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Psychosocial Correlates of Self-Harm and Suicidal Behaviour in Young People: A Review

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Abstract
Self-harm and suicidal behaviour are serious public health concerns among young people, with significant effects on individuals, families, and communities. This review outlines definitions, prevalence, theoretical frameworks, and psychosocial factors linked to these behaviours. Key risks include depression, emotional regulation difficulties, impulsivity, low self-esteem, family conflict or abuse, bullying, and negative school experiences, while protective factors such as supportive family relationships, positive peer connections, and academic engagement can reduce vulnerability. The review also highlights the role of social media, evidence-based prevention and treatment approaches, and concludes with implications for clinicians, schools, and policy, along with directions for future research.

Keywords: Self-harm; Suicidal behaviour; Psychosocial factors; Young people

Introduction
Self-harm refers to the deliberate infliction of injury on oneself, often as a means of coping with overwhelming or distressing emotions. Suicidal behaviour, on the other hand, involves thoughts, plans, or actions directed toward ending one's life. Among children, adolescents, and young adults, these behaviours pose serious challenges, bringing profound emotional and social consequences for individuals, families, and communities. Research indicates that up to one-third of adolescents engage in self-harm, while many also experience suicidal thoughts or attempts (Shek, 2012). Globally, suicide remains one of the leading causes of death among older adolescents and young adults, and nonfatal self-harm—with or without suicidal intent—is relatively common during teenage years. These behaviours emerge from the interplay of biological, psychological, social, and cultural factors, highlighting the importance of understanding psychosocial correlates for effective prevention and intervention (World Health Organization, 2025; Hawton, Saunders, & O'Connor, 2012).

It helps to separate two commonly discussed phenomena:

- **Non-suicidal self-injury (NSSI)** — deliberate self-inflicted damage to the body (e.g., cutting, burning) without conscious suicidal intent. NSSI often functions to relieve strong negative emotions or to communicate distress. (Nock, 2006).
- **Suicidal behaviour** — includes suicidal ideation (thinking about suicide), suicide attempts (self-injury with intent to die), and completed suicide. Some individuals who self-harm do so with suicidal intent; others do not. The relationship between NSSI and later suicide attempts is complex but important: NSSI is associated with increased risk for later attempts in many studies. (Glenn & Nock, 2017; Mars et al., 2019).

Prevalence rates differ depending on the sample studied and the methods used, such as community surveys versus clinical settings. Self-harm tends to increase during adolescence, with research consistently showing notable lifetime rates of non-suicidal self-injury (NSSI) and suicidal ideation among teenagers. Cross-cultural studies estimate that between 13% and 33% of adolescents engage in self-harming behaviours, and suicide remains one of the leading causes of death in this age group (Shek, 2012). Gender differences are evident: adolescent girls more frequently report self-harm and suicidal thoughts, whereas boys have higher rates of completed suicide, largely due to the use of more lethal methods (Hermosillo-de-la-Torre et al., 2021). Longitudinal, population-based studies further indicate that adolescents who engage in self-harm or experience suicidal ideation face a significantly elevated risk of later suicide attempts (Hawton et al., 2012; Mars et al., 2019).

Psychological Correlates

Adolescents with high psychological distress—including depression, anxiety, or low self-esteem—are at greater risk for self-harm and suicide (Meng et al., 2022). Many use self-harm to manage intense or negative emotions. Those with mood disorders are especially vulnerable, with self-harm sometimes serving as a maladaptive way to cope (Meng et al., 2022).

Depression and anxiety: Strong and consistent correlates. Depressive symptoms (low mood, hopelessness) are among the most common proximal predictors of suicidal ideation and attempts. (Hawton et al., 2012; Mars et al., 2019).

Emotion-dysregulation: Difficulty managing intense feelings (anger, sadness, shame) is strongly linked to both NSSI and suicidal behaviour; many young people use self-injury to regulate overwhelming emotion. (Glenn & Nock, 2017).

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Impulsivity and substance use: Impulsivity and acute intoxication increase risk for acting on suicidal thoughts; substance misuse often co-occurs with self-harm. (Nock et al., 2006).

Hopelessness and cognitive patterns: Pessimistic thoughts, rumination, and cognitive rigidity are common in those with suicidal ideation.

Self-Esteem: Low self-esteem is a well-documented risk factor for self-harm. Teens with high self-esteem report less self-injurious behavior. Building self-esteem may function as a protective intervention (Meng et al., 2022).

Family Correlates

Positive family functioning—characterized by support, communication, and low conflict—acts as a protective shield (Shek, 2012). Families where parents are separated or remarried may place adolescents at higher risk. If adolescents feel unsupported or experience frequent conflict, their chance of self-harm or suicidal behavior rises (Shek, 2012; Meng et al., 2022).

Childhood abuse and neglect: Physical, sexual, and emotional abuse and neglect are robust risk correlates for later self-harm and suicide attempts.

