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Evaluation of stress coping styles and emotional intelligence in psychiatrically treated, self-harming adolescent patients with selected reference clinical features

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Summary

The primary goal of the study was an evaluation of dominating stress coping styles in adolescent patients with self-harm records, who were psychiatrically treated, taking into account the level of their emotional intelligence vs. the psychiatric diagnosis, the type of motives and decision involved in self-harming and the presence of suicidal attempts (SA) in the past. The secondary goal included an analysis of the correlations between particular stress coping skills and the level of emotional intelligence.

Material and methods: The reported studies involved self-harming patients, aged of 13-18 years during their psychiatric hospitalisation (N = 31). The applied tools included the Coping Inventory for Stressful Situations (CISS) and the Two-Dimensional Inventory of Emotional Intelligence (DINEMO).

Results: An evaluation of the correlation between stress coping styles and the levels of emotional intelligence in the studied group and the types of mental disorders did not reveal any significant differences between the evaluated subgroups. Patients, who confirmed an instrumental motive, obtained statistically significantly higher scores on the task-oriented scale vs. those who performed the acts of DSH for reactive or pathological reasons. Taking into consideration the type of decision, involved in self-harming acts, did not demonstrate any differences in the stress coping styles of the patients, however, those patients, who had planned an act of DSH, achieved statistically significantly higher scores in the OTHERS scale of the DINEMO. Patients with DSH and with SA in the past (77% studied group), achieved similar results in CISS and DINEMO vs. the self-harming patients without SA in the past. In the study group, one statistically significant correlation was demonstrated between CISS – the avoidance-oriented style – and the I in DINEMO.

Conclusions: 1. Patients with DSH records and without SA constitute a fairly uniform group with regards to stress coping styles, taking into account the type of psychic disorders and the urgency of self-harm decision. 2. Their use of the task-oriented style may be associated with

instrumental auto-aggression. 3. DSH may be a non-verbal form of communicating problems to others. 4. Adolescents, who perform the acts of self-harm, are endangered by suicidal attempts, regardless of their stress coping styles or the level of their emotional intelligence. 5. A development of constructive stress coping skills against strong emotional reactions is a recommended method in the therapy of patients with DSH.

Key words: stress coping styles, emotional intelligence, deliberate self-harm

Introduction

Despite preventive actions, undertaken in Poland during the recent years, it has not been possible to reduce the incidence of deliberate self-harm (DSH) without suicidal intent among hospitalised psychiatric adolescent patients, the incidence rate still remaining at the level of 30%-40% [1,2]. British studies [3,4] have demonstrated that the subjects, who attempt multiple acts of self-harm, more often die from suicide than subjects from a control group. Moreover, it is generally assumed that, in case of deliberate self-harm in youth, it is rather difficult to unequivocally exclude suicidal intentions in subjects of this age group, mainly for their emotional ambivalence [5]. Polish psychiatrists, who hospitalise teen-agers for deliberate self-harm, do not as a rule, take into account these behaviours in the diagnosis, specified in the discharge report. It has serious clinical implications since, on one hand, deliberate self harm is not highlighted as a significant risk factor of suicide in a developmental population, while discharging psychiatrists do not prompt further therapy to be oriented towards this particular type of behaviour. Neither in DSM IV – TR [6] nor in ICD 10 [7] is there any separate category for psychiatric disorders, otherwise defined as the deliberate self-harm syndrome (DSHS), while multiple DSHs are identified as a symptom of borderline disorders, impulse control disorders or as a behaviour, additionally encoded with X (deliberate poisoning or body injuries, including suicide), see ICD 10, Chapter „External causes of disease and death”. Almost 30 years ago (1984), both Kahan and Pattison already acknowledged a need to distinguish DSHS at Axis I of DSM (Diagnostic and Statistical Manual of Mental Disorders) [8,9]. In the suicidological studies of the recent years, a clear

