






Factors influencing self-harm behavior in female adolescents

Fatores que influenciam o comportamento de automutilação para adolescentes do sexo feminino

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ABSTRACT

Objective: to describe the factors that influence self-mutilation behavior from the perspective of female adolescents. **Methods:** a qualitative study was conducted with five adolescent girls attending a modality I Psychosocial Care Center. Data was triangulated using the techniques of individual semi-structured interviews, observation, and documentary analysis. The empirical data from the documentary analysis, the transcripts of the interviews with the full narratives, and the observation records were organized in the Research Diary and subjected to content analysis. **Results:** it was found that situations experienced in childhood in the family environment, such as rejection, abandonment, violence, and paternal distancing, together with the mental suffering manifested in adolescence, were shown to be factors influencing self-mutilation. **Conclusion:** there was an increase in concern about the emotional development of children and the repercussions manifested in adolescence, as well as the contribution of the family context in this process. **Contributions to practice:** the factors influencing self-harm must be considered and addressed by the nursing team in order to provide quality and effective care. This includes the implementation of actions to promote mental health, prevent psychosomatic disorders, and reduce the mental suffering observed in this target group.

Descriptors: Self-Mutilation; Adolescent; Pediatric Nursing; Qualitative Research.

RESUMO

Objetivo: descrever os fatores que influenciam o comportamento de automutilação na perspectiva de adolescentes do sexo feminino. **Métodos:** estudo qualitativo, realizado com cinco adolescentes atendidas em Centro de Atenção Psicossocial de modalidade I. Utilizou-se a triangulação dos dados a partir das técnicas de entrevista individual semiestruturada, observação e análise documental. Os dados empíricos oriundos da análise documental, as transcrições das entrevistas com as narrativas na íntegra e os registros de observação foram organizados no Diário de Pesquisa e submetidos à análise de conteúdo. **Resultados:** constatou-se que situações vivenciadas na infância no âmbito familiar, como rejeição, abandono, violências e distanciamento paterno, juntamente com o sofrimento mental manifestado na adolescência, foram evidenciados como fatores que influenciam a automutilação. **Conclusão:** observou-se aumento da preocupação com o desenvolvimento emocional da criança e os reflexos manifestados na adolescência, bem como com a contribuição do contexto familiar neste processo. **Contribuições para a prática:** os fatores influenciadores da automutilação devem ser considerados e abordados pela equipe de enfermagem, a fim de proporcionar uma assistência de qualidade e efetiva. Isso inclui a implementação de ações de promoção da saúde mental, prevenção de transtornos psicossomáticos e redução do sofrimento mental observado neste público-alvo.

Descritores: Automutilação; Adolescente; Enfermagem Pediátrica; Pesquisa Qualitativa.

Introduction

Self-harm behavior considered a public health problem, is understood as an attitude that consists of consciously causing harmful acts against one's own body, such as cuts, scratches, punctures, bites, pinches and/or beatings, done by hand or with the use of objects⁽¹⁾. This is a compulsorily notifiable phenomenon in Brazil and, between 2009 and 2021, 650,346 cases of interpersonal/self-inflicted violence were reported among adolescents aged 10 to 19, with a higher frequency among females aged 15 to 19 and brown people⁽²⁾.

Despite the scarcity of research describing the physical and psychological damage caused by this practice when not treated early⁽¹⁾, it is known that this behavior has consequences for the lives of adolescents, involving physical, psychological, and behavioral aspects. In their perception, the physical aspects include the immediate manifestations after the behavior, such as scars, bruises, edema, erythema, and pain. On the other hand, the psychological aspects observed after the act include feelings of guilt, difficulty in talking about it, and shame, leading to the need to hide the marks with long-sleeved clothes. Lastly, the behavioral aspects reported often took the form of reduced and/or absent intra-family communication and indisposition⁽¹⁾.

In this scenario, family relationships have been shown to be protective or risk factors for the presence of self-mutilation behavior in adolescence⁽³⁻⁷⁾. In terms of protective aspects, these relationships are recognized as essential, as they ensure feelings of security and possibilities of trust, support, and support throughout the different challenges experienced during adolescence. Thus, in healthy conditions, family support should offer affection, dialog, and interest in the adolescent's way of life, in order to identify risk factors during this period of life⁽³⁻⁵⁾.