Family conflict, parental mental illness, and poor attachment: A chaotic, unsupportive family environment increases risk; conversely, supportive parental involvement is protective.

Socioeconomic Status and Structure

Some research finds low family income and unstable family structure (such as divorce or remarriage) add risk, while stable two-parent families offer protection (Shek, 2012). Other studies suggest that socioeconomic status is less important than emotional support from family members (Meng et al., 2022).

Social Correlates

Peer and School Environment

Positive experiences at school and good relationships with peers and teachers can reduce risk. Academic success and school engagement provide a sense of belonging and help buffer against harmful feelings. In contrast, negative experiences at school or with peers (like bullying or social exclusion) can increase vulnerability (Shek, 2012). Seeing peers or online content depicting self-harm raises risk of imitative behaviour. Studies show that exposure (friends, internet) helps differentiate adolescents who attempt suicide from those who think about it. (Mars et al., 2019).

Community and Societal Factors

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Stigma around mental health, cultural beliefs, and access to mental health services also shape the risk environment. In cultures where self-harm or suicide are highly stigmatized, youth may hide behaviors and avoid seeking help (Shek, 2012).

Gender and Demographic Correlates

Girls are more likely to engage in self-harm and express suicidal thoughts, but boys are more likely to die from suicide (Shek, 2012; Hermosillo-de-la-Torre et al., 2021). Age, immigration status, and living in urban versus rural settings can also influence risk, but family and psychological factors often play a larger role (Shek, 2012).

Acute stressors & access to means

Recent losses, relationship breakups, legal problems, academic stress: Acute life events often precipitate suicidal behaviour.

Access to lethal means (e.g., medications, firearms): Availability increases risk of attempts becoming fatal.

From self-harm to suicide — who progresses?

Not all young people who self-harm go on to attempt suicide. Longitudinal research indicates that psychiatric disorder (especially major depression), repeated exposure to self-harm, and greater severity/frequency of self-injury raise the risk of later suicide attempts. Exposure to others' self-harm and proximal stressors also appear to increase progression. (Mars et al., 2019; Glenn & Nock, 2017).

Prevention and Intervention

Prevention of self-harm and suicidal behaviour requires addressing multiple ecological levels, including the individual, family, school, and broader community. Strategies include:

- **Family-focused approaches**: Enhancing parent–child communication, reducing conflict, and strengthening attachment bonds.
- **School-based programs**: Teaching coping strategies, stress management, and emotional regulation skills.
- **Youth development initiatives**: Promoting self-esteem and resilience through structured activities.
- **Mental health literacy**: Increasing awareness of risk factors and help-seeking pathways among adolescents, families, and educators.

- **Community environment**: Creating safe, supportive school and neighbourhood contexts (Shek, 2012; Meng et al., 2022).

Prevention and Treatment: Evidence at a Glance

1. School and Community-Based Approaches

- **Gatekeeper training**: Training teachers, peers, and counselors to identify warning signs and facilitate referrals.
- **Whole-school programs**: Initiatives to improve connectedness, reduce bullying, and foster inclusivity have shown preventive effects.

2. Psychological Therapies

- **Dialectical Behaviour Therapy for Adolescents (DBT-A)**: Demonstrated reductions in repeated self-harm and suicidal ideation (Mehlum et al., 2014; McCauley et al., 2018).
- **Cognitive Behavioural Therapy (CBT)**: Adapted protocols for suicidal adolescents are effective in reducing distress and risk behaviours.
- **Family-based interventions**: Involving parents in therapy enhances protective support systems.
- **Crisis and hospital-based care**: Safety planning interventions and structured follow-up reduce short-term recurrence of self-harm.

3. Public Health and Policy Actions

- **Means restriction**: Limiting access to common methods of self-harm is an effective suicide-prevention strategy.
- **Media and digital policies**: Responsible reporting and safer online platforms reduce contagion effects and harmful exposure (WHO; Lancet Commission, 2024).

Practical Implications for Clinicians and Schools

1. Directly and empathetically inquire about self-harm or suicidal ideation — evidence indicates this does not increase risk.
2. Assess suicidal intent, planning, access to means, and protective factors.
3. Implement safety planning and ensure consistent follow-up, particularly after emergency care.
4. Promote connectedness within schools by training staff, preventing bullying, and encouraging referral pathways.

5. Address digital risk by guiding safe internet use and providing links to supportive online resources.

Conclusion

Self-harm and suicidal behaviour among young people are influenced by complex psychosocial factors, including depression, poor emotional regulation, family adversity, and peer victimisation. Evidence supports the effectiveness of targeted therapies such as DBT-A, CBT, and school-based prevention programs. A combined approach—integrating clinical interventions, supportive family and school environments, safe media practices, and strong policy measures—offers the most promising pathway for reducing risk and promoting resilience in youth.

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