting for a change in external circumstances or mood, where the respondent simply "waits to see if it gets better." Some respondents explicitly mention suppression, stating "I try to suppress the urge to hurt myself." Others describe a conditional postponement, waiting for a specific negative emotional

state to return ("I'll wait until my thoughts start eating me up again" or "only in depressive moments").

Specifics: Absence of Postponement: Although the research focused on reasons for postponement, data analysis revealed a significant group of respondents for whom this concept is irrelevant, as they fall into the category of **absence of postponement (does not postpone)**. These respondents describe their behavior as highly impulsive, automatic, and immediate.

The absence of a time delay between thought and act in this group makes it impossible to apply the cognitive or social brakes described above. These findings complete the context of the research and point to the existence of a group with a high degree of impulsivity, whose members state that "I don't postpone, I do it immediately" or that they perform the act "in a moment." The feeling of loss of control is strong here, as evidenced by the statement: "It is stronger than me, I cannot postpone it."

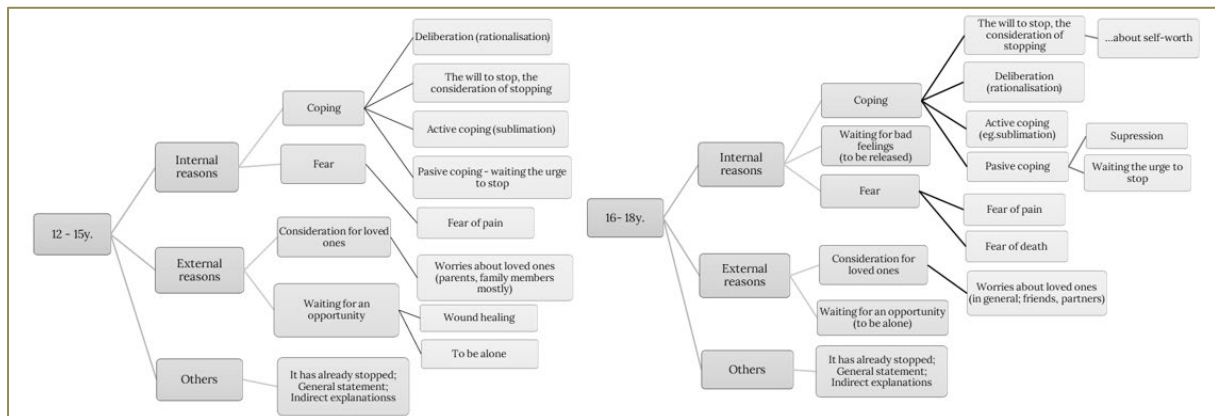


Figure 2: Resulting category schemes in two age groups

4. Discussion and Conclusions

This study presents selected data from a larger national research project on SH in the Slovak adolescent population. The aim was to clarify the process between the urge for SH and SH itself, which provides an opportunity for the timing and focus of intervention by psychologists or other helping persons.

By clarifying the time between compulsion and self-harm itself, we found that adolescents do not postpone SH (within 1 hour) or postpone it for more than a day. More than 40% of respondents did not answer this item, which raises an interpretative question regarding the generally missing data in questionnaires on the topic of self-harm or other intimate or risky topics. The answer can only be deduced, it can mean not delaying or unwillingness to answer, which can also have more explanations. It can be a topic that is too intimate, traumatic, resulting from a depressive symptomatology (lack of interest, low energy). On the other hand, it can be a suppression of awareness of the seriousness of the topic (trivialization), similar to risky experimenting with drugs, when the adolescent is not aware of the degree and severity of repeated use. However, only hypothetical justifications are given, and the clarification of the real reasons for non-replies in the SH questionnaires needs to be included in further investigation.

Reasons for postponing SH, which were the content of the open answers, were divided into 8 categories based on the analysis, while some of which differ slightly between cohorts. The categories represent internal and external sources of justification of postponing. Some statements could not be categorized because they did not relate to the issue in terms of content

(general statements, it has already stopped, indirect explanations). Adolescents who responded, in the majority, justify postponing SH with coping (active or passive). Active management of the urge to SH is also supported by clinically oriented approaches that target cognitive processing of the compulsion (e.g., re-evaluating the significance of the situation and the consequences of the behavior) and expanding the repertoire of coping strategies (Aldao et al., 2010). Nielsen et al. (2017) report that reappraisal coping was a significant predictor of self-injurious thoughts and, together with other functional coping strategies (e.g., access and emotional-regulatory strategies), differentiated ideation and enactment of SH. Our qualitative data are consistent with this finding, as several adolescent statements describe the process of actively resisting the urge through weighing "pros and cons", being aware of the negative consequences of SH and looking for alternative ways of coping. At the same time, McEvoy et al. (2017) report that in situations where compulsion did not lead to SH, cognitive contents that had a deterrent effect were more often present (e.g., thoughts about the uselessness of SH, positive internal dialogue, and consideration of the impact on oneself and others), while strong discouraging evaluations appeared to be protective in cases where SH did not occur.

This mechanism supports the interpretation of our categories (e.g., deliberation/rationalization, consideration for loved ones), which also capture the "cognitive brakes" between compulsion and SH. From a developmental point of view, it is important that in the older age group (16–18 years) the topic of self-worth and ending SHB appears. The results of Czyz et al. (2019) point to the importance of a broader repertoire of coping strategies and their perceived usefulness in relation to the occurrence of SH in the daily functioning of at-risk adolescents. Therefore, we interpret our finding on the "self-worth" motif in the older cohort as a clinically relevant intervention goal and hypothesize that reinforcement of self-image and adaptive coping strategies may promote the natural regression of SHB in late adolescence.