tendency has emerged towards a separate evaluation of DSH with or without suicidal intent [10, 11, 12]. In the English language medical literature, DSH without suicidal intent is referred to as 'non-suicidal self-injury' (NSSI). This status quo allows developing official management standards, oriented towards treatment of the disorders as either primary or concomitant. DSH often occurs in children and adolescents with externalisation disorders and are included in the diagnostic criteria of borderline personality disorders (identified after the 18th year of life) [7, 10]. In certain studies, no relationship was demonstrated between the occurrence of DSH and the type of psychic disorders [1]. If subsequent DSH events are attempted by a teen-ager without psychotic or severe affective disorders, psychotherapy becomes the treatment of choice, mainly in the cognitive-behavioural approach [13,14]. An identification of psychological mechanisms may facilitate the selection of effective therapeutic strategies. Many DSH confirming patients were in the past exposed to a number of various stressors, especially physical abuse [10]. It is known that DSH is often a kind of response to stimulated stress axis, their purpose being tension discharge [15]. Endler and Parker [16] have described the following three stress coping styles: 1/ task-oriented style (by cognitive transformation or attempted situation change), 2/ emotion-oriented style (i.e., anger, sense of guilt, with an attempt to decrease emotional tension), 3/ avoidance-oriented style (recourse to others by involvement in substitute activities, such as shopping or search for social contacts). The results of some – so far scarce – studies indicate that the level of emotional intelligence may also be associated with the occurrence of autoaggressive behaviours in youth [17], as they demonstrate, among others, problems with emotion control. A normal emotional development, translating to emotional competences, is often responsible for coping with problem or stress situations.

Thus, important for clinical doctors may be an answer to the question, whether the acts of DSH, which are undertaken under the influence of various motives and with different

premeditation, by adolescents with different psychiatric diagnoses and possible suicidal attempts in history, remain in any correlation with the dominating stress coping styles and the level of emotional intelligence. Solving the question if the DSH performing patients are a uniform group or if they differ among one another in selected ranges, may be an important indication for planned therapy.

The goals of undertaken studies included: 1/ an evaluation of dominating stress coping styles in adolescent patients with self-harm records, who were psychiatrically treated 2/ evaluation of emotional intelligence level – depending on psychiatric diagnosis, the type of motive and decision of DSH and the presence of suicidal attempts in the past; moreover 3/ a correlation between particular stress coping styles and the level of emotional intelligence.

Material

Thirty-one (31) patients were qualified to the study, their age ranging between 13 and 18 years (the study group – the mean age ± SEM: 16.61 ± 1.09 years, including 24 girls: 16.54 ± 1.10 years and 7 boys: 16.86 ± 1.7 years), hospitalised at the Department of Adolescent Psychiatrics of the Medical University in Lodz, Poland, in whom current self-harms were diagnosed in form of self-injuries without suicidal intentions.

Each patient was qualified to the study group after previous psychiatric consultation and excluding of psychotic or organic disorders and after IQ determination to be within the reference values.

The patients were qualified to the study with, at least, one act of self-harm within the last month, such as self-injury without suicidal attempts, attempted in the course of hospitalisation. It was accepted that the study group differentiating factors could include: psychiatric diagnosis according to ICD 10 [7], the type of motive and decision involved in DSH and suicidal attempts in history.

Method

Two psychological tools were used in the study:

1/ The Coping Inventory for Stressful Situations (CISS) by Endler N.S., Parker J.D.A. [18] in the Polish adaptation of Szczepaniak P., Strelau J. and Wrześniewski K. [19]. This questionnaire has been designed to diagnose stress coping styles and consists of 48 statements, concerning various behaviours which may be undertaken in stressful situations. The self-writing form (CISS questionnaire) allows determining subject's action in response to stress. Using a 5-step scale, the examined subject selects the frequency of undertaking a given action in difficult and stressful situation. The results are configured in three scales:

1. SSZ – task-oriented style;
2. SSE – emotion-oriented style;
3. SSU – avoidance-oriented style.

This style may demonstrate two forms: ACZ – involvement in subsidiary activities (SSU-ACZ) and PKT – search for social contacts (SSU-PKT).