However, in some situations, the family relationship itself can be a risk factor for this behavior, especially when it is associated with the mental su-

ffering of adolescents. This includes cases in which, as children, they experienced conflicts with their parents or between siblings; domestic violence; sexual, physical, or emotional abuse; parental divorce; parental absence or excessive presence; self-inflicted violence in the family; alcohol and drug abuse by family members; death or illness; unemployment and family psychological dysfunction⁽⁵⁻⁷⁾.

Therefore, it is essential to promote healthy childhood development and, in order to do so, the family context must be considered as protective or risky for mental health in adolescence⁽⁵⁻⁶⁾. Among the health professionals who provide care in this scenario, the nursing team is the category directly involved in the care of children, adolescents, and their families in different health services, from primary care to reception in the Family Health Strategy (FHS) to specialized mental health services, such as the Child and Adolescent Psychosocial Care Center (CAPSi), which offers effective care through prevention, promotion and psychosocial rehabilitation actions for adolescents who practice self-mutilation and their families^(3,7).

In this context, nursing plays an extremely important role^(3,7). During health and nursing care at the FHS, nurses can establish a bond with the adolescent and their family, a crucial strategy in mental health assessment, and identify early signs of self-injury, providing instant care and the necessary interventions, such as referral to the specialized service offered at CAPSi⁽³⁾. It also plays an important educational and awareness-raising role on the subject and its risk factors for this audience⁽⁷⁾.

In this respect, there is still a gap in the scientific literature on the risk factors that influence self-harm behavior among adolescents according to gender⁽⁵⁾. Also, considering the complexity involved in the process of adolescence and the vulnerability to mental illness at this stage of life, it is essential to develop research that approaches the narratives elaborated by female adolescents, with a view to understanding, filling the gap, and generating knowledge about the factors that influence this behavior. This knowled-

ge has the potential to support health managers and professionals, including the nursing team who are directly involved in caring for children, adolescents, and their families, in developing strategies that take into account the specificities of this social group.

In view of the problem presented, the research question was: what are the factors that influence the practice of self-mutilation in the perception of adolescents? To answer this question, this study aimed to describe the factors that influence self-mutilation behavior from the perspective of female adolescents.

Methods

This is a qualitative study that used the Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item checklist, as a guide. The research was carried out from April to June 2023 in a modality I Psychosocial Care Center (CAPS), located in a municipality in the interior of the state of Mato Grosso, Brazil, which treats patients of all age groups who present intense psychological suffering due to severe and persistent mental problems, including adolescents with self-harm behavior.

The participants were adolescents treated at CAPS I, selected using the convenience sampling technique according to the inclusion criteria: having practiced self-harm in the last year and being between 10 and 19 years old, the adolescent age cycle established by the World Health Organization (WHO). Exclusion criteria were those who were under the effect of sedative medication at the time of data collection. At the time of data collection, the service had a register of 11 adolescents being monitored for self-harm. However, three were excluded because they had not practiced this behavior in the last year. Of the remaining eight adolescents, five females were identified and located and, after being invited, agreed to take part in the study.

For the fieldwork, we opted for the data triangulation technique, with a view to covering the maximum breadth of understanding of the object under in-

vestigation⁽⁸⁾ using the techniques of semi-structured interviews, observation, and document analysis. Initially, the fieldwork was carried out through regular visits to CAPS I, with the aim of establishing contact with the professionals and the adolescents monitored by the service. One of the researchers, a nursing undergraduate with no professional ties to the service, then identified five adolescents who were being cared for and agreed to take part in the research. Documentary analysis was carried out by accessing the medical records to confirm that they met the inclusion criteria and also to collect the following information: gender, date of birth, schooling, use of alcohol or other drugs, family type, medical diagnosis, and respective International Classification of Diseases (ICD-10), as well as the use of medication.

