

Deliberate Self-Harm in Children- A Growing Problem

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Pattison and Kahan first described 'deliberate self-harm' as a syndrome in 1983 [1]. The typical pattern described was that of onset in late adolescence, multiple recurrent episodes, low lethality and harm deliberately inflicted upon body. Most authors distinguish between deliberate self-harm and suicide, based on the absence or presence of the apparent intent to kill oneself. While others use it as an all encompassing term that includes a wide range of behaviors ranging from attempted hanging to superficial cutting [2]. Regardless of the definition, it is known that a prior attempt of deliberate self-harm is one of the strongest predictors of future completed suicide [3]. While much has been talked about suicide attempts and acts of deliberate self-harm among adolescents, there is a relative paucity of research evidence regarding acts of deliberate self-harm amongst children under the age of 13 [4]. A study by Sourander, *et al.* [5] suggested that deliberate self-harm among children is a herald for self-harm behavior in adolescents

In the current issue of *Indian Pediatrics*, Krishnakumar, *et al.* [6], report a study where 30 children, aged 6 to 13 years were followed up in the Child Guidance Clinic after being admitted to the inpatient pediatric unit for attempted self-harm. This is one of the first studies that focuses specifically on children less than 13 and does not target children and adolescents as a mixed group. Consenting parents and children were interviewed using the concerned part of NIMH DISC and child informant interview. Stressors were categorized as acute, chronic and acute on chronic, as well as on the basis of source of stress as parent, family, school, peer and teacher related. Children whose act of self-harm was

considered to be an act of suicide attempt were further subcategorized and were analyzed separately. 73% of this subgroup had some kind of a psychiatric disorder (depressive disorder, ADHD and conduct disorder). The male to female ratio was 2.3:1. The most common method used was self-poisoning. 24% of the children had learnt about suicide by watching television. The authors concluded that the self-harm behaviors and the associated risk factors in this young population were similar to those in adolescents.

In several ways the results of this study are consistent with those in existing literature. The authors cite certain regional and cultural factors possibly contributing to some of the results. Some differences from western studies are noted, including a male preponderance, and absence of substance use and sexual abuse as possible associated risk factors [7]. Taboo of mental illness and deliberate self-harm, neglect of the girl child all leading to underreporting and overall lower prevalence of substance use and sexual trauma in rural South India could explain some of these differences.

As the authors note, their data possibly represent only the tip of the iceberg; deliberate self-harm is slowly becoming a public health problem. There is an increasing need to educate not only pediatricians but also parents and school teachers to identify early signs of depression and anxiety in young children. Since routine annual physical examinations are not a norm in India, the responsibility of teachers and parents is even greater. Moodiness, sadness, academic decline and social withdrawal may be early signs of an underlying mood disorder in children [8]. Early identification of symptoms and

timely intervention is one of the best preventive measures on self-harm and suicidal behaviors. It is a myth that talking about suicide increases risk of suicide. Curtailing the access to media and better parental supervision and guidance during media viewing can also minimize self-harm in young children.

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