2/ The Two- Dimensional Inventory of Emotional Intelligence (DINEMO) by Matczak A., Jaworska A., Ciechanowicz A., Stańczak J. and Zalewska E. DINEMO [20] has been designed to measure the basic components of emotional intelligence, such as the ability to get access to own and other's emotions, their respect and understanding of their functions. Salovey and Mayer's concept has been the theoretical foundation for the tool design.

DINEMO includes the following scales:

OTHERS scale – the ability to identify, understand and respect the emotions of other people.

I scale – the ability to identify, understand and respect own emotions.

Data, concerning DSH, were archived in a special „Questionnaire for self-harm evaluation". It contained questions on the performed acts of self-harm without suicidal intentions, at the time of enquiry and before [1,2,21], as well as on suicidal attempts in history. The questions also addressed the following issues: the motives for DSH undertaking (instrumental, reactive, pathological), the type of decision, when undertaking self-harm activity (impulsive, planned) and psychiatric diagnoses according to ICD 10 for examined patients (affective disorders: F30-39, neurotic disorders, stress-related and somatic: F40-48 and behaviours and emotions starting usually in childhood and adolescence: F90-98).

A review of literature was the base for the design of questions, providing independent variables, most frequently repeated in available reports. All the patients were evaluated by the same group of researchers with clinical experience.

A statistical analysis of obtained results was performed with the use of the following tools:

- W Shapiro-Wilk's test – evaluation of the normality of variables;
- Student' t test or U Manna-Whitney's test for two independent variables.

The results have been presented as arithmetical means ± standard error of arithmetic mean ($\bar{x} \pm SEM$). Spearman's correlation coefficient (R) or Pearson's correlation coefficient (r). The value of $p<0.05$ was accepted as the level of statistical significance. Statistical calculations were done with the *Statistica for Windows* 7.0 software.

Results

In the group of self-harming, adolescent patients (N=31), more than 2/3 (N=24) had performed more than 4 acts of DSH in their life, while the last episodes were most frequently impulsive in character. Affective disorders were the dominating diagnosis in the studied group of patients (14/31). Suicidal attempts in history were found in 24 examined patients (77%). The patients performed DSH acts most often by instrumental motive (20/31).

An analysis of the relationship between stress coping styles and the level of emotional intelligence in self-harming, teen-age patients and the type of their psychic disorders – with a division into 3 diagnostic groups: affective disorders, neurotic disorders and behavioural disorders – did not show any statistically significant differences among the evaluated subgroups – see Table 1.

Table 1. Analysis of the relationship between stress coping styles and the level of emotional intelligence in self-harming, teen-age patients and the type of their psychic disorders

	Diagnosis															Significance p
	affective disorders N=14					neurotic disorders N=8					behavioural disorders N=9					
	Mean	SD	Median	Upper quartile	Lower quartile	Mean	SD	Median	Upper quartile	Lower quartile	Mean	SD	Median	Upper quartile	Lower quartile	
Age	16.4	1.1	16.5	15.0	17.0	17.0	1.1	17.0	16.5	18.0	16.7	1.1	17.0	16.0	17.0	0.3832
SSZ	51.1	7.8	50.0	44.0	54.0	46.3	9.5	45.0	42.5	48.5	47.9	6.9	49.0	44.0	50.0	0.3138
SSE	54.0	6.8	53.0	49.0	58.0	54.6	10.8	57.5	50.5	61.5	56.8	9.2	55.0	54.0	63.0	0.7012
SSU	49.2	9.8	48.5	43.0	56.0	50.3	12.5	48.5	46.5	58.0	55.0	8.8	55.0	47.0	62.0	0.4928
SSU-ACZ	23.3	4.9	24.5	18.0	28.0	23.5	4.6	23.0	21.5	24.5	25.9	7.1	25.0	21.0	30.0	0.6624
SSU-PKT	17.3	3.8	17.5	14.0	19.0	17.0	5.5	17.5	15.0	20.5	18.9	3.1	20.0	17.0	21.0	0.5408
DINEMO	5.5	2.6	5.5	3.0	8.0	5.0	2.4	5.5	2.5	7.0	4.4	2.9	4.0	2.0	6.0	0.6288
Others	5.7	2.5	5.5	4.0	8.0	5.3	2.1	5.5	4.5	6.5	5.2	2.9	5.0	3.0	7.0	0.9301
I	5.0	2.2	5.0	3.0	6.0	4.4	2.3	5.0	2.5	6.0	3.8	1.6	4.0	3.0	5.0	0.3936