The researcher then took part in a preparatory workshop on interviews in qualitative research conducted by one of the researchers, who has a master's degree and experience in conducting qualitative interviews. Afterward, the researcher returned to the service on the date and time of the adolescents' next appointments, as scheduled by the service. When she found them, she invited each adolescent and their legal representative to take part in the study. After both had accepted and signed the Free and Informed Consent Form and the Assent Form, a semi-structured interview⁽⁹⁾ was carried out individually in a reserved room at the service.

During the interview, the researcher guided the dialog using a script made up of open and closed questions, based on the Functional Assessment of Self-Mutilation (FASM) scale⁽¹⁰⁾, translated into Brazilian Portuguese. The scale addresses questions about the experience of self-mutilation behavior, as well as factors that trigger this practice. The five interviews lasted an average of 40 minutes and were closed according to the saturation criterion established by the richness of the data, which should present intricate, detailed, and nuanced layers about the phenomenon under investigation⁽⁹⁾. The narratives were recorded using a cell phone, resulting in a total recording time

of 03h46 minutes. The interviews were later transcribed, but due to the adolescents' inconsistent attendance at scheduled appointments at CAPS I, it was not possible to have them validated by the adolescent participants.

Finally, using an "observer-as-participant" observation technique⁽⁹⁾, the researcher observed the participants during the interview, a moment considered important for the purposes of the research. Immediately after the interviews were completed, observation notes were recorded with the researcher's impressions of the interviews and the adolescents' behavior, as well as their non-verbal communication (voice intonation, gaze deviation, gestures, and facial expressions), and their dress.

To organize the data, all the empirical material collected was typed into a research diary⁽¹¹⁾, which contains information from the documentary analysis, transcripts of the interviews with the full narratives, and records from the observation. The corpus of analysis for this study was a file, typed in Word, with 135 pages. A thematic content analysis was used, which was reviewed and discussed by two researchers independently. The analysis was then organized, coded, categorized, and inferred⁽¹²⁾. Disagreements between the researchers were resolved through dialog and critical analysis, in order to reach a core of meaning with the agreement of both. This procedure led to the emergence of two thematic categories: self-mutilation

behavior and the influence of the family context; and self-mutilation as a relief from emotional suffering.

In order to guarantee the confidentiality of the adolescent participants, the acronym AD was used, derived from the term adolescent, accompanied by a number from 1 to 5, according to the order in which the interview took place: AD 1, AD 2, AD 3, AD 4 and AD 5. The Human Research Ethics Committee of the State University of Mato Grosso approved the research with opinion number 5,895,417/2023 and Ethics Appreciation Certificate 66686823.5.0000.5166.

Results

Five female adolescents took part in the study, aged between 14 and 17, most of them self-declared to be of non-white skin color (black or brown), students, and not using alcohol or other drugs. It is worth noting that all the participants had a psychiatric diagnosis, but only three of them were undergoing drug treatment.

In terms of family type, one adolescent came from an institutionalized family, one came from a substitute family, one came from a consensual union and two adolescents came from female single-parent families. As for the part of the body injured, the arm was the most frequent region (5/5), from cuts with sharp materials (4/5). It should be noted that all the adolescents had scars resulting from self-mutilation at the time of the interview (Figure 1).

Characteristics	Adolescents				
	1	2	3	4	5
Gender	Female	Female	Female	Female	Female
Age (years)	17	15	14	14	14
Race/color	White	Brown	Brown	Black	Brown
Schooling (years)	3rd year of High School	High school	9th-grade Elementary school	1st year of high school	9th-grade Elementary school
Use of alcohol or other drugs	No	No	No	No	No
ICD-10	F43.1: Post-traumatic stress disorder	F41.2: Mixed anxiety-depressive disorder / F60.9: Unspecified personality disorder	F43.1: Post-traumatic stress disorder	F60.3: Personality disorder with emotional instability	F32.8: Other depressive episodes / F43.1: Post-traumatic stress disorder

(the Figure 1 continue in the next page...)