Another identified strategy for resisting the urge to SH is the conscious decision to stop or considering ending this behavior, in which adolescents resist the urge primarily by their own decision. This type of coping can be classified as an active strategy, as well as an effort to divert attention to another activity. The importance of decision-making, strengthening personal responsibility and active involvement of the individual in the process of change is also emphasized by experts in the field of prevention and intervention of risky behaviour (Richardson, 2002; Röhr, 2015). Adaptive forms of coping, which are supported by resilience as a protective personality characteristic, are repeatedly identified as important factors reducing the risk of persistence of maladaptive strategies of emotion regulation, including SHB. Research shows that the ability to regulate negative emotions and seek alternative sources of relief may reduce the need to resort to SH as a regulatory mechanism (Baumeister et al., 1998; Michelmore & Hindley, 2012).

As a passive strategy of postponing SH, we identified waiting for the compulsion to subside on its own, or suppressing it without actively working with the content of the compulsion. At the same time, a specific category of postponement has appeared in the older age group, which is waiting for the deterioration of the mental state. Older adolescents thus in some cases use SH as a tool for relief from intense negative experiences, which corresponds to models of emotion regulation and escape management (Gross, 2015). The mechanism of this behavior can be compared to the effect of addictive substances, which an individual reaches for in situations of psychological discomfort in order to achieve short-term relief (Lieberman, 2006; Michelmore & Hindley, 2012; Rojková & Górna, 2022). Among the internal sources of resisting the urge to SH, we also included the experience of fear of pain and fear of death, which occurred sporadically in both age groups. Similar findings are reported by previous research, which points out that anticipation of the negative consequences of SH may in some cases act as an inhibitory factor for behavioral enactment (Hamza et al., 2012). Specifically,

the fear of death associated with the anticipation of fatal consequences appeared in our data exclusively in the older age group, which may reflect a higher level of cognitive reflection on behavioral risk in late adolescence, but also an increased severity of psychological distress in vulnerable individuals. The authors point out that with a higher intensity of compulsion and a longer-term occurrence of physical SH, self-regulatory mechanisms may be weakened, especially in adolescents with depressive symptoms or an accumulation of stress and traumatic experiences (Marchand et al., 2013).

External reasons for postponing SH include consideration for loved ones and the social environment. The importance of socio-emotional support as a protective factor against the onset or continuation of SHB has been emphasized by several authors, who point out that ties to family, friends, and significant others can dampen the transition from compulsion to behavior (Baumeister et al., 1998; Hamza et al., 2012). The differences between younger and older age groups, where the family motif is more pronounced in younger adolescence than partner relationships, are consistent with developmental models of social and intimate relationships in adolescence (Baumeister et al., 1998). The category of waiting for a suitable opportunity, characterized by an effort to be alone and without the presence of witnesses, may indicate the exhaustion of previous coping strategies. The authors report that resisting intense thoughts on SH for a long time can lead to the depletion of the self-regulatory resources needed to interrupt episodes of SHB, thereby increasing the likelihood of behavioral enactment (Hasking et al., 2017). This process has been compared in the literature to the compulsive mechanisms known from addictions, where the behavior is primarily motivated by the pursuit of short-term relief from negative experiences, without actively seeking alternative strategies or social support (McCann, et al., 2012).

In the younger age group, the motif of "wound healing" also appeared, which was analytically included among the external reasons for postponement as a subcategory of "suitable opportunity". However, the motif may also be related to the fear of the consequences of SH, which indicates an overlap of internal and external regulatory mechanisms in the process of resisting compulsion, as described by the models of cognitive-emotional regulation of SH (Hasking et al., 2017).

4.1 Limits

The limitations of this study stem from the risks of using the self-assessment method (questionnaires) to obtain data. However, an intimate topic such as SH cannot be examined in any other way. We have already elaborated on the issue of missing data and the need for its solution above (for future research, we suggest items oriented towards the reason for non-completion). The advantage of the research is the qualitative data obtained through open-ended responses, which, although they have great variability, bring a wider spectrum and nuances of reasons for the processes that take place hidden between the urge and postponement of SH. The data for this research were obtained in-person in primary and secondary school classrooms; the limit and reason for the number of missing responses could be the perceived risk of non-confidentiality and non-anonymity of the data. An alternative would be online collection, which, however, due to the underage sample, cannot be ensured from an ethical point of view on public portals. A compromise could be to fill out the questionnaires electronically on individual devices after administration directly in the classrooms at a specified time. A useful extension of the research in the future would be to distinguish between past and current individuals with SH, which, based on our findings, are recognizable already in adolescence. Data from former self-harming individuals would be useful for finding their own effective resources for coping with the urge to SH, as well as the SH itself.

4.2 Conclusions

The results provided useful insights into the processes of coping with the urge to SH in individuals with a repeated form of SH. The processes between the urge and SH are different with respect to the severity (phase of development) of SH and may indicate this risk characteristic.

Adolescents during early and late adolescence are able to apply active, passive coping strategies, take into account the loved ones or decide to stop this behavior. On the other hand, there are adolescents who do not want to postpone (are just waiting for the bad mood or feelings), have exhausted their coping resources, or SH is compulsive in nature and the postponement of SH is caused (if it occurs) only by searching for a suitable situation or method of execution. The results support the thesis of the need and importance of early supporting the development of coping strategies in adolescence, which can be generally effective in eliminating risky behavior of a compulsive nature. Across both age cohorts, interventions should primarily focus on strengthening adolescents' coping strategies and cognitive reappraisal skills, while tailoring support to developmental differences in self-worth and social relationships. At the same time, they raise a question mark in the form of a high proportion of self-harming adolescents who do not want to share their experience.

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