SSZ – task-oriented style; **SSE** – emotion-oriented style; **SSU** – avoidance-oriented style; **ACZ –** involvement in substitute activities (**SSU-ACZ**); **PKT** – search for social contacts (**SSU-PKT**); **DINEMO** – total score, **OTHERS** – the scale of interpersonal abilities, **I**- the scale of intrapersonal abilities

An analysis of examined patients with regards to the motives of performed DSH acts (see Table 2) has demonstrated that the patients, confirming the instrumental motive, achieved statistically significantly higher scores in the task-oriented scale vs. those who performed DSH for reactive or pathological motives.

Evaluation of the type of decision of performed self-harms by the examined patients – impulsive, planned DSH (see Table 3), does not show any differences with regards to used stress coping styles. In turn, the self-harming patients, who planned their acts, achieved statistically significantly higher scores in the OTHERS DINEMO scale than the patients self-harming by impulse.

Table 2. Analysis of the relationship between stress coping styles and the level of emotional intelligence in self-harming, teen-age patients and motive

	Motive															Significance p
	instrumental N=20					reactive N=6					pathological N=5					
	Mean	SD	Median	Upper quartile	Lower quartile	Mean	SD	Median	Upper quartile	Lower quartile	Mean	SD	Median	Upper quartile	Lower quartile	
Age	16,5	1,1	17,0	15,5	17,0	16,3	1,2	16,5	15,0	17,0	17,6	0,5	18,0	17,0	18,0	0,0696
SSZ	**51,4**	**8,5**	**50,5**	**44,5**	**56,5**	**42,7**	**5,8**	**43,5**	**42,0**	**46,0**	**46,4**	**3,1**	**48,0**	**43,0**	**49,0**	**0,0249**
SSE	55,0	8,2	54,5	48,0	61,0	52,2	11,1	54,0	51,0	57,0	58,4	6,1	58,0	57,0	58,0	0,4663
SSU	51,8	8,6	50,5	46,0	59,0	48,5	17,1	49,0	31,0	66,0	52,0	7,9	49,0	48,0	50,0	0,9168
SSU-ACZ	24,9	5,7	25,0	20,5	28,5	21,2	6,4	18,5	17,0	24,0	24,6	2,1	24,0	23,0	25,0	0,2746
SSU-PKT	18,0	3,2	18,0	15,5	20,0	16,7	6,9	18,5	11,0	22,0	17,6	4,0	15,0	15,0	19,0	0,9584
DINEMO	5,5	2,6	6,0	3,5	8,0	4,2	2,6	4,0	2,0	7,0	4,6	2,9	5,0	2,0	5,0	0,5118
Others	5,9	2,5	6,0	4,5	8,0	4,8	1,9	4,5	3,0	6,0	4,4	2,5	4,0	4,0	5,0	0,3279
I	4,6	1,7	4,5	3,5	5,5	3,7	2,3	4,0	1,0	6,0	5,2	2,9	6,0	4,0	6,0	0,5802

SSZ – task-oriented style; **SSE** – emotion-oriented style; **SSU** – avoidance-oriented style; **ACZ –** involvement in substitute activities (**SSU-ACZ**); **PKT** – search for social contacts (**SSU-PKT**); **DINEMO** – total score **OTHERS** – the scale of interpersonal abilities, **I**- the scale of intrapersonal abilities

Table 3. Analysis of the relationship between stress coping styles and the level of emotional intelligence in self-harming, teen-age patients and the type of self-harm decision