Characteristics	Adolescents				
	1	2	3	4	5
Use of medication	No	Yes	No	Yes	Yes
Family type	Shelter for minors	Partner	Other family	Mother	Mother
Parts of the body usually injured	Arms	Arms and legs	Palmar region and arms	Arms	Arms
Ways and means used	Cut; Sharp object (sharpener blade)	Cut; Sharp object	Cut; Sharp object (shard of glass)	Cut; Sharp object (blade)	Scratches; Nails
Scars in the interview*	Yes	Yes	Yes (recent)	Yes	Yes

*Notes: ICD-10: International Code of Diseases

Figure 1 – Characterization of the adolescents participating in the study. Diamantino, MT, Brazil, 2023

After the content analysis process, the senses and meanings of the participants' narratives were grouped into nuclei of meaning and then into two thematic categories, which revealed, based on the experiences of the adolescents taking part in the study, the factors that influenced their self-mutilation behavior.

Self-mutilation behavior and the influence of the family context

The results revealed that the family context was a factor that influenced the adolescents' self-mutilation behavior. According to the participants, the feeling of family rejection was present in their narratives. This was related to the abandonment of their parents in childhood, recognized as a traumatic situation that caused emotional suffering: *Sometimes I get a bit distressed thinking that he [referring to the father] didn't want to accept me. Only me, you know? The rest, his other children, he wanted them, only me he didn't (AD 2). Then my mother didn't want me. Neither did [my father], nobody wanted me! ... I feel all [this] because I think I'm rejected, because my parents didn't want me. And I wanted to be with them at a time like this, but they didn't want me! (AD 3).*

Notes on AD 3 indicate that she was a very depressed teenager, and showed that she had a sentimental wound when she reported that she had been rejected by her parents and excluded from the house where she lived. She showed herself to be very needy of the family relationship but revealed that she was

unable to obtain this bond where she was living.

Among the situations involving the family, exposure to violence stood out in the narratives of the adolescents taking part in this study. Different types of violence were highlighted, such as psychological, physical, and sexual, to which the adolescents were exposed in the family environment: *And in that beating he [referring to his father] gave me, I told my aunt that he had been abusing me since I was nine and that my mother knew and that my mother didn't do anything. ... And she [referring to her mother] always beat him up. He's already broken her tooth, he's already stuck a knife in her, and she almost lost her first set of twins because of being beaten by him (AD 1).*

The observation notes on AD 1 state that, according to the adolescent, her parents were the cause of her self-harm. The family breakdown affected her life, while the sexual abuse suffered since childhood influenced her behavior in adolescence. When she was asked about her family relationships, it was noticeable that the paternal and maternal figure/presence, as well as the recollection of childhood memories, made her emotional, tearful, and hurt.

Still, on the subject of sexual violence, another teenager recalled: *She [referring to her stepmother] used to leave me alone, so when I asked for something, she would give it to me, but she would fall for the illusions of my older siblings, right? And then she started mistreating me in the house. ... He [referring to the stepmother's husband] abused me at home, when she was working (AD 3).*

Other notes about AD 3 indicate that the participant manifested a feeling of rejection, having been the victim of family neglect, abandonment, and parental scorn during her childhood, which led to an emotional wound. The sadness on the participant's face and her difficulty in dealing with this situation were notorious. The fact that she grew up in an environment that didn't provide affection, or even care that is fundamental to a child's life and that she was abused from a young age, caused revolt. It was also noted that she had not yet overcome these traumas, which led her to self-mutilate frequently.

Another aspect of the family context that enhanced the practice of self-mutilation involved the daughter's relationship with her father. Two adolescents related the manifestation of this behavior to the distancing from the father figure, which occurred due to the death of their father: *When he died, my mother, I don't know, like at his wake, my mother said: "I couldn't take it anymore, and stuff". Then she went into despair. Then, when she despaired, I despaired too* (AD 4). *And since I also lost my father at a very young age [he died], I didn't live with him for moments... as father and daughter. So I think that also caused it [referring to self-mutilation]* (AD 5).

The results presented in this category point to aspects influenced by the family context as a potential factor in the occurrence of self-mutilation behavior in adolescence. However, these traumatic situations experienced within the family led to emotional manifestations, which will be explored in the next category.