	Self-harm decision									Significance p
	Impulse N=24					Planning N=7				
	Mean	SD	Median	Upper quartile	Lower quartile	Mean	SD	Median	Upper quartile	Lower quartile	
Age	16.6	1.1	17.0	15.5	17.5	16.7	1.0	17.0	16.0	17.0	0.8434
SSZ	49.3	8.5	49.0	44.0	53.5	47.7	6.9	46.0	43.0	49.0	0.3938
SSE	53.9	8.2	55.5	48.0	58.0	58.6	9.1	54.0	52.0	68.0	0.3686
SSU	49.8	10.1	48.5	45.0	57.0	55.9	10.2	52.0	48.0	66.0	0.1854
SSU-ACZ	23.5	6.0	23.0	18.0	26.5	26.1	2.5	25.0	24.0	28.0	0.1291
SSU-PKT	17.5	4.1	18.0	15.0	20.0	18.4	4.2	17.0	15.0	22.0	0.7220
DINEMO	4.6	2.6	4.5	2.0	7.0	6.7	1.9	7.0	5.0	9.0	0.0604
Others	**4.9**	**2.3**	**5.0**	**3.0**	**6.5**	**7.3**	**2.1**	**8.0**	**5.0**	**8.0**	**0.0269**
I	4.3	2.1	4.5	3.0	6.0	5.3	1.8	5.0	4.0	6.0	0.3890

SSZ – task-oriented style; **SSE** – emotion-oriented style; **SSU** – avoidance-oriented style; **ACZ –** involvement in substitute activities (**SSU-ACZ**); **PKT** – search for social contacts (**SSU-PKT**); **DINEMO** – total score **OTHERS –** the scale of interpersonal abilities**, I-** the scale of intrapersonal abilities

Examined patients with DSH and with suicidal attempts in the past achieved similar results in the particular scales of stress coping and in DINEMO (the level of emotional intelligence) vs. self-harming patients without suicidal attempts in the past (see Table 4).

Table 4. Analysis of the relationship between stress coping styles and the level of emotional intelligence in self-harming, teen-age patients and suicidal attempts (SA) in the past

	After SA in the past N=24					No SA in the past N=7					Significance p
	Mean	SD	Median	Upper quartile	Lower quartile	Mean	SD	Median	Upper quartile	Lower quartile	
Age	16.5	1.1	17.0	15.5	17.0	16.9	1.1	17.0	16.0	18.0	0.5051
SSZ	50.3	7.0	49.0	44.0	53.5	44.3	10.4	44.0	34.0	48.0	0.0682
SSE	55.5	6.7	55.5	51.0	58.5	53.3	13.5	52.0	45.0	63.0	0.6361
SSU	52.3	9.3	51.0	46.5	60.0	47.3	13.2	47.0	37.0	60.0	0.3092
SSU-ACZ	24.1	5.4	24.5	19.5	27.5	24.0	6.3	23.0	17.0	30.0	0.7579
SSU-PKT	18.3	3.5	18.0	15.5	20.0	15.7	5.5	15.0	13.0	21.0	0.2650
DINEMO	5.2	2.5	5.0	3.0	7.0	4.7	3.0	4.0	2.0	8.0	0.7037
Others	5.4	2.4	5.5	3.5	7.5	5.6	2.9	5.0	4.0	8.0	0.9053
I	4.8	2.0	5.0	3.5	6.0	3.4	1.8	4.0	1.0	5.0	0.1317

SSZ – task-oriented style; **SSE** – emotion-oriented style; **SSU** – avoidance-oriented style; **ACZ** involvement in substitute activities (**SSU-ACZ**); **PKT** – search for social contacts (**SSU-PKT**); **DINEMO** – total score; **OTHERS** – the scale of interpersonal abilities, **I**- the scale of intrapersonal abilities

An analysis of correlation between stress coping styles and the level of emotional intelligence in self-harming patients (see Table 5) demonstrated a statistically significant, positive correlation between a more frequent use of the avoidance-oriented style and its version – search for social contacts – and the results obtained in the DINEMO I.