Self-mutilation as a relief from emotional distress

In this study, the adolescent participants also reported that one of the main factors influencing their decision to self-mutilate was the need to escape from bad thoughts. Among the narratives, the need to deal with emotional suffering, manifested by despair and the need to forget traumatic situations, experienced mainly in the family context, still in childhood, were highlighted, according to the following reports: *Thinking about the past, you know, that silly minute we have to think*

about life? That was it... And I started remembering the past, my brother who had passed away, my father. I started to Judge God because I said: if there is a God, why is this happening to me, why did he let it happen? Then I did it!" (AD 1). *I think I felt very alone. Then ... the bad thoughts came that I wasn't enough, if nobody wanted to be my friend or didn't want to have anything to do with me, it was because I ... was wrong... Normally, when I'm in the middle of an anxiety crisis, I have a thousand thoughts, so to distract myself from the thoughts I do this* (AD 2).

In addition to these narratives, two other adolescents also stated that the practice of self-mutilation was directly related to the frequent occurrence of bad thoughts: *I try to think about the things that have happened to me, good things, some parts. But the rest is all things, thoughts, bad things that happened to me in the past. ... Because it [referring to self-mutilation] makes me forget. But then I even think it does, like forgetting, I don't forget, because it's no use, the thought comes back again, then you're stuck there* (AD 3). In the notes on AD 3's observation, it was noted that there was substantial suffering in her speech, due to the psychological traumas, the abuse suffered since childhood, and the fact that she didn't feel part of the family she was part of at the time of the interview. She showed a very deep sadness on first contact and remained downcast throughout the interview: *Because I feel a lot of despair at the time, like, I might be normal, but a lot of bad thoughts come up. So I feel a lot of despair and the urge to scratch myself is very strong. So I just go and scratch myself and then I go to sleep and pretend nothing happened the next day* (AD 5).

For the adolescents, self-mutilation was carried out to achieve a feeling of relief. The narratives indicated that the practice of this behavior was closely related to emotional issues. For this reason, they looked for strategies to momentarily relieve the pain and obtain emotional satisfaction, with a sense of well-being, as the following statements highlight: *Because it's a relief at the time. But the pain won't go away! It will only cover a hole... At the moment it goes away, then it doesn't!* (AD 1). *Because I feel relieved, I don't know, I find it satisfying, I don't know!* (AD 4). *Oh, it's bad, isn't it? Of course, it is! But because I feel a sense of relief, I only do it again when I'm desperate and anxious* (AD 5). Notes on AD 5 show that the participant reported situations that

made her sad. At one point during the interview, she couldn't hold back her tears and cried, expressing her psychological distress.

Also according to the adolescents' experiences, this behavior was carried out as an attempt to regulate emotions. The participants reported feeling anger, anguish, and hatred in relation to the traumatic situations they had experienced, as the following statements reveal: *I got angry at everything! The children, any child who spoke to me, I was swearing at, hitting, it was a very discordant time in my life, you know? And the day I did that, it was late afternoon, I went into my room, locked the door, I got very angry, very hateful, you know that hate in my eyes? (AD 1). I can't explain it. It's a feeling, in this case, it's like an anguish that keeps pounding on your mind (AD 2).*

Other emotions expressed included a sense of despair and bouts of anxiety: *I just felt like it and it was in the early hours of the morning. I was very desperate. So I just felt like it and started scratching myself. Because I didn't ... want to cut myself, so I just scratched myself, really hard (AD 5). I feel ... hatred, and despair and I have ... also ... anxiety attacks. I get that anxiety, then I have nothing to do, then I immediately turn to my body, and I consider doing everything in my body (AD 3).* It was possible to infer from observing AD 3 that she carried out the behavior of self-mutilation because she was unable to cope with the emotional difficulties she was going through.