Table 5. Correlations between stress coping styles and the level of emotional intelligence in self-harming, teen-age patients

		SSZ	SSE	SSU	SSU-ACZ	SSU-PKT	DINEMO S	Others	I
SSZ	r		0.07	0.09	-0.01	0.24	0.30	0.23	0.31
	Significance p		0.7240	0.6250	0.9400	0.1890	0.0960	0.2170	0.0880
SSE	r	0.07		0.49	0.36	0.44	0.04	-0.05	0.22
	Significance p	0.7240		0.0050	0.0450	0.0130	0.8130	0.7710	0.2370
SSU	r	0.09	0.49		0.76	0.91	0.24	0.07	0.48
	Significance p	0.6250	0.0050		0.0000	0.0000	0.1880	0.7230	0.0070
SSU-ACZ	r	-0.01	0.36	0.76		0.61	0.15	0.00	0.35
	Significance p	0.9400	0.0450	0.0000		0.0000	0.4310	0.9860	0.0550
SSU-PKT	r	0.24	0.44	0.91	0.61		0.24	0.05	0.49
	Significance p	0.1890	0.0130	0.0000	0.0000		0.1850	0.7810	0.0050
DINEMO	r	0.30	0.04	0.24	0.15	0.24		0.89	0.71
	Significance p	0.0960	0.8130	0.1880	0.4310	0.1850		0.0000	0.0000
Others	r	0.23	-0.05	0.07	0.00	0.05	0.89		0.36
	Significance p	0.2170	0.7710	0.7230	0.9860	0.7810	0.0000		0.0490
I	r	0.31	0.22	0.48	0.35	0.49	0.71	0.36	
	Significance p	0.0880	0.2370	0.0070	0.0550	0.0050	0.0000	0.0490	

SZ – task-oriented style; **SSE** – emotion-oriented style; **SSU** – avoidance-oriented style; **ACZ –** ACZ involvement in substitute activities (**SSU-ACZ**); **PKT** – search for social contacts (**SSU-PKT**); **DINEMO** – total score, **OTHERS** – the scale of interpersonal abilities, **I**– the scale of intrapersonal abilities, r –Pearson's correlation coefficient

Discussion

According to some researchers [22], DSH performing subjects requires separate prospective studies, allowing for evaluation of repeated DSH predictors, e.g., passivity, avoiding problems (The Utrecht Coping List), and for undertaking appropriate prophylactic actions. McAuliffe et al. [23], while comparing patients, who had self-harmed themselves again, at least once a year from the evaluation at the first visit for DSH (so-called repeaters), with those who had not, demonstrated that the formed (1/5) had had a lower ability to generate alternative solutions of interpersonal problems (in the Optional Thinking Test). In that study, 2/3 of the patients, admitted for DSH earlier (i.e., before the first evaluation) had used to perform the acts. The fact was associated with a repeated DSH event in the course of one-year observation. In the presented group (N=31) of adolescent patients, a similar percent confirmed previous DSH events (>4 prior to inclusion into the study).

Since no prospective studies could be performed in that project, the researchers concentrated their attention on an analysis of selected clinical variables only. As each of the examined patients confirmed an experience of certain violence act in his/her life, the cases of physical abuse were not separately evaluated, although literature reports emphasise a distant relationship between abuse in childhood and later DSH episodes [10,12].

Psychological theories provide various explanations for the motives of autoaggressive behaviours, indicating, in this way, the type of recommended therapeutic intervention. In as much as in case of unequivocal suicidal behaviours the authors of various theoretical concepts treat then as either an escape from psychic pain and frustrated life needs (Shneidman) or a for of emotional deregulation (Linehan), cognitive changes (Beck) or biographic memory deficit (Williams) [15], an effect of personal correlates is emphasised in case of DSH, including impulsive behaviours [24].

Both the analysis, performed during the study, and earlier studies did not confirm any relationship between the occurrence of DSH and a specific diagnosis of psychic disorders [1,13]. Taking into account the character of applied psychological tools, the reported study did not consider patients with psychotic or organic disorders or those with mental impairment, thus the patients presented disturbances belonging to the 3 main diagnostic categories (F3, F4, F9). Despite that limitation, the obtained results may confirm the separate character of multiple DSH episodes in adolescents without suicidal intent when compared with repeated suicidal attempts, in which a strong relationship with depression diagnosis was demonstrated long ago [25]. No relationship was analysed in the study between the occurrence of DSH and personality disorders of the borderline type, since, for age reasons, none of the patients fulfilled all the criteria of the diagnosis. Probably, some of the studied patients with DSH and diagnosed behavioural disturbances in adulthood will meet the criteria of this disorder [10].

In performed studies, self-harming patients, who had confirmed the instrumental motive, achieved statistically significantly higher scores in the task-related scale vs. those who attempted self-harming for other indicated reasons (reactive or pathological). The result may confirm the adaptive role of deliberate self-harm. Numerous authors have shown that, beyond the knowledge of DSH conditions, in which they had been attempted, teaching the patients to develop more adaptive ways to cope with difficult situations and to increase their tolerance to stress and abilities to solve problems are the key conditions for effective treatment of self-harm inclinations [12, 26] [27]. In turn, Evans et al. [28] found out that adolescents with DSH concentrated less on the problem, while presenting more avoidant behaviours.

The results of presented studies have demonstrated that self-harming patients, who deliberately planned their behaviour, achieved statistically significantly higher scores in the DINEMO (Two-Dimensional Inventory of Emotional Intelligence) OTHERS scale than those,

who self-harmed by impulse. It appears from the studies of Klonsky [29] and Nock [10] that DSHs play an important role, among others, in affective control and interpersonal abilities.

The studies of Dougherty et al. [30] have proven that the adolescents, psychiatrically treated for DSH and with suicidal attempts (SA) in history, presented much more severe clinical symptoms, including signs of depression and the sense of helplessness, and a higher level of impulsiveness than those without SA in history. In the performed studies, the fact of SA in history did not reveal any significant relationship either with stress coping styles or with emotional intelligence levels. However, the patients with SA records highly prevailed among the studied subjects with DSH (77%) and more often demonstrated the task-oriented style than those without SA in history. It is then possible that, in case of higher numbers of patients in the subgroups, the differences could have attained statistical significance. It appears from certain studies that, from the clinical perspective, DSHs are the basis for suicidal risk evaluation, while from the perspective of an autoaggressive teen-ager, they can be perceived as the way of coping with negative affective conditions, such as anger, aggression or depression [31].

Despite the small number of patients with DSH in the studied subgroups, the applied statistical analysis allowed to indicate certain distinctions which (when verified in studies with larger populations and bigger financial support) may become the basis to design specific psychotherapeutic interventions and actions, with an emphasis on the development of constructive stress coping methods in the treated patients. In case of repeated impulsive DSH episodes, a behavioural training would be advisable, oriented towards teaching and exercising new abilities, especially in interpersonal contacts, i.e., externalisation of difficult emotions, verbalising the patients' problems, asking for help and looking for support. In case of patients, who are planning the acts of autoaggression, the use of functional resources of other subjects is recommended. Deliberately self-harming patients, who fail coping with their emotions and

who have a low ability to evaluate environmental resources, are often prone to imitate the dysfunctional ways of aggression discharge or other, negative emotions. The admission of large numbers of patients with similar coping strategies is associated with the risk of imitation, including the following of abnormal patterns of coping with psychic tension by skin self-injuries.

Conclusions

1/ Patients with DSH records and without SA constitute a fairly uniform group with regards to stress coping styles, taking into account the type of psychic disorders and the urgency of self-harm decision.

2/ The use of task-oriented stress coping style by self-harming teen-age patients may be related with instrumental auto-aggression.

3/ DSH may be a non-verbal form of communicating problems to others.

4/ Adolescents, who perform the acts of self-harm, are endangered by suicidal attempts, regardless of their stress coping styles or the level of their emotional intelligence.

5/ A development of constructive stress coping skills against strong emotional reactions is a recommended method in the therapy of patients with DSH.

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