In practice, this behavior was carried out by the adolescents impulsively. According to the experience of one participant, at the time of self-mutilation, impulsiveness became an aspect that enhanced the practice: *Because most [teenagers] do it in a moment of crisis, they don't think too much about it. ... It's impulsive! ... I used to do it more impulsively (AD 2).*

Another aspect highlighted was the difficulty in accepting one's own image. The narratives indicated difficulty in perceiving value in themselves and also dissatisfaction with their self-image, generating emotional fragility: *I look at myself and feel nothing! People don't even say I'm beautiful... that my skin is beautiful. I don't accept myself! I don't like myself! I don't like my skin, I don't like my hair, I don't like anything about me. ... Because I don't think I'm beautiful and I never will. I don't like my body... that's why I cut myself (AD 3). AD*

3's notes also add that the participant showed a deep sadness in her face and dissatisfaction with her image: *I had the 'lesche' [Leishmaniosis] in 2021... This is a spot from it, a scar. I had it on my nose and my foot too, it's all scarred. I didn't know it was one, so it started out as a little ball. As it grew, it kind of deformed my mouth, you know? My mouth got crooked and a lot of wounds started appearing on my foot. So, as my nose was full of little balls like that, I could barely look at myself in the mirror, and that really took its toll on my psyche (AD 5).* Notes on AD 5 reveal that leishmaniosis left scars on her face, between her nose and lips. This made her unhappy with her physiognomy and she didn't like to look at herself in the mirror.

Finally, it was shown that, in addition to the family context, the different feelings expressed by the adolescents and the need to relieve the emotional suffering involved in this scenario influenced the manifestation of self-mutilation behavior, considered as an alternative to escape and relief.

Discussion

This study was carried out considering the perception of female adolescents who had a history of self-harm and were being monitored by a mental health referral service, with mostly self-declared black or brown skin color, psychiatric diagnoses, and different family types. Corroborating these characteristics, scientific evidence indicates that the occurrence of self-harm has been more frequent among female adolescents^(2,13-14), with an estimated ratio of 2.6 girls to one boy⁽¹⁵⁾. In addition, female adolescents are 2.21 times more likely to commit suicide than male adolescents⁽¹⁶⁾.

The participants' experience highlighted the family context as a potential factor for the occurrence of self-mutilation behavior, with the experience of rejection, abandonment, exposure to violence, and distancing from the father figure. It is known that traumatic experiences in childhood have been recognized as an important risk factor associated with the practice of self-injurious behavior in adolescence^(5-6,17-20). Corroborating these findings, neglect, abuse, and violence

during childhood in the context of the family environment have been identified as risk factors for self-harm in adolescence⁽⁵⁾.

In this respect, traumatic experiences suffered in childhood have also been pointed out as influencing this behavior in adolescence^(10,17). Loneliness has been associated with the prevalence of self-mutilation among adolescents⁽¹⁰⁾ and it has been revealed that difficulties in family life affect the practice of self-mutilation, including the presence of family conflict, lack of family support, parental separation, maternal rejection, and the use of alcohol and other drugs in the family⁽³⁾. In addition, when checking the relationship between traumatic events in childhood and the occurrence of self-injurious behavior in 494 adolescents, it was found that among those who had a history of exposure to emotional, sexual, and physical abuse, the chances of self-injury were twice as high when compared to those who were not exposed to these types of violence⁽¹⁷⁾.

Specifically in the international context, there has also been a positive association between aspects related to the family and the occurrence of self-harm in this group, such as rejection by parents, little emotional affection, maternal overprotection⁽¹⁸⁾, and lack of trust in family members⁽¹⁵⁾. Also in this regard, exposure to maltreatment in childhood, such as emotional abuse and neglect, has been pointed out as a factor that increases the propensity of adolescents to practice self-mutilation behavior⁽¹⁹⁾.

Adolescents who have been exposed to traumatic situations in childhood, such as the death of close family members, different forms of violence, and intra-family conflicts, are vulnerable to emotional distress⁽⁶⁾. In addition to the family context, the emotional suffering of the adolescent participants was highlighted as a factor influencing the occurrence of self-mutilation behavior. The narratives and memories of the participants highlight the need to regulate emotions, seeking to escape from bad thoughts and impulsively reaching for a sense of relief from feelin-

gs such as anger, anguish, anxiety, hatred, despair, and poor self-image.

In adolescence, emotional distress can be triggered by negative emotions such as anger, guilt, anguish, anxiety, sadness, grief, worthlessness, negative body image, loneliness, impulsiveness, stress, and emptiness^(1,10,13,20-22). As a way of releasing the psychic tension generated by emotional suffering, adolescents often resort to self-mutilation, which can be a form of communication reflected in action that relieves this suffering, even if only momentarily^(13,20). In some situations, adolescents can experience such intense psychological suffering that the physical pain caused by self-mutilation appears to relieve the emotional pain⁽²²⁾.

Still in this sense, the practice of self-mutilation has also been carried out with the intention of regulating the emotions of the adolescent participants, since the behavior was conceived as a compensatory strategy to deal with and regulate distressing emotions, especially to relieve thoughts or feelings^(10,13,22-23). Therefore, its manifestation should be interpreted as a sign that something is causing emotional distress, and its practice seeks to alleviate negative feelings experienced by the adolescent^(22,24-25).

In relation to the emotional vulnerability that children, and later adolescents, can experience, it is important to establish protection strategies. In this context, positive family relationships, represented, for example, by strengthening the bond between parents and children, are shown to be a protective factor⁽⁵⁻⁶⁾, because in circumstances where families are based on affection, non-violent communication, and trust, there is a greater propensity to protect the mental health of adolescents⁽⁶⁾. In addition to aspects involving the family, having life satisfaction, coping skills and resilience, social support, establishing friendships, good performance and a positive experience at school, quality sleep, and involvement with religion were often highlighted as protective factors against the occurrence of self-harm among adolescents⁽⁵⁾.

With regard to nursing, it is essential to recognize that these professionals play a crucial role in assisting adolescents and their families. Knowledge of the factors that can influence self-harm behavior in adolescence is essential for identifying adolescents at risk. This enables emotional support to be offered to both adolescents and their families, as well as leading to appropriate management, without judgments or stigmas that could hinder early identification of cases and longitudinal care⁽²⁶⁾.

It is important to emphasize that nursing work should consider various contexts for promoting mental health and caring for self-harm, including the family and the school. These are key spaces for implementing strategies to prevent and reduce mental suffering in this population⁽²⁴⁻²⁵⁾. The results of this study corroborate the understanding of how the family relationship was an influencing factor in the self-harm behavior experienced by the adolescent participants, reinforcing the current scientific discussion about this growing phenomenon, which has also pointed to family factors such as conflicts, domestic violence, divorce, and death as influencing its occurrence⁽⁷⁾. It is necessary to mitigate these factors and encourage the development of interdisciplinary and intersectoral coping strategies to provide comprehensive care for children and adolescents in situations of emotional distress, and those most at risk of self-harm among adolescents and young people^(2,17).

Study limitations

The study was carried out looking specifically at the experience of female adolescents treated at a single health service. In order to achieve a more comprehensive understanding of the phenomenon, it is necessary to carry out investigations that take different health services as a backdrop and also involve more adolescents, including males, since such studies could indicate differences between the genders in the factors influencing this behavior.

Contributions to practice

The study makes fundamental contributions to health professionals, as well as to the nursing team, which is directly involved in caring for adolescents and their families. It is essential for nurses to develop skills and abilities that involve understanding self-mutilation behavior as a way of communicating emotional suffering. The factors that influence this practice need to be considered and addressed by the nursing team in order to provide quality and effective care, with actions for the prevention, promotion, and psychosocial rehabilitation of adolescents who self-mutilate and their families. Therefore, nursing needs to act in an interdisciplinary and intersectoral approach, establishing partnerships with schools, for example, an important space for early identification and intervention in the practice of self-harm in adolescence.

Conclusion

The study made it possible to describe the factors that influence self-mutilation behavior in the perception of female adolescents. Based on the participants' experience, it was found that situations experienced in the family during childhood, such as rejection, abandonment, violence, and paternal distancing, as well as the emotional suffering manifested in adolescence, were influential in the practice of self-mutilation. There was an increase in concern about the child's emotional development and its repercussions during adolescence, as well as the contribution of the family context in this process.

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Authors' contribution

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